

Kilkenny incest investigation / [investigation team headed by Catherine McGuinness] ; report presented to Mr. Brendan Howlin T.D. Minister for Health by South Eastern Health Board
May 1993

Item type	Report
Authors	South Eastern Health Board (SEHB)
Rights	EHB
Downloaded	4-Nov-2017 13:44:29
Link to item	http://hdl.handle.net/10147/46278



KENNY INCEST INVESTIGATION

**Report presented to
Mr. Brendan Howlin T.D.
Minister for Health
by
South Eastern Health Board**

May 1993

102911



May Kelly



**REFERENCE
ONLY**

KILKENNY INCEST INVESTIGATION

Report presented to
Mr. Brendan Howlin T.D.
Minister for Health
by
South Eastern Health Board

May 1993

**REGIONAL LIBRARY AND
INFORMATION SERVICE**

DUBLIN:
PUBLISHED BY THE STATIONERY OFFICE.

To be purchased through any Bookseller, or directly from the
GOVERNMENT PUBLICATIONS SALE OFFICE,
SUN ALLIANCE HOUSE, MOLESWORTH STREET, DUBLIN 2.

(Pl. 9812)

Price £6.00

**REGIONAL LIBRARY AND
INFORMATION SERVICE**

Contents

	Introduction	5
Part I	Kilkenny Incest Case	7
Chapter 1	Circumstances leading to the Investigation	9
Chapter 2	Terms of Reference	11
Chapter 3	Procedure of the Investigation Team	13
Chapter 4	The Health Care System... ..	17
Chapter 5	Legal Framework	25
Chapter 6	Theoretical Framework	35
Chapter 7	The Family Story	45
Chapter 8	Case History — Mary’s Contact with Health Services	55
Chapter 9	Analysis and Conclusions	73
Part II	Recommendations of Investigating Team	91
Chapter 10	Introduction to Part II	93
Chapter 11	Recommendations	95
	Child Care Act, 1991	95
	Constitutional Change	96
	Child Abuse Procedures	96

Child Abuse Registers	...	...	...	...	...	...	98
Reporting of Child Abuse	...	...	...	...	...	...	99
Confidentiality	...	...	...	...	...	...	101
Case Conferences	...	...	...	...	...	...	103
Inter-agency Co-operation	...	...	...	...	...	...	105
Inter Country Co-operation	...	...	...	...	...	...	108
Recording of Information	...	...	...	...	...	...	109
Prevention	...	...	...	...	...	...	110
Treatment	...	...	...	...	...	...	112
Training and Supervision	...	...	...	...	...	...	113
Domestic Violence	...	...	...	...	...	...	114
Persons with Mental Handicap	...	...	...	...	...	...	116
Appendix	List of Persons and Organisations who made submissions	...	...	...	...	...	119

Introduction

In presenting this report to the Chief Executive Officer of the South Eastern Health Board and to the Minister for Health there are a number of people to whom I would like to express my gratitude.

Firstly, I would like to thank all those who gave evidence to the inquiry and who co-operated with the team in investigating this case. I would also like to thank all the groups and individuals who responded to our request for written submissions. These proved to be most helpful in formulating our recommendations.

I am very grateful to the members of the staff of various departments of the South Eastern Health Board who assisted the team in the preparation of files and other background information which was essential to us in our work. The Librarian of the South Eastern Health Board, Ms. Ann Tierney gave invaluable help to the team in researching the relevant literature. The team extend a special thanks to the staff of the community care department for all their help and assistance which they gave us in so many ways during the course of our investigation and in particular our thanks are due to Eleanor Moore and Mary Mooney who bore the brunt of typing and printing all the preliminary drafts and the final report. This involved a great deal of work during the late evenings and over the weekends.

Above all I offer my personal thanks to the other members of the investigation team — Brid Clarke, Martin Hynes and Sheelah Ryan — and to our secretary John Magner. Their commitment, expertise and hard work has meant that this report is comprehensive and, I hope, will make a positive contribution to the development of child care policies and services.

The members and I are unanimous in the conclusions and recommendations of the report.

Catherine McGuinness, S.C.

PART I

Kilkenny Incest Case

CHAPTER 1

Circumstances leading to the Investigation

On March 1st, 1993, at the Central Criminal Court, a forty-eight year old County Kilkenny father of two was given a seven year jail sentence, having pleaded guilty at an earlier court hearing to six charges of rape, incest and assault from a total of fifty-six charges covering the period 1976 to 1991.

The sentence attracted considerable media coverage as details became public of a history of physical and sexual abuse which had been ongoing for a fifteen year period.

At the court hearing on the 1st March, it emerged that the victim had had a number of hospital admissions over the years for the treatment of serious physical injuries and had been in contact with health professionals including general practitioners, social workers and public health nurses.

As the details of the case emerged an investigation into the case, which became generally known as the Kilkenny Incest Case, was ordered by Mr. Brendan Howlin, T.D., Minister for Health. Mr. J. A. Cooney, Chief Executive Officer, South Eastern Health Board was requested to appoint an investigation team headed by Ms. Catherine McGuinness, S.C. and comprising four members, two of whom would be from health boards other than the South Eastern Health Board.

On 4th March, 1993, the other members of the team were appointed, as follows:
Mr. Martin Hynes, Programme Manager, Community Care Department, South Eastern Health Board,
Ms. Brid Clarke, Head Social Worker, Eastern Health Board,
Dr. Sheelah Ryan, Director of Community Care and Medical Officer of Health, Midland Health Board,
Mr. John Magner was appointed as Secretary to the Investigation Team.

CHAPTER 2

Terms of Reference

The terms of reference given by the Minister for Health were as follows:

- **to carry out an investigation, insofar as the health services are concerned, of the circumstances surrounding the abuse referred to in the case heard in the Central Criminal Court on the 1st March, 1993, and in particular to establish why action to halt the abuse was not taken earlier, and**
- **to make recommendations for the future investigation and management by the health services of cases of suspected child abuse.**

The Minister decided that the investigation would be on an informal basis and would not be a statutory inquiry.

The victim is now in her late twenties. A significant part of the abuse was inflicted on her when she was over sixteen years of age. The investigation team believed that their comments and recommendations could not be confined to cases of child abuse only. This issue was raised with the Minister and with his consent the investigation team have somewhat broadened the terms of reference to include adult abuse and the management of such cases.

Because the management of child abuse cases is complex, and inter agency cooperation is essential, the investigation team in its recommendations has dealt with the interaction between the statutory health services and other key agencies.

CHAPTER 3

Procedure of the Investigation Team

The investigation team met for the first time on the 8th March, 1993, and completed its work on 14th May, 1993.

At its inaugural meeting the investigation team agreed to carry out a detailed analysis of the case including a comprehensive review of the files maintained by the South Eastern Health Board of the victim's contact with its services and to interview staff and other persons principally involved with the case from 1976 to 1992. This included hospital medical and nursing staff, general practitioners, public health nurses, social workers, directors of community care & medical officers of health and senior management personnel in the South Eastern Health Board.

The investigation team interviewed the victim and members of her family and relevant persons from other agencies.

The investigation team also held discussions with Ms. Maureen Gaffney, B.A., M.A., Senior Clinical Psychologist, Eastern Health Board; Research Associate, University of Dublin and Mr. William Duncan, M.A., F.T.C.D., Barrister at Law, Associate Professor of Laws, University of Dublin.

The investigation team also invited written submissions from interested parties. Persons and organisations who made submissions are listed in Appendix 1.

Following its first meeting the investigation team held a press conference and issued the following statement.

"The investigation team held a full day meeting today and was provided with a considerable volume of documentation setting out the history of the South Eastern Health Board's involvement with the Kilkenny Incest Case together with hospital records. We discussed in detail the terms of references which are:

- *to carry out an investigation, insofar as the health services are concerned, of the circumstances surrounding the abuse referred to in the case heard in the Central Criminal Court on the 1st March, 1993 and to make recommendations for the future investigation and management by the health services of cases of suspected child abuse.*

We have planned a detailed work programme including interviews with all relevant parties over the next two weeks.

We have decided to seek submissions from relevant persons and groups as to the management of abuse cases and the improvement of procedures and services.

