

Chapter 6 Health Authorities

Introduction

- 6.1 Very few of the complaints of clerical child sexual abuse which the Commission has examined were made initially to the health authorities. The vast majority were made, initially, either to the Church authorities or to the Gardaí. The health authorities had relatively little involvement in the complaints which were made prior to the mid 1990s.
- 6.2 They did have an involvement in the 1988 complaint in relation to Fr Thomas Naughton. As is noted in Chapter 29, this is one of the few cases examined by the Commission in which the health board personnel took a proactive role in trying to prevent abuse. Their involvement in subsequent complaints was limited. Other people who were handling complaints, particularly the Archdiocese and the heads of religious orders, were under the impression that the health authorities had a much wider remit than they actually had.
- 6.3 The majority of complaints examined by the Commission were made by adults. This meant that, to a large extent, the role of the health authorities has been limited to offering complainants counselling and support services.
- 6.4 During the 1970s and 1980s, the government was well aware that the law on child protection was inadequate. The delay in devising and implementing amending legislation is quite extraordinary. When new legislation was finally implemented in 1996, it did not make any significant change in the role the health authorities could play in cases of extra-familial child sexual abuse. Guidelines for dealing with child sexual abuse have existed since 1983 but, again, they are not of major relevance to cases of extra-familial abuse or, indeed, to the reporting by adults of childhood abuse.
- 6.5 Major changes to the structure of the health authorities were made in 1970 and again in 2005 when the Health Service Executive (HSE) was established. Child protection services were developed over this period. They were mainly concerned with abuse within families and with trying to prevent children being put into residential care.

6.6 The HSE had considerable difficulties in providing the Commission with information relevant to its remit. This may be explained by the relatively minor role the health authorities played in dealing with clerical child abuse. However, the Commission is concerned that the information available to the HSE is not maintained in a manner which would facilitate a more active role. It is also concerned that other agencies rely on the HSE in circumstances where it does not have the capacity to respond.

The law on child protection²⁶

6.7 The need to update the law on child protection was clearly recognised well before the start of the period covered by this Commission, that is, 1975. However, no significant change took place until the 1990s. The delay in devising and implementing appropriate legislation, when the need for that legislation was widely recognised, was extraordinary. In the Commission's view, the law as it stands at present does not provide adequate powers to the health authorities to promote the welfare of children who are abused, or in danger of being abused, by people outside the family and, in particular, by people who have privileged access to children.

Children Act 1908

6.8 Until the *Child Care Act 1991* was fully implemented in 1996, the main legislation dealing with child protection issues was the *Children Act 1908* as amended.²⁷ The Children Acts provided the statutory framework for the industrial and reformatory school system. Under the Acts, the state was responsible for child welfare in cases where the parents or guardians were found not to be providing proper guardianship. This included physical neglect and abuse of children. In 1970, the Committee on Industrial and Reformatory Schools (generally known as the *Kennedy Report*) recommended, among other things, that a new updated Children Act be introduced but this was not done for over 20 years.

6.9 The *Health Act 1970* introduced changes to the structures for the delivery of health and social services but did not make any substantive

²⁶ A comprehensive description of the development of policy in relation to child protection is given in O'Sullivan Eoin, "Residential Child Welfare in Ireland 1965 – 2008" in *Report of the Commission to Inquire into Child Abuse* (Dublin: Stationery Office, 2009) (The Ryan Report).

²⁷ It was amended by the Children Acts of 1910, 1929, 1934, 1941 and 1957.

change to the law on child protection. It did not set out the powers of the health boards in relation to child protection. It was, wrongly, assumed by government and the boards themselves that they had powers to act as ‘fit persons’ for the purposes of taking children into care. It provided that the health boards were to carry out the functions conferred by the Act and the health functions which were formerly carried out by the local authorities but it did not enumerate these functions or the powers available to carry out such functions.