The Chairman and Chief Executive Officer of the Board met with the investigation team this morning. They welcomed the setting up of the investigation and assured the investigation team of their full cooperation and have provided the necessary facilities to enable the investigation team to undertake its work.

We are aware that this is an issue of public sensitivity and importance. However, we do not think it would be appropriate to issue any further press statements until such time as the work of the team has been completed."

In Dáil Éireann on the 9th March, 1993, in reply to a parliamentary question, the Minister for Health said that it was his intention to publish the findings and recommendations of the investigation team subject to the need to preserve the anonymity of the victim and the other parties concerned.

It was decided that the investigation be conducted in private. This decision was taken because of the personal and sensitive nature of the information, the family's right to privacy and the need to facilitate full and frank discussion of the issues involved. The holding of the investigation in private also concurred with the Minister's wishes to preserve anonymity.

The team conducted the investigation on the most informal basis possible. Since it was not a statutory inquiry the team had no power to *sub poena* witnesses. Witnesses were informed that they could be accompanied by their professional association or union representative when giving evidence. A number of witnesses chose this course.

For purposes of accurate and full recording the investigation team had the services of a stenographer for all interviews.

The medical, nursing and social work files of the South Eastern Health Board were made available to the team.

As the family is originally from England, and lived there until 1975, the team contacted the relevant U.K. health and social services authority seeking information about the family. No records pertaining to the family were found. It is customary for that authority to destroy case files five years after the closure of a case. Furthermore, that health authority does not retain medical records of persons who are out of the country for more than three years.

Discussion of physical and sexual abuse of children has begun relatively recently to shed its taboo status. More specifically the area of abuse has received greater attention in recent literature and in the training of professionals in the health, social and education services. **The team has endeavoured to interpret and review those services provided to the victim and her family in the light of the legal situation and professional practices which pertained during the period in question and the report should be considered in that context.**

The team considered a number of issues which were relevant to the investigation. Some of these were related to the public concern which arose from the case about the role of the statutory authorities in protecting children and young persons from sexual and physical abuse. The team also considered the psychological research which has been carried out into families where abuse has occurred, the family dynamics and the role of the victim.

The team also tried to set the facts of this case in the context both of individual responsibility and of the responsibility of the society as a whole. Finally, the team makes recommendations for the enhancement of future practice in the diagnosis and management of abuse.

The team recognised the public concern about the apparent failure to act on the part of the caring agencies during the period of the physical and sexual abuse of the incest victim. The team recognised also the difficulty which faces professionals in cases like these where they can be accused, often only with the benefit of hindsight, either of having *inappropriately intervened in a family situation* or of having failed to intervene where it would have been appropriate to do so.

In relation to this issue the question of statutory powers of intervention in cases of child and adult abuse was considered. The statutory provisions governing the area of physical and sexual abuse have served as a framework which guides professional practice and it is clear that professionals involved in this area cannot act beyond their legal powers. These statutory provisions evolve over time and reflect the social and political milieu of their time. The team has endeavoured through its report to contribute to the process of social change whereby not only statutory provisions be developed but also, the financial and other resources required to make them effective would be provided. This requires both political will and clear public commitment and support.

The team also considered the issue of legal and moral responsibility for victims of abuse. The responsibilities of the individual and the State are complementary. Personal autonomy and individual responsibility should be weighed against factors which diminish them such as age, mental well being and so on. The boundaries between personal autonomy and State intervention must be determined for each individual case and a balance must be preserved between the rights of individual and family privacy and the duty of the State or society to intervene in situations of danger or abuse. This task is by no means simple.

The investigation team is conscious that in conducting this investigation it has the incalculable benefit of hindsight.

Many things which appear obvious as warning signals today may not have appeared so significant at the time. Firstly, each individual had only partial knowledge of the facts of the case. Secondly, awareness and knowledge of child sexual abuse has only developed in recent years. Guidelines for the identification, investigation and management of child sexual abuse were not published by the Department of Health until 1987. Here we would refer to a quotation from the report of the British inquiry into the death of Malcolm Page in 1981:

"We have spent a lot of time in examining and analysing this case and in doing so we were not subject to the pressing everyday and often equally important and urgent problems confronting the individuals and agencies involved with helping the Page Family. Looking back it is very easy to ask the question, why didn't you do this or that? There can be no certainty that the "this or that" would have made any difference. In our view the only proper criterion is to look at decisions and actions within the context in which they were made or taken and this context must necessarily encompass the knowledge and experience of the individuals involved and the pressures on the agencies for which they worked."

The investigation team does not wish to victimise the family further through the publication of sensitive information and identification of individuals involved.

The task set for itself by the team within this report has been to bring to light the events as they unfolded over the period in question, and to examine and review the roles played by the parties involved in terms of the social situation current at the time. The team examined *inter alia* such issues as conflicts of evidence and the respective roles and involvements of a range of professionals, statutory and otherwise. The success of the report may be measured firstly in the degree to which it gives an understanding of the case history, and secondly, the extent to which it serves to enlighten future practice in the management of abuse.

In presenting our report we refer to the victim at the centre of our investigation as "Mary". We have done this to protect her identity and that of her family and those who had contact with her over the period concerned.

CHAPTER 4

The Health Care System

The executive powers of the State are exercised by or on the authority of the Government in accordance with the laws enacted by the Oireachtas. Under the Ministers and Secretaries Act, 1924 the business of the Government is assigned on a functional basis to Ministers.

The Department of Health, which was established as a separate Department in 1947, is the responsibility of the Minister for Health and the functions of the Minister and his Department include:

- the formation of policy.
- drawing up of programmes for the implementation of agreed policy and allocating funding accordingly between the various health agencies.
- co-ordination, appraisal and reviewing the effectiveness of policies and the overall organisational arrangements for the delivery of health services and the issue of advice and guidelines accordingly.
- co-ordination of the international activities of the health service.

The statutory responsibility for administering the services provided for in legislation and by ministerial initiative is vested in eight regional health boards.

Notwithstanding the statutory responsibility of the health boards, many hospital and institutional services, community based health, welfare and social services and a range of advisory and counselling services are provided by non statutory organisations. In most instances the reporting, accounting and funding relationship of these agencies is directly with the Department of Health rather than with the health boards. Furthermore the Health Act, 1970 empowers health boards to make arrangements with other bodies to provide, health, welfare and social services and the extent and nature of the funding, reporting and accounting relationships vary.

Health Board Management

Section 4 of the Health Act 1970 provides for the establishment of a board which shall comprise of a majority of elected representatives of local authorities in its functional

area, with the balance comprising of health profession representatives and nominees of the Minister.

Each health board is also required under the Health Act, 1970 to have a Chief Executive Officer to whom certain functions relating to personnel and eligibility of individuals for services are reserved under the Act. All other matters can be exercised by the board. However, the board has recognised the need to delegate day to day management of services to the Chief Executive Officer while retaining control over key policy matters.

The work of each health board is divided into three programmes, covering respectively community care services, general hospital services and special hospital services. Each of these programmes is managed by a Programme Manager reporting directly to the Chief Executive Officer.

There are functional officers in charge of Finance, Personnel, Management Services and Technical Services and this group of officers together with the Programme Managers under the Chief Executive Officer forms the management team of the board.

The South Eastern Health Board is the statutory authority for providing health and personal social services to the people of counties Carlow, Kilkenny, Tipperary (S.R.), Wexford and of Waterford City and County. The population of the area (1991 Census) is 383,303

Community Care

The community care programme has primary responsibility in the Board for the provision of personal, social and welfare services and is therefore described in more detail below.

The community care programme covers a broad range of services including

- community protection, including prevention of infectious disease, child health examinations, immunisations, drug controls, health education and other preventive services.
- community health services including primary health care services such as general practitioner services, drug supply and refund schemes, home nursing, dental, ophthalmic and aural services.
- community welfare including cash payments, grants to non statutory agencies and personal social services provided by social workers, meals on wheels organisations and staff of day-care services.

Additionally there are residential services, including residential centres for children, welfare homes for the elderly and residential homes for mentally handicapped people within the programme.