Attempts to change the law

6.10 The government was conscious of the need to update the law. The then Minister for Health told the Dáil on 23 October 1974 that the government had recently decided that the Minister for Health should have the main responsibility for children's services. He went on:

“I am immediately setting up a full-time task force, to report to me as soon as possible, on the necessary updating and reform of child care legislation and of the child care services. The group will comprise a number of outside experts and representatives from each of the Government Departments concerned with child care— Health, Education and Justice.”

6.11 Three years later, that task force had not reported. The Minister for Health, when asked if he intended to amend the *Children Act 1908*, replied on 5 April 1978 that *“The Task Force on Child Care Services will consider the up-dating and modernisation of the law in relation to children. This is likely to lead to new legislation which will involve replacement or amendment of the Children Act, 1908”*. The Minister went on to agree that there was a need for a new Act and that there was a degree of urgency about this.

6.12 On 28 June 1978, the Minister for Health said he was not aware that the validity of the ‘fit person order’ procedure under the *Children Act 1908* was in doubt. The opposition spokesman outlined the difficulty. Even though the problem was recognised, it was not addressed until 1989.

6.13 The task force which had been established in 1974 reported in 1980. Its report was published in 1981.

- 6.14 On 17 December 1981, the Minister for Health acknowledged to the Seanad that “*The Department and the health boards run into difficulties in that the existing legal remedies for protecting children at risk are not entirely satisfactory. We intend to improve this situation under the proposed new children's legislation*”.
- 6.15 A draft Bill was prepared in 1982/3 which, among other things, proposed to give the health boards clear responsibility for the welfare of children but this was never brought before the Oireachtas.
- 6.16 In the 1980s there were two attempts to introduce legislation dealing with child protection. In 1985, the *Children (Care and Protection) Bill* was published. This Bill proposed a clear obligation on health boards to promote the welfare of children in their area. It included sexual abuse as a criterion for care proceedings. This Bill was at committee stage when the government resigned in 1987. The *Child Care Bill 1988* was introduced by the new government. It eventually became the *Child Care Act 1991*. The main parts of this were not implemented until 1996.
- 6.17 While the *Child Care Bill 1988* was before the Oireachtas, the *Children Act 1989* was passed to deal with the consequences of a Supreme Court decision²⁸ in relation to the powers of health boards to act as ‘fit persons’ under the *Children Act 1908* – the issue which had been aired in the Dáil in 1978 but on which no action had been taken. The Minister for Health said that the legal advice available to the Department of Health in 1970 was that health boards could act as ‘fit persons’ for the purpose of taking deprived children into care.²⁹ According to the minister, it was considered that such work formed an integral part of the community care and social work services that were beginning to be built up under the health boards:
- “Increasingly, health boards got involved in dealing with child abuse and neglect, bringing cases before the court and offering themselves as fit persons. This practice has been endorsed by successive Governments to the extent that the health boards are now recognised,*

²⁸ *The State (D and D) v G and others* [1990] IRLM 130.

²⁹ Minister for Health, 2nd stage speech, *Children Bill 1989*; Dáil Reports, 7 November 1989.

*in fact if not in law, as the State's child care and child protection agencies".*³⁰

6.18 The Minister went on to acknowledge that "*doubts were expressed by some lawyers and others about the legal authority of health boards to involve themselves in child care. However, the general view was, and is, that this is essential work which must be done in the interests of the children concerned and that the most appropriate agencies to perform it are the health boards*".

Children in institutional care

6.19 A number of children who were abused by the priests investigated by this Commission lived in children's residential centres. The *Report of the Commission to Inquire into Child Abuse* (The Ryan Report) deals in detail with abuse in such centres. This report is concerned only with a small number of such institutions and the role of the health authorities within them. In 1988, there were 24 residential homes (industrial schools) which were, as the Minister for Health described it, "*subject to certain limited controls*" under the *Children Act 1908* and 17 homes approved under the *Health Act 1953*. The 17 approved homes were not subject to "*specific statutory regulation*".³¹ They did not become subject to statutory regulation until the relevant sections of the *Child Care Act 1991* were implemented in 1996.³²

6.20 This means that, before 1996, the health board social workers had no statutory responsibility for monitoring residential institutions even though they were placing children in these institutions and the health board was paying for their care. The abuse in the institutions which is relevant to this report all occurred in the 1970s and 1980s. Social workers gave evidence to the Commission that they did try to encourage better standards. Their role was accepted and welcomed by some residential institutions but they were effectively excluded by some other institutions. The health boards did have responsibility for placing many of the children in the institutions and were involved to a considerable extent with these children – see Chapters 28 and 41. The health boards' responsibility ended when the child reached the age of 16 but sometimes the social workers remained in contact and helped

³⁰ *Ibid*

³¹ Minister for Health, 2nd Stage speech, *Child Care Bill 1988*; Dáil Reports 14 June 1988

³² Statutory Instrument 397/1996

former residents. The resident managers in the industrial schools and the managers in the other children's homes were responsible for the day to day care and management of the residents.

Child Care Act 1991

6.21 The *Child Care Act 1991* was the first Act to place statutory responsibility on the health boards to promote the welfare of children not receiving adequate care and protection. Its only reference to child sexual abuse was to provide that sexual abuse of children would be among the criteria for seeking court orders.

6.22 The stated purpose of the *Child Care Act 1991* is "*to provide for the care and protection of children and for related matters*". Section 3 of the Act places a statutory duty on health boards to promote the welfare of children who are not receiving adequate care and protection. This section came into effect in December 1992.³³

6.23 The main part of Section 3 is as follows:

"(1) It shall be a function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection.

(2) In the performance of this function, a health board shall—

(a) take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children in its area;

(b) having regard to the rights and duties of parents, whether under the Constitution or otherwise—

(i) regard the welfare of the child as the first and paramount consideration, and

(ii) in so far as is practicable, give due consideration, having regard to his age and understanding, to the wishes of the child; and

³³

Statutory Instrument 349/1992

(c) *have regard to the principle that it is generally in the best interests of a child to be brought up in his own family.*

(3) A health board shall, in addition to any other function assigned to it under this Act or any other enactment, provide child care and family support services, and may provide and maintain premises and make such other provision as it considers necessary or desirable for such purposes, subject to any general directions given by the Minister under section 69.”

6.24 Section 69 provides that “*The Minister may give general directions to a health board in relation to the performance of the functions assigned to it by or under this Act and the health board shall comply with any such direction*”. No such direction has been issued.

6.25 As is pointed out in the *Ferns Report*, this new obligation was not accompanied by new powers to intervene in specific situations. When introducing the Bill in 1988, the Minister for Health talked about the “*imaginative use*” of the new provisions. Legal provisions need to be clear and unambiguous with little scope for, and no requirement to use, imagination.

6.26 As already stated, the *Health Act 1970* did not enumerate all the functions of the health boards. The *Health Act 2004* which established the Health Service Executive (HSE) is drafted in a similar way: it confers on the HSE those functions which were formerly carried out by the health boards. The Commission considers that it would be preferable if there was a clear unambiguous listing of the statutory functions and powers of the HSE so that there could be no doubt about the extent of its power to intervene in child protection issues.

What is the role of the health authorities in relation to clerical child sex abuse?

6.27 Under the *Child Care Act 1991*, the health boards, and now the HSE, have a general duty to promote the welfare of children who are not receiving adequate care and protection. The Commission agrees with the *Ferns Report* analysis of the powers of the health boards. The *Ferns Report* takes the view that the powers conferred on the health boards by the 1991 Act are

designed to protect a child from an abusive family situation. It is the parents or guardians who are responsible for dealing with the matter in cases of third party or extra-familial abuse. The *Ferns Report* also points out that the powers available to the health boards under the 1991 Act are not significantly greater than those available under the 1908 Act.

6.28 Notification to the health board of alleged abuse by priests does not seem to serve any useful purpose if the health boards do not have any power to do anything about it.