For the management of community care services each health board is divided into a number of community care areas each serving a population of 100,000 approximately. Each area is served by a multidisciplinary team generally comprising area medical

officers, public health nurses, social workers, environmental health officers, community welfare officers, dental, pharmacy and other community based therapists and is headed by a director of community care and medical officer of health (DCC/MOH). The DCC/MOH in turn reports to the programme manager at regional level.

This structure reflects the principle that services should be client centred and delivered at local level by multi disciplinary teams.

Within the community care programme services provided for children fall into two broad categories, Personal Social Services and Child Health Services.

Personal Social Services for Children and Families

The term personal social services refers to all those social services other than health, education, income maintenance and housing that are directed towards meeting peoples social support needs, usually on a community basis. Sub divisions of personal social services include:

- social work services;
- services supplementary to family care;
- child care workers, home help services, home management advisors;
- day care i.e. day nurseries, child minding, play groups, day fostering;
- community projects;
- alternative care — including adoption, fostering and residential care.

A major review of personal and social services for children was undertaken by the Task Force on Child Care Services which was established in 1974 by the Minister for Health. The final report of the Task Force was published in 1980. Additionally an Adoption Review Committee was set up by the Minister for Health. This committee reported in 1984. These two reports contain comprehensive analysis and discussion of various aspects of child care and adoption.

Child health services are preventive and diagnostic in orientation and are provided primarily by public health nurses and area medical officers. In addition to preschool and school health services, they include home visiting by public health nurses and in some cases services provided by psychologists engaged by health boards.

Preschool Services

Health examinations are provided for preschool children through developmental clinics and child welfare clinics. Developmental clinics provide for developmental examinations at six to ten months, twelve to eighteen months and two years and are available to all children, though attendance is not compulsory. Approximately 25% of children who are examined at these clinics require further attention by way of either referral to a specialist, referral to a G.P. or recall for further observation.

School Health Services

These include

- a comprehensive medical inspection of all children between their sixth and seventh birthdays;
- routine annual screening by the district nurse for vision, posture and cleanliness, audiometric testing of special groups;
- selected medical examination of nine year old children;
- examination in any year of a child referred by the parent, teacher, or district nurse or a child due for re-examination.

Role of the Director of Community Care and Medical Officer of Health (DCC/MOH)

The DCC/MOH manages health care services in a community care area. The principal duties and responsibilities of the post are:

- to assess and agree priorities for health care needs and services in the community
- to develop targets and plans for services in the community
- to ensure that plans for the community are put into action appropriately
- to follow up and report on performance of services
- to establish a high level of efficiency and better services
- to enhance the effectiveness of the senior members of the community care team and their staff.

In addition to the managerial roles the DCC/MOH has specific public health functions in his/her capacity as Medical Officer of Health.

Within the community care programme responsibility in relation to child abuse rests with the DCC/MOH as outlined in the Department of Health Guidelines. This matter is dealt with more fully in Part II of our report.

Role of Public Health Nurse in Child Health Services

The Public Health Nurse (PHN) has a variety of functions in her role as a community nurse including working with the elderly, physically handicapped, mentally handicapped and children. In the area of child care her role is preventive, educational and supportive.

The PHN visits all new born infants and all families regardless of income are eligible for this service. The frequency of these visits depends largely on the infant's progress and the family's needs. On her first visit the PHN will examine the baby, discuss the care, the feeding and general management of the baby and will observe the effect of the arrival of the baby on the family, particularly on siblings. Further visits, in addition to the above issues, will also deal with immunisation advice, the ongoing assessment of the child's development, diet and feeding practices, physical care, behaviour and

stimulation. The PHN also provides a range of child developmental checks from six weeks up to school age. Mothers are informed of the PHN's availability at the local health centre, where they can call without an appointment if further advice is needed.

In the case of "at risk" families the PHN will be aware of the factors affecting a child's development and her visits will be more frequent. These visits may continue up to the time the child is aged six. She will encourage, support and supervise these families and make the family aware of all available services and their entitlements to these services. In certain cases she may encourage the family to bring the child to the area medical officer in the local health centres. *For many families such support meets their needs.*

In other situations the PHN may have greater concern for the welfare of the children, particularly if there is evidence of family violence, obvious neglect etc. In these circumstances there are a number of options available including contact with the family doctor, referral to the social worker and/or submitting a report to the superintendent public health nurse and possibly the DCC/MOH. Where there is an involvement of other health care professionals, the PHN will continue with the already established pattern of visiting to the family and will work closely with the other professionals to support the family and look after the child's interest. In some cases the PHN will be the "key worker" in dealing with children at risk.

Role of Social Worker

Social workers are employed to provide a community based range of services to a variety of client groups including the elderly, the disabled, children and families. In practice, because of the demands of family and child care, most of the effort is concentrated on this area and indeed is often focused, almost exclusively, on vulnerable families with children who are "at risk".

Social Workers get referrals from a variety of sources including PHN'S, GP'S, area medical officers, teachers and others involved in community services.

In dealing with children at risk, the social worker is usually the key worker involved. This aspect of their work has shown a steep and unprecedented rise in recent years. For example, there were 88 referrals of suspected child sexual abuse in 1984. This figure had risen to 1,242 by 1989.

The demands of child protection work are constantly increasing. As was pointed out in "Committee on Social Work Report: 1985".

"As front line workers, social workers can be involved in serious, demanding, risk taking situations where immediate professional and policy decisions have to be made".

To accomplish this work successfully social workers must have a wide range of skills. When a referral is first made, the social worker must seek to gain the family's confidence and secure access to the child in order to make an initial assessment. Then, using professional judgement as to the severity of the risk factors which exist for the child, a case conference will be sought. Decisions will be made at this case conference such as

whether to maintain surveillance on the child's situation and to support the child and family in their own home or to admit the child into care.

In each case, the social worker will mobilise a wide range of services through effective liaison within the Community Care team and with other professionals. If a decision is made that the child be removed from home, the social worker must have sufficient expertise to prepare court reports and to give credible and authoritative evidence in order to obtain a Place of Safety Order or a Fit Person Order from the court. The social worker also has the responsibility of finding safe alternative living arrangements for the child. This could be with another family member, with a foster family or in residential care.

Throughout this process the social worker must maintain a somewhat paradoxical role with the child's parents. Notwithstanding the removal of the child from the family, the social worker will endeavour to work with the parents after the child has been removed and will ensure and supervise ongoing contact between the child, foster parents or residential centre and the natural parents. Thus, the social worker must be able to effectively use his or her authority while at the same time employing sensitive counselling and supportive skills with parents who may have feelings of grievance, guilt or loss.

Role of General Practitioners

General Practitioners deal with the whole range of illnesses and medical care in the community, including child care. They are usually very well accepted in a community and are generally seen as being helpful to someone to talk to about their problems. Because of this they are in a position to mobilise external family support in times of crisis and will often know generations of the same family and in many cases will have treated parents since they themselves were children. Families choose their GP. In most urban areas and in many rural areas families have a ready choice of family doctors. If they are medical card holders they may choose a doctor who lives within a seven mile radius of the family home.

This contact and intimate knowledge of the family means that the GP can have a key role in the early detection of stresses which may in turn lead to child abuse. Because they may also be treating other members of the same community they will be often aware on an informal basis of problems within families. Because of the ongoing supportive relationship with the family they are in a position to discuss this with the family, particularly if there are any signs of abuse, and are in a strong position to mobilise the support system.

If on a visit there is reason to suspect child abuse the GP can make enquiries as to how this occurred. The GP will endeavour to help parents to talk about why it happened and what factors contributed to it. Very often the GP is in a position to carry out unobtrusive surveillance on a child which he/she suspects to be at risk. If there is cause for concern he/she will normally inform the DCC/MOH.

If the GP is seen as prying into family matters or endeavouring to probe into matters which the family do not wish to divulge the family may simply stop attending or may

transfer their business to another doctor, very often one who does not practice in the community where the family live and who does not know the family history. It can be a feature of child abuse cases that parents will bring a child to several different doctors.

General Practitioners must therefore handle cases of suspected abuse with sensitivity and will endeavour to enlist the support and cooperation of the parents in referring the child to another agency.