6.29 The method by which the boards recorded such notifications, that is, by the name of the child, while appropriate for family abuse, is not appropriate for extra-familial abuse. There is no point in recording alleged abuse by a person who is in a public position, for example, a priest, a teacher, sports coach, by the name of the abused person. This information needs to be recorded by the name of the alleged abuser and by the school, parish, sports club or other relevant body. The Commission is not aware of any legal reason why this information could not be collated and classified in this way by the HSE. For the avoidance of doubt, the Commission considers that the HSE should be given specific statutory power to maintain such a record.

6.30 The Commission is not suggesting that it would be appropriate for the HSE to have the power to intervene where the child is being appropriately cared for by parents or guardians. It is concerned about the lack of clear power to collate and maintain relevant information and to share that information with other relevant authorities.

6.31 In the case of *MQ v Robert Gleeson and others*,³⁴ Mr Justice Barr took the view that health boards had an implied right and duty to communicate information about a possible child abuser if, by failing to do so, the safety of some children might be put at risk. Before making such a communication, the health boards had certain duties to the alleged perpetrator. This judgement has been viewed quite differently by the *Ferns Report* and the health boards/HSE. The *Ferns Report* was clearly concerned about the legislative basis for this wide ranging duty to communicate while the health boards/HSE

³⁴ [1997] IEHE 26

concerns relate to restrictions on their ability to communicate because of the requirements to inform the perpetrator. The *Ferns Report* took the view that the only power available to health boards to inform parties that allegations of child sexual abuse have been made against a particular person is “*one inferred from the wide ranging objective of child protection*” imposed on health boards by the *Child Care Act 1991*. It went on to express the view that the implication of such a duty on health boards without any express legislative powers is an issue which should be carefully considered by the Legislature. The HSE told the Commission that the judgement in this case (generally known as the Barr judgement) had

“significant implication for the management of child sexual abuse cases by the Health Boards/HSE. It provided that the Health Boards/HSE (except in cases where a child is believed to be at immediate risk of suspected child sexual abuse) before passing on any information with regard to a suspected child abuser to a third party, must give the allegations in writing to the alleged perpetrator. The alleged perpetrator must then be given the opportunity to respond in person to the HSE before the HSE makes its decision on whether or not to pass on the information to a third party. Recent legal advice is that the opportunity to appeal the decision of the HSE to pass on information to a third party must also be given to the alleged perpetrator.”

6.32 The Commission considers that the law should be clarified in order to confer on the HSE a duty to communicate to relevant parties, such as schools and sports clubs, concerns about a possible child abuser. The extent of the HSE obligation to notify the alleged perpetrator, if any, should also be clarified.

Structure of health authorities

6.33 The structures for the delivery of health and social services have changed considerably during the period covered by this Commission of Investigation. Prior to the establishment of the health boards in the early 1970s, health and personal social services were the responsibility of the local authorities. In Dublin, the Dublin Health Authority constituted the combined health departments of the then Dublin County Council and Dublin

Corporation. The Dublin Health Authority was dissolved in 1971.³⁵ The *Health Act 1970* provided for the establishment of eight health boards. The Eastern Health Board (EHB) covered the counties of Dublin, Kildare and Wicklow. The Archdiocese of Dublin is largely within the area covered by the EHB. There are small parts of the Archdiocese in the South Eastern Health Board region (in counties Carlow and Wexford) and a small part in the Midland Health Board region (Co Laois).

6.34 In 2000, the Eastern Regional Health Authority (ERHA)³⁶ was established. It was the overarching authority for the three health boards which were formed within the former EHB area. These three boards were the Northern Area Health Board, the East Coast Area Health Board and the South-Western Area Health Board.

6.35 In January 2005, the Health Services Executive (HSE) was established.³⁷ It took over all the functions of all the health boards.

6.36 For most of the cases covered by this report, the relevant health authority was either the Eastern Health Board (EHB) or one of the three health boards under the ERHA structure. Other health boards did have some involvement because some of the abuse occurred outside the Archdiocese and because priests moved to live in other health board areas. In general, we refer to the 'health board' or 'health boards' throughout the report without always identifying the specific board or boards involved.

*Development of Child Protection Services*³⁸

6.37 At the start of the period covered by this report, the statutory duties of health authorities in relation to children were mainly concerned with the provision of a school medical service, adoption services and residential or foster care for those whose parents or guardians were unable or unwilling to care for them.