Multi-Disciplinary Team

In carrying out the functions and responsibilities in relation to child protection each discipline is heavily dependant on the ready willingness, cooperation and participation of other professionals both within the community care structure, across the community care and hospital inter-face, with GP's and with other professionals including gardaí, teachers and voluntary child care services.

The assessment of child abuse is carried out by a multi-disciplinary team. A more recent development in some areas has been the establishment of formal validation units. The primary objective of these units is to provide a diagnostic assessment which is both investigative and therapeutic for the child.

The case conference is the crucial link and occupies a central position in the decision making process in individual cases. We have referred in some detail to the issue of case conferences in Part II of our report.

CHAPTER 5

Legal Framework

In dealing with the investigation and management of cases of child abuse, the health services operate, and must continue to operate, within the framework of the law. The role of the health services as provided through the various health boards is governed by law in a number of ways.

Firstly, the health services are governed by statute law, including both the statutes under which the health boards are set up and function, and the particular statutes which deal with the protection of children in cases of child abuse. Secondly, the health services are governed by the Constitution, in particular by its provisions dealing with the rights of the family, of parents and of children. Also of importance are constitutional rights to fair procedures. This aspect of the law includes the interpretation by the High Court and the Supreme Court both of the Constitution and of the relevant statutes in cases involving the health services in their role of protecting children against abuse. In so far as the health services protect children by seeking orders taking children into care, either on an emergency or a long-term basis, their procedures are also affected by the nature of the law of evidence.

This section of our report deals with all these aspects of the law in regard to the investigation and management of child abuse. It also goes on to deal with the legal protection available to adults and in particular adult women in cases of physical or sexual abuse.

Statute law

The health boards were established under the Health Act 1970 and the power of a health board to carry out any particular function is limited to what is provided by that Act and by other relevant statutes giving particular powers and functions to the health boards. Neither a health board nor any employee of a health board may exceed those statutory powers and functions; to do so is to act “ultra vires” or outside its powers and any such act may be successfully challenged in the courts.

A clear example of this limitation of powers in the area of child care may be found in the case of the State (D and D) -v- G and Others (1990) ILRM 130. In this case a child

had been put into the care of a health board as a “fit person” by the District Court. The Supreme Court held that a health board had no power conferred by statute to act as a “fit person” as defined by the Children Act 1908. As a result the Children Act 1989 had to be enacted as an emergency measure to enable the health boards to act as “fit persons” and to legalise the position of the children held in their care at the time of the Supreme Court judgment.

The statutory and organisational structure of the health care system is set out in greater detail in Chapter 4 of our report.

The major statutory provisions for protecting children who are at risk are still contained in the Children Act 1908 and it is these provisions which applied at all material times in regard to the particular case which is the subject matter of our inquiry. Under the 1908 Act, a child may be removed from the custody of his or her parents and placed in the care of a relative or other fit person in specified circumstances. This may be done in two ways. Sections 20-24 of the 1908 Act set out emergency procedures for providing immediate protection. Section 24 is most often used. It provides for the issuing of a warrant by a District Judge which may authorise a member of the gardai to search for the relevant child or young person, to enter specified premises (by force if necessary) for that purpose and to remove the child or young person to a place of safety. The child or young person must then be brought before the District Court and the judge may then make a further order committing the child to the care of a relative or other fit person.

Although any person may commence place of safety proceedings, in practice the applicant is usually a health board and it is the health board which is generally named as the fit person. The order can only be made if it appears to the District Judge on the basis of an information, usually sworn by a social worker, that there is reasonable cause to suspect that the child “has been or is being assaulted, ill treated or neglected in a manner likely to cause him unnecessary suffering or to be injurious to his health” or that one of a list of offences set out in the Act has been committed in respect of him or her. A place of safety is any garda station, hospital, doctor’s surgery or other place willing to receive the child or young person. The Section 24 procedure may be operated swiftly and on an ex parte basis. In other words, it is not necessary in the first place to give the parents or guardian notice of the application. Section 20 of the 1908 Act offers an even swifter protective device for cases where there is reason to believe that a specified offence has been committed. It authorises a member of the gardai in such a case (without first obtaining a warrant from a District Judge) on his own initiative to remove a child to a place of safety pending criminal proceedings against the alleged offender. Section 20 however is seldom used since it implies that there must subsequently be a prosecution for an actual offence and if such prosecution is not carried out, the place of safety order lapses.

After the child has been taken to a place of safety, the whole matter must be brought back to the District Court for both sides to be fully heard. If the case for taking the child into care is fully established on evidence, the court makes an order committing

the child to the care of "a relative or other fit person" until the child reaches the age of sixteen years, or for a shorter period of the court thinks fit.

Where a situation of emergency, that would justify the seeking of a place of safety order, does not exist, care proceedings can be taken under Section 58 of the 1908 Act. Under that Section, any person may apply to the District Court for an order committing a child who is in need of care or protection to an industrial school or to the care of a fit person. The grounds upon which an order may be made are set out in detail in the section and include situations where the child is found begging or receiving alms or is found not having any home or settled place of abode or visible means of subsistence or is found destitute and having parents who are undergoing penal servitude or imprisonment or is under the care of a parent or guardian who by reason of criminal or drunken habits is unfit to have care of the child, etc.. While in theory an application under Section 58 may be made by any person, in practice again it is the health boards who make these applications and the most common ground used is that the child "is found having a parent or guardian who does not exercise proper guardianship".

For the purposes of seeking orders under the 1908 Act, it must be noted that a child is defined as a person under 15 years of age and proceedings under Section 58 may be taken only in respect of a child so defined. In theory proceedings under Sections 20-24 may also be taken in respect of a "young person" aged 15 to 17 years, but both in the case of Section 58 and in the case of Sections 20 — 24, the child or young person in question may only be committed into care until he or she reaches the age of 16 years. Proceedings under Section 20-24 in respect of children over 15 are thus largely ineffective and in practice are never brought.

It should be noted that under the law as it stands at present a social worker, public health nurse or other child care employee of the health board has no right to enter a child's home to investigate whether a child is being abused. This applies even if reports have been received which would give clear indications of possible abuse. The health board also has no legal right to have a child medically examined or to have the child interviewed on an investigative basis without the permission of the parents.

The Child Care Act 1991 makes a number of important changes in the law as regards the protection of children and the promotion of their welfare and provides a new statutory framework for the functions of the health services in this area. Detailed discussion of the provisions of the 1991 Act is not included here and may be found elsewhere, e.g. in Volume 10 Number 4 of the Irish Social Worker which contains a number of articles on different aspects of the new Act. However, a number of important changes should be noted.

In Section 2 of the Act, a child is defined as being "a person under the age of 18 years other than a person who is or has been married". Section 3 gives to every health board an actual statutory duty to promote the welfare of children in its area who are not receiving care and protection. In the performance of this function a health board is to take such steps as it considers requisite to identify children who are not receiving

adequate care and protection and to coordinate information from all relevant sources relating to children in its area. The health board is also to have regard to the rights and duties of parents, whether under the Constitution or otherwise, and is also to have regard to the principle that it is generally in the best interests of a child to be brought up in his own family. Prior to the enactment of this section, a health board had no specific statutory duty of this kind. Section 5 of the Act requires health boards to provide accommodation for homeless children as an alternative to taking them into care and Sections 9 and 10 enable health boards to make arrangements with voluntary bodies to provide child care and family support services on their behalf and to grant aid such bodies.

Part III of the Act provides for the protection of children in emergencies and in effect replaces Section 20-24 of the 1908 Act. Part IV deals with care proceedings and sets out new grounds for the making of a care order under Section 18. Under the section the District Court must be satisfied that

- (a) the child has been or is being assaulted, ill treated, neglected or sexually abused, or
- (b) the child's health, development, or welfare has been or is being avoidably impaired or neglected, or
- (c) the child's health, development or welfare is likely to be avoidably impaired or neglected.

Part IV also contains a new provision allowing for the court to make a Supervision Order authorising the health board to have a child visited regularly in the child's own home.

Section 19, which deals with Supervision Orders, give the health board power to enter a child's home for regular visits where a Supervision Order is in force.

With regard to medical and psychiatric examinations of children, under the emergency procedures set up by Part III, the district court has power to direct "*the medical or psychiatric examination, treatment or assessment of the child*". Where the court makes a supervision order it also may require the parents of the child to cause him to attend for medical or psychiatric examination, treatment or assessment. Where a child has actually been placed in the care of a health board under Part IV the health board has power to consent to any necessary medical or psychiatric examination, treatment or assessment. The health board has no such specific power under the 1908 Act even when a child is in care, except in the case of an absolute medical emergency.

Part V of the Act deals with the jurisdiction and procedure of the courts and provides for the appointment of a guardian ad litem to represent the child in care proceedings. A guardian ad litem is an independent non-legal person who acts on behalf of the child, carries out investigations and makes reports to the court. This is a new provision in the Irish jurisdiction, although there has been provision for some time in England for the appointment of guardians ad litem in these circumstances.

Part VI of the Act deals with the position of children in the care of health boards and with such matters as access by parents to children, etc.

However, the provisions of the 1991 Act did not come into operation automatically on the enactment of the legislation by the Oireachtas. They require to be brought into operation by ministerial order. At the date of writing, the sections which have been brought into operation are Sections 1, 2, 3, 5, part of Section 6, Sections 7, 8, 9, 10, 11, 66, 69, 71, 72, 73, 74 and part of Section 79. It will be seen that these do not include the major sections dealing with children at risk under Parts III, IV, V and VI. It therefore remains the position that the protection of children in emergencies and the taking of children into care are still governed by the provisions of the Children Act, 1908.

In considering the reporting and investigation of suspected child sexual abuse, it should be noted that no statute lays down in express terms a duty on any person private or official to report child sexual abuse or suspected child sexual abuse. This applies to health care and child care workers, as it does to teachers, friends and neighbours. The criminal law in Ireland does still contain an offence called *misprision of felony* which punishes failure to report the actual commission of certain serious offences (or felonies) such as rape and buggery. However, misprision does not extend to many of the offences relevant in the context of child sexual abuse (i.e. incest, indecent assault, unlawful carnal knowledge of a girl between 15-17 years of age) because these offences are defined in the criminal law as misdemeanours rather than felonies. Also, misprision possibly does not extend to felonies disclosed professionally to a lawyer, doctor or clergyman. In the English case of *Sykes -v- D.P.P.* (1962) A.C. 528, Lord Denning in his judgment conceded that certain relationships including those of doctor and patient and clergyman and parishioner, might give rise to a claim in good faith that it would not be in the public interest to disclose the felony. The crime of misprision does not extend to a mere suspicion that a felony has been committed — there must be actual knowledge that the felony has been committed. It seems unlikely that this offence will be used in the future in connection with the reporting of child sexual abuse.

The Department of Health guidelines on child abuse issued in 1987 are not legally binding. The same applies to the previous guidelines issued by the Department of Health and others issued by individual health boards.

The Constitution

In considering the present functions of the health services in the context of child abuse, and in making any recommendations for change, the overriding importance of the relevant articles of the Constitution must be borne in mind. Article 41.1 provides

“The State recognises the Family as the natural primary and fundamental unit group of Society and as a moral institution possessing inalienable and imprescriptible rights, antecedent and superior to all positive law.”

“The State, therefore, guarantees to protect the Family in its Constitution and authority as the necessary basis of social order and as indispensable to the welfare of the Nation and the State.”

Article 42.1 provides

“The State acknowledges that the primary and natural educator of the child is the Family and guarantees to respect the inalienable right and duty of parents to provide according to their means for the religious and moral, intellectual, physical and social education of their children.”

These Articles stress the fundamental rights of the family and of parents in regard to their children.

Power to remove a child from the family is given only by Article 42.5 which provides

“In exceptional cases, where the parents for physical or moral reasons fail in their duty towards their children, the State as guardian of the common good, by appropriate means shall endeavour to supply the place of the parents, but always with due regard for the natural and imprescriptible rights of the child”.

As can be seen, this sub-article sets up stringent pre-conditions for the removal of a child.

The family as referred to in Articles 41 and 42 of the Constitution has been defined by the Supreme Court as being confined to the family based on marriage — parents who are not legally married do not possess rights under Articles 41 and 42. However, it has been held (for example in the case of *G -v- An Bord Uchtála*) that an unmarried mother has a general constitutional right to the custody of her child under Article 40 of the Constitution and in practice the courts are also reluctant to remove children from the care of unmarried parents unless a very strong case for doing so can be established.

The constitutional rights of the child are not formally set out in the Constitution but they have been asserted by the High Court and Supreme Court in a number of cases and have in particular been described by Chief Justice O’Higgins in his judgment in the case of *G -v- An Bord Uchtála* (1980) IR 32.

“The child also has natural rights. Normally, these will be safe under the care and protection of its mother. Having been born, the child has the right to be fed and to live, to be reared and educated, to have the opportunity of working and of realising his or her full personality and dignity as a human being. These rights of the child (and others which I have not enumerated) must equally be protected and vindicated by the State.”

In general however, the courts have held that the child’s rights are to be found within the family rather than being specific rights of the child against the family or the parents. This viewpoint found powerful expression in the judgment of the present Chief Justice, Mr. Justice Finlay in the case of *K.C. and A.C. -v- An Bord Uchtála* (1985) ILRM 302. In his judgment, the Chief Justice said that in addition to the rights of every child which are provided for in the Constitution, a child has rights under the Constitution as a member of a family “*to belong to a unit group possessing inalienable and imprescriptible rights antecedent and superior to all positive law, to protection by the State of the family to which it belongs and to be educated by the family and to be provided by its parents with religious, moral, intellectual, physical and social education.*” In effect the court held that the duty of the

parents of a legitimate child to provide for the upbringing and education of their child conferred a corresponding right on such child to be brought up and educated by its parents. This constitutional right of the child seems to render it constitutionally impermissible to regard the welfare of the child as the first and paramount consideration in any dispute as to its upbringing or custody between parents and third parties such as health board without first bringing into consideration the constitutional rights of the family. In the K.C. and A.C. case the court held that parents could only be deprived of custody of their legitimate child for compelling reasons or in an exceptional case where the parents have failed and continue to fail to provide education for the child for moral or physical reasons.

The terms of Articles 41 and 42 have had a considerable effect on the enactment of legislation concerning children. An example of this is that until 1988 there was no provision for the adoption of legitimate children because it was felt that such legislation might infringe the rights of the family in the Constitution. When the Adoption Act, 1988 was introduced providing for adoption of legitimate children in restricted circumstances, the entire terms of the Act reflected Article 42.5 of the Constitution and it is only in these circumstances that the adoption can take place.

The terms of the Child Care Act, 1991 are also clearly affected by the constitutional position and reference is made in the Act to the constitutional rights of the family, the parents, etc.

The Supreme Court has also dealt with the constitutional interpretation of the Children Act 1908 in a number of cases notably the State (D and D) -v- G and Others (1990) ILRM 10 and 130 and F. -v- The Superintendent of Ballymun Garda Station, J.R. and the Eastern Health Board and District Justice James Paul McDonnell (1991) 1.IR 196

In the preliminary ruling by the Supreme Court in the State (D and D) -v- G and Others, the right of parents to fair procedures in child sexual abuse cases was stressed and detailed provision was made for this. In F -v- The Superintendent of Ballymun Garda Station, Mr. Justice Hugh O'Flaherty in the Supreme Court spoke of the 1908 Act as follows:

"While the Children Act 1908 may have been an enlightened piece of legislation when enacted, it is now showing its age. Unless and until new legislation is introduced, this court must determine how it aligns with the Constitution and with other legislation governing the welfare of children. Providing the Act has the correct mechanisms it does not matter if some of its language may be in archaic terms..... The provisions (of the 1908 Act) that the court now has to construe may be regarded as providing part of the machinery whereby children's rights both constitutional and legislative are safeguarded."

In the future, if it is sought to provide for any new powers and functions of the health services in regard to child sexual abuse, the importance of Articles 40, 41 and 42 of the Constitution must be borne in mind. Otherwise such new provisions could be open to constitutional challenge.