³⁵ Statutory Instrument 117/1971.

³⁶ *Health (Eastern Regional Health Authority) Act 1999*; Statutory Instrument 68/2000.

³⁷ *Health Act 2004*; the relevant parts came into effect on 1 January 2005.

³⁸ The HSE provided the Commission with a very helpful Report on the *Context of Development and Operation of Social Work Services in Dublin, Kildare and Wicklow*. This description is based on that report and on evidence given to the Commission by a number of social workers.

6.38 Professionally qualified social workers began to be recruited to work in child care and family work in Ireland in the 1970s. The first professional qualification course for social workers in Ireland was introduced in 1968. Some social workers were being employed in voluntary hospitals - they were known as lady almoners.

6.39 At that time, child protection was generally considered to be the responsibility of the Irish Society for the Prevention of Cruelty to Children (ISPCC). The ISPCC did not have statutory responsibility for the protection of children. It did have a role in relation to removing children from their families if they were being abused or neglected and it was regarded as 'a fit person' under the *Children Act 1908*. It only started to get state financing in 1963 even though there was statutory provision for such funding at least since the *Public Assistance Act 1939*. In 1968 the ISPCC decided to recruit qualified social workers.

Dublin Health Authority 1960 - 1971

6.40 The Dublin Health Authority had a central Children's Section where two children's officers (qualified nurses) dealt with statutory child care work such as adoption and fostering and, in particular, the physical health of fostered children. In the early 1960s, the work of the Children's Section was broadened in order to address concerns about the number of children being admitted to industrial schools. In 1966, the Dublin Health Authority created a third post of children's officer in its children's section as well as the country's first post of social worker in the statutory health service.

6.41 In 1968, two further social workers were appointed. They were based in the community. By 1971, there were 11 social workers employed but they did not all have professional qualifications. The central Children's Section continued in existence for some time after the establishment of the health boards but the social workers who were employed there were gradually moved to the community care areas as they became established and organised. In 1974 there were just three social workers employed in community services for the EHB area.

Health boards 1972 - 2004

6.42 The *Health Act 1970* provided for the establishment of eight health boards. The operating structure of the health boards was not set out in legislation but was decided after recommendations by management consultants. Each health board had three distinct programmes with a programme manager for each programme. These were the general hospitals programme, the special hospitals programme³⁹ and the community care programme⁴⁰. The community care programme was delivered through community care areas. There were ten community care areas in the EHB – each had a population of approximately 100,000 in 1972. Each community care area was managed by a director of community care/medical officer of health (DCC) who reported to the programme manager, community care. It was a requirement that the DCC be a medical doctor. When the social work service became established, the senior social worker reported to the DCC and managed a team of social workers.

6.43 Between 1974 and 1978 community care teams were established in each of the ten community care areas. As each team became established a senior social worker was appointed and the social workers from the central children's section were decentralised and reported to the senior social worker. Additional social work posts were also created and filled.

6.44 In the mid 1980s, and unrelated to the issuing of the 1987 guidelines (see below), a new structure was introduced in the five largest community care areas. This structure involved social workers reporting to a team leader who, in turn, reported to a head social worker who reported to the DCC. In effect, a new layer of management was added. However, there was not a corresponding increase in the number of social workers.

6.45 In 1995, the EHB⁴¹ appointed two directors of childcare and family support services. They each had a strategic planning role⁴² as well as being

³⁹ This mainly dealt with psychiatric hospitals.

⁴⁰ Community care covered a range of services including child developmental health services, immunisation, school health services, the Public Health Nursing service, Home Helps, community services for older people and people with disabilities as well as social work services.

⁴¹ This did not happen in other health board areas.

⁴² One of the managers told the Commission that, in practice, they spent more time on urgent matters relating to individual cases.

line managers for some specific services. Their appointment did not change the management structure for social workers dealing with child abuse.