The law of evidence

In dealing with the procedures provided under the law for the protection of children at risk, it must also be borne in mind that a health board must be able to establish its case for either emergency or long term care orders by relevant and admissible evidence. Allegations of suspected abuse — and in particular where such allegations are hearsay — are simply not sufficient to ground an order. This may seem a statement of the obvious but it is a fact often overlooked by those who publicly criticise the health boards for failure to remove a child who is at risk from the family. Evidential difficulties are often created by the fact that family members, neighbours and other persons who may have reported their suspicions or even their knowledge of child abuse to the health board are reluctant actually to come forward and give evidence in court. Where a young child is concerned, there is the major difficulty that the victim is too young to give proper evidence with an older child fear of or affection for the parent may make the giving of evidence difficult. Where there is no obvious physical injury, evidence of investigative interviewing can often be open to legal challenge. This aspect of the law has been very fully dealt with by the Law Reform Commission in their Consultation Paper on Child Sexual Abuse (Chapters 5, 6 and 7 — pages 81-187) and some of their recommendations have now been brought into effect by legislation.

It must always be borne in mind however that all persons in respect of whom allegations of ill treatment of their children are made have a basic constitutional right to fair procedures under Article 40 of the Constitution.

The above account refers in the main to the legal protection available through the health services in the case of the abuse of children. However, it must be borne in mind that a great deal of the abuse in the case referred to in the Central Criminal Court on 1 March 1993 was suffered by the woman in question after she reached the age of 16 and also after the age of 18 when she was legally an adult. As will be seen in the history of the case as set out by us in Chapter 8, Mary did not come into contact with the social work services until she was 16 at the time of the birth of her child. Protection under the Children Act, 1908 was therefore not available to her and the question of taking her into care could not arise. It is therefore relevant to consider what legal protection is available to a person over the age of 16 who is suffering physical or sexual abuse.

It is open to an abused person to lay a complaint with the Garda Síochána and thus set in motion a prosecution, either for rape and related offence (in the case of sexual abuse) or for common assault and related offence (in the case of physical violence). These matters come within the criminal law and are outside the scope of our terms of reference.

In the civil law, protection is available in certain circumstances through the Family Law (Protection of Spouses and Children) Act, 1981. Under this Act (Section 2) the court may on the application of a spouse grant a barring order against the other spouse excluding him or her from the family home either for a period or indefinitely “*if it is of opinion that there are reasonable grounds for believing that the safety or welfare of that spouse or of any child so requires*”. Section 2(2) provides that a barring order may if the court thinks fit prohibit the respondent spouse from using or threatening to use violence against, molesting or putting in fear the applicant spouse or any child.

Under Section 3, as a preliminary to hearing a barring order application, the court may grant a protection order directing that the respondent spouse shall not use or threaten to use violence against, molest or put in fear the applicant spouse or the child. The protection order can be granted on an ex parte basis.

Breach of either a protection order or a barring order is a criminal offence (Section 6).

The remedies of barring and protection orders are however available only to a spouse against her or his spouse. It cannot be used in any other family relationship — by a daughter against an abusive father, by a sister against an abusive brother, by a mother against a violent son. It also does not apply to violence or abuse between cohabitants who are not legally married and this would include those who have entered into a second “marriage” after a legally unrecognised divorce or a Roman Catholic Church annulment.

The protection offered by the 1981 Act is therefore limited in its scope. An action for a barring order can only be initiated by a spouse. It cannot be initiated by a third party (e.g. a social worker) for the protection of a child or young person in the family. The limitations of the 1981 Act are clearly set out in the paper on “Violence against Women in the Home” by Roisin McDermott of Women’s Aid contained in the published account of the Garda Síochána and Department of Justice conference on Safety for Women held at Dublin Castle in October 1992.

Where violence or abuse occurs between family members who are not spouses, it is possible for the injured or abused party to seek an injunction, but this is a more complex and expensive legal process and is also less effective in its enforcement procedures.

Further difficulty can be caused to an abused person seeking legal remedies by the limitations of the civil legal aid scheme which is strictly means tested and where most law centres have long waiting lists for getting an appointment with a legal aid solicitor.

In all of the above situations, the personnel of the health services have no direct role in taking legal action. Their role is limited to advising an abused person of the legal remedies available and the giving of assistance and support in seeking the proper legal advice.

It is not part of our function under the terms of reference of this inquiry to consider the provisions of the criminal law in regard to child abuse or in regard to physical and sexual abuse of women. We note however that these areas have been very fully covered by the Law Reform Commission in their consultation papers and reports on Child Sexual Abuse, Rape and Sexual Offences against the Mentally Handicapped.

CHAPTER 6

Theoretical Framework

We carried out an extensive review of the literature on child abuse in order to enable us to understand better the significance of the various pieces of information and to construct a theoretical framework for the case. The following is a synopsis of the literature relating to child abuse, incest and family violence which is relevant to the case.

For generations, abused children have had difficulty in communicating the reality of their lives. It was only after very many years of child labour, and of physical abuse and neglect that industrialised society acknowledged the grave difficulties experienced by children by founding societies for the prevention of such cruelty. With regard to sexual abuse, society was similarly slow to respond, either by being unaware of its existence or by choosing to ignore children's own experiences. Even when as adults women related their earlier experiences, they were disbelieved.

This is hardly surprising when one considers the psychoanalytic theories which were then current. Freud, the founding father of psychoanalysis, theorised that reports from such women represented the desire of the child for the parent of the opposite sex — the Oedipus complex. Such was the influence of Freud's theory that it became a basic tenet of many of the helping professions that a child's report of sexual abuse represented only fantasy. The consequences of this were twofold. Professionals were unwilling and unable to hear and believe the word of children as it was in contradiction to professional training of great weight and status. Allied to this, there was a concurrent lack of willingness on behalf of children to make such reports. When they did speak, they were instantly quashed. It must be acknowledged that professionals were not alone in awarding such a low status to children. Society at large has always viewed children as property, without valid opinions and virtually without rights. "*Children should be seen but not heard*" has been the unwritten rule.

A key development in the area of child abuse has been the identification of the "*battered baby syndrome*" in 1962 by Drs Ray Helfer and C Henry Kempe. These Denver paediatricians described a battered baby as a child, usually under three years of age, who presented with unusual injuries, bone breaks, or head injuries which were inadequately or inconsistently explained by parents. Their finding was a major contribution to the

future management of the physical abuse of children. In response, professionals and health and social agencies developed protocols and procedures for coping with such cases and society at large was forced to recognise that children can be physically abused by adults, particularly parents.

In relation to child sexual abuse, the acknowledgement of the phenomenon has been slower and more gradual, without a significant “milestone” finding similar to that of Drs Helfer and Kempe. Rather, it can be argued that it was the women’s movement and the work of rape crisis centres which forced societies to recognise that sexual abuse of children does occur in families. *“Sexual abuse is emerging as one of the major forms of child abuse..... We now know that a great deal of sexual abuse occurs at the hands of close family members, particularly fathers and step fathers. Not uncommonly, abuse goes on for an extended period of time. Most victims never tell anyone about it.”*⁽¹⁾

The growing awareness and acknowledgement of the reality of child abuse means that we can now begin to identify the forms of abuse which children suffer and also the constellation of factors which are present in the families of victims and in society at large.

Some of our current knowledge may sit very uncomfortably alongside idealised stereotypes of society’s concern for children, and for family life. For example, we know that abuse by strangers is not common and **most abuse is carried out by adults known to the child**. By their nature, children are vulnerable and powerless in their relationships with adults — especially their parents. We realise however, that children can be harmed either by their parents or by other people who have control in their lives. This harm can be done either by direct acts or by failure to provide proper care or both. As a result, the child’s psychological development and his or her physical and emotional health may be profoundly damaged. This damage can result from four different types of abuse although these may not necessarily be mutually exclusive—

- **Physical Abuse:** Any form of physical abuse where there is definite knowledge or a reasonable suspicion that the injury was inflicted or knowingly not prevented. Such examples would be: hitting, shaking, squeezing, biting, burning, attempted suffocation, use of excessive force when handling a child and deliberate poisoning.⁽²⁾
- **Emotional Abuse:** Persistent and/or severe emotional ill treatment or rejection. This includes affection being withheld and being subject to derision and constant criticism.⁽³⁾
- **Neglect:** Persistent and/or severe neglect which results in serious impairment of the child’s health or development including non-organic failure to thrive. This includes inadequate medical care, being left alone or inadequately supervised, being starved or kept without adequate comfort such as heat.⁽⁴⁾
- **Sexual Abuse:** *“The involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles”.*⁽⁵⁾ Sexual abuse covers a wide range of behaviours, for example indecent exposure, incest, sexual

intercourse, engaging with a child in fondling, masturbation or oral sex, making the child watch sexually explicit behaviour, watch or participate in the making of pornographic material. The potential for the existence of violence in such relationships will be discussed below.