6.46 In 1997, the EHB⁴³ appointed a programme manager to deal specifically with children and families. In an unrelated move, the DCC position was phased out, and abolished in 1998, and replaced by general managers who did not have to be doctors.⁴⁴ From there on the reporting relationship was to the newly appointed general managers (a post open to all disciplines, including social workers, although in practice no social worker held such a post). The general manager in turn reported to the assistant chief executive dealing with community care services. The programme manager for children and families became an assistant chief executive and the general managers reported to her in respect of their activities in relation to services for children and families.

6.47 Around this time, the position of childcare manager was created in each community care area. This position could be filled by a social worker but this was not a requirement and, in practice, a number of other professionals were appointed. The role of the childcare manager was to co-ordinate child abuse cases and to develop a more strategic approach to childcare planning at local level. All abuse cases were notified to the childcare manager who then co-ordinated the response. The childcare manager had no supervisory role in relation to the social workers.⁴⁵ The childcare manager reported to the general manager, community care and not to the programme manager/assistant chief executive for children and families.

6.48 There seems to have been a degree of duplication of, or at least lack of clarity about the role of the childcare manager relative to the senior social worker.

6.49 Shortly after the establishment of the ERHA (in 2000) and the three area health boards, an assistant chief executive was appointed in each board with responsibility for services for children and families.

⁴³ This did not happen in other health board areas; child abuse continued to be the responsibility of the programme manager, community care in the other seven health boards.

⁴⁴ This happened throughout the country.

⁴⁵ The Commission understands that the Southern Health Board adopted a different practice; childcare managers there did manage social workers.

6.50 Reporting relationships remained the same within community care areas, with principal social workers reporting to the general manager, who in turn reported to the assistant chief executive.

HSE 2005

6.51 When the HSE was established in January 2005, the former community care offices became local health offices (LHOs). One LHO manager in each HSE region had 'lead responsibility' for childcare.

Development of awareness of child sexual abuse

6.52 Initially, the main activity of the social work service was in the area of child protection – specifically cases of physical abuse and neglect of children within their families. The role of the social workers was mainly to support families with problems with the aim of avoiding placing children in care.

6.53 Social workers told the Commission that awareness and knowledge of child sexual abuse did not emerge in Ireland until about the early 1980s. The HSE told the Commission that *"In the mid 1970s there was no public, professional or Government perception either in Ireland or internationally that child sexual abuse constituted a societal problem or was a major risk to children"*.

6.54 In 1982, some social workers from the EHB area visited California to work with people dealing with sexual abuse there. In 1983 the Irish Association of Social Workers held a conference on child sexual abuse in Dublin. In 1988, child sexual abuse assessment units were established in Our Lady's Hospital for Sick Children, Crumlin (the St Louise Unit) and in Children's University Hospital, Temple Street (the St Claire's Unit).

How complaints of child abuse were dealt with

6.55 From the introduction of the 1983 guidelines, cases of alleged child abuse or neglect were reported to the senior social worker who then allocated the case to a social worker and reported it, in writing, to the director of community care (DCC). There were some standard forms for recording allegations and for reporting to the DCC. A similar but informal arrangement (with possibly more oral than written reports) seems to have applied, at least

in some areas, prior to the introduction of the guidelines. In some cases, senior social workers developed their own forms and their own recording systems. The Department of Health started to collect statistical data on child abuse and neglect from 1978. This data was provided by the various DCCs. The DCC, or a senior medical officer designated by the DCC, might convene a case conference to discuss a particular child or family. In some cases, the DCC appointed one of the senior medical officers to deal with all child abuse issues. A social work file was created and, in some cases, it appears that the DCC might have had another file.

6.56 The EHB conducted a review of child abuse procedures in its area in 1993. Among other things, the review noted that there was considerable variation in how the different community care areas liaised with the Gardaí in relation to child sexual abuse. Confirmed cases were referred to the Gardaí; this was frequently done by the assessment units (St Louise's Unit, Crumlin and St Claire's Unit, Temple Street). These units also notified the community care area of any referrals which came directly to them. Some community care areas notified the Gardaí of suspected cases but Gardaí rarely referred cases to the health board. There were different arrangements for case conferences in the different areas. The report refers to a "*severe shortage of appropriate services*" for victims, families and perpetrators. The emphasis seemed to be on the investigation/validation of an allegation rather than on providing services. There was also a lack of uniformity in data collection and recording.