Children are innocent, dependent beings, relying on their parents or carers for the nurturing which will foster and facilitate their development into mature, independent adults. Their lack of autonomy places them in a vulnerable and powerless position within the family and society and it is this powerlessness which is at the core of sexual and other abuse.

In cases of child sexual abuse, children are asked to participate in sexual activity which they do not understand. They do not have information about sex and do not understand what the adult is asking them to do. Furthermore, and most crucially, **they do not have the power to refuse to participate.**

Usually, children proceed through recognised physical, social and emotional developmental stages. However, in what ought to be a trusting relationship, the child who is subjected to child sexual abuse experiences such common features as concealment, coercion, threat, the betrayal of trust and the distortion of relationships. The effect on the child is such that the regular pattern of development is fractured and the child can become locked into a particular stage, unable to proceed to the next.

After such a childhood, the adult can experience low self esteem, depression, difficulty in forming close relationships and can sometimes become involved in self destructive behaviours. Successful intervention either in childhood or later as an adult, assists in the resolution of this traumatic experience.

While experiencing the trauma of sexual abuse, we know that very many other factors may be combining at the same time to compound the misery of the child. Physical abuse is often also present. In addition, other family members — especially the mother — may be experiencing their own pain.

According to Steele and Alexander, when the family has a multitude of problems, and when all interpersonal relationships are disturbed, then sexual abuse is likely to occur earlier, more frequently and be associated with physical abuse.⁽⁶⁾ Women who seek sanctuary in refuges support this view and will frequently give histories of physical, sexual and mental abuse of themselves and their children.

Such abuse takes its toll on women. Walker (1979) identified the “*battered woman*” syndrome where victims describe an increasing sense of helplessness and hopelessness.⁽⁷⁾ They despair of finding safety and of terminating the violence. Such victims are depicted by Browne (1987) as having poor self esteem and denying and minimizing the extent of the violence.⁽⁸⁾ Women who experience domestic violence have unrealistic hope that change is imminent and they believe the promises made by the violent male that such violence will cease.

Advising on how such women present to professionals, Assistant Chief Constable Davies of the English Police Staff College urged awareness of the following factors:

- “she may be in physical fear of her partner.
- she may fear for her future, for the future of the relationship, for the future of the roof over her head and her income.
- she may be afraid for her children. It is not infrequent that batterers will batter both wife and child. She may have suffered violence to herself, but not complained to the police because she fears for her child’s safety.
- she may be afraid that her complaint will cause her children to lose their father.
- she may have nowhere else to go.
- she may have no money and no support.
- she may be afraid that she herself will lose her children.
- she will almost certainly be feeling guilty and wondering whether she is a bad wife or a bad mother.
- she may feel whatever happened must have been her fault, that she may have provoked the problem.
- she may despite it all still have affection for her partner and have some wish to save the relationship”.⁽⁹⁾

All these factors contribute to keeping women within a violent relationship. It might also be argued that many of the above factors not only keep the women in the violent relationship, but may equally serve to imprison her children. When they do break free and subsequently return home, victims state that it is lack of income and accommodation which forces them to succumb again to the violent situation. Once again, the inferior social and economic status of many women and children in the wider society is seen as an inescapable feature in the complex picture which we are studying.

As mentioned earlier, the child victim will often experience a constellation of abuses and neglect. One form of child sexual abuse particularly pertinent to this investigation is incest — sexual activity between family members. Studies in the United States indicate that father/daughter and stepfather/daughter incest account for three-quarters approximately of reported incest cases. Girls involved with father/stepfathers during pre-adolescence or very early adolescence are often the oldest daughters.⁽¹⁰⁾ Kempe and Kempe state:

“Father/daughter incest is usually non violent. However, in preadolescence and early adolescence, the association between physical abuse and sexual exploitation is sometimes striking, and it is not uncommon for the adolescent girls we see as runaways or with physical injuries to admit in treatment to suffering from both forms of abuse”.⁽¹¹⁾

In searching for a cause, three theoretical perspectives have been identified by Patricia Beezley Mrazek as applicable to incest:⁽¹²⁾

- **The sociological perspective**, which associates low socio-economic class,

poverty, overcrowding, social isolation and external stress with incest. Arguments against this viewpoint would state that the poor are more “*policed*” by social services and that incest occurring in such families will be more likely to come to attention. As stated earlier, sociologists would also highlight the low status of women and children in society at large and within the domestic sphere.

- Other theories point to **alcohol and drug abuse** by the perpetrator as precipitating factors in the occurrence of incest. Beezley Mrazek argues that alcohol and drug misuse may only be contributory factors rather than prime causes.
- The **psychodynamic perspective** stresses a family systems approach where, when incest occurs each member of the family will have a contributing role. Thus, the internal family dynamic will function pathologically and will involve: “*the offender, the victim and other family members, such as the wife*”.⁽¹³⁾ This dynamic which occurs in incestuous families will be discussed later.

There are varying theoretical perspectives presented as to the cause of child sexual abuse. Theorists seem to agree that child sexual abuse cannot be attributed to one single cause: child sexual abuse is a complex, multi-faceted problem and therefore in forming a response, a unilateral approach is unlikely to succeed. All stress the importance of the location of power within the relationship rather than a need for sexual gratification on behalf of the perpetrator.

Feminist writers emphasise the issue of gender and power and highlight the oppression of women and children in their relationships with men, particularly within the family. Family therapists, on the other hand, describe child sexual abuse as a symptom of and a response to, difficulties within the family system. Such theorists refer to blurred roles and boundaries within the family system and dysfunctional marital relationships and it is to these family difficulties that we now turn.

It has already been shown that child victims can be developmentally and emotionally disturbed in their progress towards maturity. It was noted that physical and emotional abuse may be experienced along with sexual abuse. The families of these children can be violent and they and their mothers will feel trapped and powerless. It is hardly surprising then when looking at the marital relationship within incestuous families, studies indicate that “*most parents have never attained a mature sexual relationship with a closeness, mutual sensitivity, spontaneity and skill which would make this aspect of their marriage anything but a disappointment*”.⁽¹⁴⁾

Together, parents maintain the shell of a marriage. Theorists believe that the mother willingly abdicates more and more of her responsibilities to a daughter, often the eldest, as well as the special place of favourite companion to the father. A father is apt to turn for sex to a daughter with whom he does not have a firm early parent/child attachment. Sometimes in treatment is found an unresolved oedipal wish by the daughter to replace the mother, with father’s unconscious agreement.⁽¹⁵⁾ In effect role reversal may occur as the mother looks to her daughter to meet her own needs for protection of her marriage. Sometimes “*the sharing by the father/daughter in a narcissist way of a particular talent or interest*”⁽¹⁶⁾ puts value on the relationship. Paradoxically, this daughter will also

be subjected to physical abuse, emotional abuse and neglect and this she will often have in common with other children in the family.