6.57 The HSE told the Commission that, by the late 1990s, health boards experienced serious difficulties in recruiting enough qualified social workers and child care workers.

"These staff shortages affected the time social workers could spend on training opportunities, the recruitment of foster carers, attending to children in care and court appearances. Social work managers prioritised workloads whereby child protection duties were given top priority."

6.58 This shortage continued into the 2000s and does not seem to have been resolved.

The Commission's dealings with the HSE

6.59 The HSE appointed a senior social worker as the liaison person with the Commission on its establishment in March 2006. The Commission wrote formally to the HSE on 2 May requesting copies of all documents held by the HSE which were relevant to the Commission's work. A number of informal discussions were held in order to clarify the Commission's requirements. The HSE explained that it would have difficulties finding information on clerical child sexual abuse as the social work records were held in the names of the children. The Commission had further correspondence with the HSE's legal advisors in relation to the terms of reference and issues of confidentiality.

6.60 As no documents had been received, the Commission told the HSE, on 4 September 2006, that it intended to issue an Order for Discovery. The HSE legal advisors replied outlining the difficulties being experienced in finding relevant files. The main problems related to:

- the fact that files were kept by the name of the child;
- manual searches were required;
- the size and the various changes in structure of the EHB area;
- the absence of any central filing system, even when files were archived.

6.61 The HSE asked the Commission to provide a list of alleged victims. The Commission could not do this. The Commission saw its task as establishing the totality of the complaints which had been made to the relevant authorities in the period covered by the Commission's remit. Providing the names of alleged victims who were already known to the Commission to the HSE would establish only that the HSE had or had not received a complaint about that victim. The Commission needed to know if the HSE had received complaints from people who were not known to the Commission – people who had not complained to the Archdiocese or the Gardaí or directly to the Commission itself.

6.62 On 14 September 2006, the Commission itemised a number of documents of a general nature which it wished the HSE to provide. On 4

October 2006, the Commission asked the HSE to nominate people to give evidence on the structures of the health board, the role and functions of the personnel involved in childcare issues, training of such personnel, general procedures for dealing with allegations of child sexual abuse and the liaison arrangements with other authorities. On 27 October, the Commission told the HSE that it was willing to further delay the issuing of an Order for Discovery provided substantive proposals including a time scale for the delivery of documents were put before the Commission by 3 November 2006. The HSE informed the Commission on 3 November 2006 that there were 114,000 social work files covering the period of the Commission's remit and that these were in up to 50 different locations. It was estimated that it would take half a day to read and consider each file. The Commission concluded that it would take nearly ten years to complete this process.

6.63 The HSE liaison person gave evidence to the Commission on 21 November 2006 on how the HSE was endeavouring to find the information which the Commission required. She explained that she had met all the then current managers, principal social workers and child care managers in May 2006 to discuss the best approach to gathering information for the Commission. The major difficulty for the HSE was that records in relation to child abuse were held by victim rather than by perpetrator. She asked the relevant people to make every effort to look within their area for records and to speak to former staff about their recollections of dealing with clerical child sexual abuse.

6.64 The Commission formed the impression that the HSE was not adopting a systematic approach to locating records. There was an identifiable group in each community care area dealing with child abuse issues and there was, at this stage, no listing of the relevant people or no written reports on what steps had been taken to try to find files.

6.65 Social workers and managers from the HSE gave evidence to the Commission in late 2006, about health board structures and, in particular, structures for dealing with complaints of child sexual abuse.

6.66 The Commission issued an Order for Discovery in February 2007 and the affidavit of discovery was delivered in March 2007. This was not

complete and further documentation was supplied at later stages as the Commission became aware, through its own investigations, that the health boards had been involved in various cases. Initially, the HSE provided the Commission with documentation in relation to 12 priests in the representative sample. The documentation which had been provided by the Archdiocese of Dublin showed there had been contact with the health boards in relation to eight others. Subsequently, documentation received from the religious orders showed contacts with the health boards in at least three other cases. Some of the documentation received from the HSE was provided as late as 2009 when the Commission forwarded extracts from the draft report to the HSE. Indeed, the Commission heard of a complaint in June 2009 just as this report was being finalised. This complaint was made to the health board in 2002 and reported by the HSE to the Archdiocese in May 2009. The fact of this complaint was not notified by the HSE to the Commission although it was clearly within the Commission's remit.

6.67 In March 2007, the Commission heard evidence from a number of current and former senior social workers about the child protection system generally. From October 2007, they gave evidence in relation to individual cases. The Commission was impressed by the social workers' commitment and concern. They were clearly trying to do the best they could in circumstances where their powers were unclear and their resources limited. The Commission did not inquire in any detailed way into the resources available to social workers but it notes that, until the late 1990s, virtually all their notes were handwritten.

Guidelines for dealing with child sexual abuse

6.68 Over the period covered by the Commission's remit, there have been a number of guidelines issued by the Department of Health and procedures agreed between the health authorities and the Gardaí in relation to suspected child sexual abuse. None of these is legally binding. The Commission examined these guidelines in order to establish how complaints of child sexual abuse were handled and to establish the level of communication that existed between the various authorities. As the *Ferns Report* has noted, the guidelines "*have little application to the case where a person (whether an adult or child) made a specific allegation that he or she was sexually abused*

as a child other than by, or with the connivance of, his or her parents or guardians”.

1977 – 1983: Guidelines on non accidental injury to children

6.69 The Department of Health issued a *Memorandum on Non Accidental Injury to Children* in 1977. This set out the procedures to be followed and provided guidance for social workers and others on the identification, monitoring, management of cases and co-ordination and exchange of information on cases of neglect or non accidental injury to children. It did not mention child sexual abuse. It recommended that the Gardaí be informed in cases where a criminal offence might have been committed.

6.70 In 1980, the 1977 guidelines were replaced by more specific guidelines - *Guidelines on the Identification and Management of Non-Accidental Injury to Children 1980* - but, again, there was no mention of child sexual abuse. The *Guidelines on Procedures for Identification and Investigation on Non-Accidental Injury to Children 1983* do refer to child sexual abuse.

1987 Child Abuse Guidelines

6.71 The *Child Abuse Guidelines* issued in 1987 include a section on child sexual abuse. The guidelines set out procedures for validation and management of allegations of child sexual abuse. Among other things, they provided that, if the Gardaí were not already involved, they should be notified by the director of community care where there were reasonable grounds for suspecting child sexual abuse. They also provided that cases of child sexual abuse which came to the attention of the Gardaí should be reported to the local director of community care.

1995 Notification of Suspected Cases between health boards and Gardaí

6.72 This set out the procedures to be followed by the health boards and the Gardaí in cases of physical and sexual abuse of children. It provided that each was obliged to notify the other of such cases.

1999 Children First Guidelines

6.73 These guidelines set out new definitions for each category of abuse including sexual abuse and provided how different agencies such as health

boards, hospitals, voluntary agencies and the Gardaí should respond to complaints. They provided for specific arrangements for exchange of information between the health boards and the Gardaí.

6.74 The *Children First* guidelines provide for a Child Protection Notification System (CPNS). This is a record of every child about whom, following a preliminary assessment, there is a child protection concern. At present, names are placed on the CPNS list held by the child care manager in each local health area following a multidisciplinary discussion between the principal professionals involved. Names remain on the list with the file marked as open or closed.

6.75 *Our Duty to Care* was published by the Department of Health and Children in 2002. It provides guidance to voluntary and community organisations that offer services to children on the promotion of child welfare and the development of safe practices in work with children. Many of these organisations come under the broad description of Catholic Church authorities.

6.76 *Trust in Care* was published in 2005. It is a policy for health service employers on, among other things, managing allegations of abuse against staff. Again, many health service employers are Catholic Church authorities.