The mother in this family, without the closeness and mutuality which is hoped for in marriage will feel fearful and powerless. Her perceived lack of autonomy has been described earlier when we discussed violence and these factors apply here also to incestuous families. We cannot take for granted a mother's reflexive "instinct" to "protect her young". It appears that her own experiences will determine how a mother will respond when her children are at risk. *"The mother is unable to protect herself or her children because she has never known enough happy family life to know how to achieve and preserve it.... At other times the mother is too preoccupied with her many problems to realise that incest is occurring or feels too helpless, too fearful of the loss of the relationship she depends on, to risk intervention. In these families a child may learn that there is really nobody to trust for protection".*⁽¹⁷⁾

Allied to her own lack of experience of a happy family life, the mother's experience of marriage will be equally dismal. Within the marriage, her perceived lack of her own power is a repeated refrain in current literature. As Sgroi states: *"The incest victim's mother is usually in a subordinate position to the perpetrator since incest perpetrators in known cases are most frequently male power figures in the home.... Most mothers of incest victims are married to men who have unrealistic expectations of them. "The dependent husband" wants his wife to prop him up on every level: "the dominant husband" wants his wife to be so dependent that his own needs for power and control are continually satisfied. Wives who stay with such husbands may accept either the dependant or dominant role that is assigned to them.*

The likelihood that these women will seek relief from duress or boredom or frustration and meet their own needs elsewhere (by becoming psychologically absent or physically absent or both) is very great. In both patterns husband/wife interaction, the wife frequently eschews a true maternal role with her children. She may often view the children as rivals while simultaneously meeting some of her own special needs by interacting with the children on a peer level".⁽¹⁸⁾

All of these factors mean that when child victims of incest turn to their mothers for support, they may not be protected. Sometimes, the mother is physically absent, thereby affording the opportunity for the incest to occur. Sometimes, she may be psychologically absent, absorbed in her own concerns. She may be unwell: *"Depression, either overt or masked, is also very common. Many of these women have poorly developed social skills, few friends or outside interests and in general, little aptitude for developing and maintaining relationships".*⁽¹⁹⁾

Studies of incestuous families indicate that most mothers of incest victims have some awareness that incest is occurring. In many instances the victim will have told her mother. The response of mothers to these disclosures can vary. Some will not believe the child, others will ignore the child's disclosure, others will promise to intervene and protect the child, but will fail to do so. It is perhaps one of the most uncomfortable features of incestuous families that other than the perpetrator, the adult closest to the child will not take action to stop the abuse. *"Few mothers have the strength or resources to accomplish this by themselves. Many mothers fear change, shrink from separation, dread retribution*

by the perpetrator, and shirk or feel inadequate to perform the tasks and fulfil the responsibilities required to stop the incest”. ⁽²⁰⁾

Fathers: Extra-familial offenders are generally lonely, unassertive and socially isolated. These offenders rarely use violence and will use methods of seduction and enticement to gain the child's co-operation. Such people will also try to put some of the blame on the child and will surround their activities with secrecy.

Abusers within the family present sometimes as loners, but can often be “*bullies who use violence and threats to induce their wives and daughters to gratify their desires*”.⁽²¹⁾ It is also known that these violent and/or drunken abusers progress quickly to sexual intercourse unlike abusers from outside the family who become involved in fondling, caresses etc. Most begin to abuse when the child is at pre-puberty and will continue to abuse for several years. The oldest daughter is the most vulnerable especially in families where there is a role reversal in the mother/daughter relationship. These offenders rarely commit sexual assaults outside the family home.

Groth states that: “*Sexual offenders against children may be divided into two basic types with regard to their primary sexual orientation and level of socio-sexual development*”.⁽²²⁾ The first type are those which he calls the “*fixated offender*” i.e. their sexual development arrests at a particular stage and their sexual preference is fixed on children. These generally are described as paedophiles. The second type, which Groth calls the “*regressed offender*” are those adults who under increasing stress, responsibilities and conflicts, turn to children for satisfaction. Such perpetrators treat children as pseudo adults and are more likely to select girls as victims rather than boys. It is considered that ninety percent of offenders fall into this second category.⁽²³⁾

One of the key features of incestuous families which has been identified is their social isolation. “*Incest perpetrators tend to perceive the outside world as hostile and convey this perception to the child as both a reason and an excuse for the incestuous behaviour incestuous families, at the behest of the perpetrator, are frequently very isolated. Family members tend to have few friends and few peer activities*”.⁽²⁴⁾ Thus, the child living in an incestuous family can live in circumstances which insulate her from her peers and her community. So closed is the system within her dysfunctional family, and so limited her range of alternative experiences, that she will be unable to form a realisation of how other families live.

As was shown earlier, the sexual abuse which the child experiences comes as yet another dimension of an even wider picture of a bleak life. “*We have yet to encounter a case in which the incestuous activity was an exception to what otherwise was a stable, harmonious, well functioning family. Instead, the incest always constituted only one issue in a multi-problem family.*”⁽²⁵⁾

Within this isolated setting where the child experiences myriad problems, the family dynamic shows a strong sense of dependency, enmeshment and symbiosis between its members. Having heard clearly the perpetrator's message of the hostility of the outside world, other family members will resist contact with their wider family, neighbours and their community. Bearing these factors in mind, it is easy to recognise that successful

intervention in such situations can be very difficult. *“For this reason the formation of extended and meaningful extra familial relationships on the part of the spouse or offspring or the intervention attempts by external agencies or programmes are very threatening to the offender. Such contacts pose the risk of family abandonment or of weakened control over the family.”*⁽²⁶⁾

Thus, initiatives or contact which the wider society will view as helpful may well be seen by the child of such a family as merely a threat to their own and their family's survival.

Prevalence of Child Sexual Abuse

Studies have indicated varying incidence rates of the prevalence of child sexual abuse. A number of difficulties exist in attempting to establish the true incidence:

- varying definitions of child sexual abuse can be applied:
- the activity by its very nature is surrounded by secrecy:
- most studies focus on the adult population and their recollection of past incidents: this does not necessarily describe the current situation:
- Finkelhor, a leading theorist in this area refers to the syndrome *“sexual abuse amnesia”*.⁽²⁷⁾

While acknowledging the above factors, it is generally accepted that the prevalence rates among female victims is in the range of 10%-20%. Among male victims the figure is estimated to be approximately 10%. It is understood that child sexual abuse most often begins when children are aged between eight to twelve. A review of the literature shows that men constitute 95% of the perpetrators in cases of sexual abuse of girls: Where boys are the victims, 80% of the perpetrators are men.⁽²⁸⁾

In Ireland, the main source of data in relation to child sexual abuse is the statistics collected annually by the Department of Health. This collection of figures began in 1984. In that year, there were 88 referrals of suspected child sexual abuse of which 33 were confirmed. In 1989, the latest year for which figures are available, there were 1,242 referrals of suspected child sexual abuse of which 568 were confirmed at the time of the completion of these figures.

As Gilligan points out, available figures probably provide an under representation of the true situation. Gilligan refers to the elements mentioned earlier such as secrecy and coercion as being the factors which prevent the real incidence of child sexual abuse from coming to attention.⁽²⁹⁾

With regard to the greater Dublin area, the most recently published study is by McKeown et al.⁽³⁰⁾ This research provides a statistical analysis of all suspected and confirmed child sexual abuse cases known to Community Care teams in the Eastern Health Board region in 1988. During that year, the Eastern Health Board dealt with 990 cases of suspected child sexual abuse. Of these, 512 were confirmed. This represents a rate of 1.2 children per 1000 children in the region.⁽³¹⁾

Further data from this study show 37% of victims were under six years of age while 34% were aged between seven and twelve. Girls represented 71% of abused children.⁽³²⁾

Disclosure was made in the first instance to the mother by 43.8% of the children. When relatives, neighbours and other immediate family members are included, this figure increases to 65.6% of children concerned.⁽³³⁾ This same study shows that 63% of cases involved abuse by a family member. In almost half of the cases the alleged perpetrator was the father of the victim.⁽³⁴⁾

In 28% of cases general practitioners were involved in helping parents, investigating the case, and referring the case to another agency.⁽³⁵⁾

With regard to subsequent developments after referral to the Gardaí, based on the information available to social workers studied by McKeown et al, the following pattern emerges:⁽³⁶⁾

Total number of cases reported to health board	990
Referred by health board to Gardaí	507
Referred by Gardaí to Director of Public Prosecutions	162
Decision to prosecute	55
Defendant found guilty	38

It must be recognised that apart from the two references cited above, there is a dearth of information on child sexual abuse in Ireland.

References

- (1) Finkelhor, "Child Sexual Abuse: New Theory and Research", The Free Press, New York 1984 pp 1-3.
- (2) DHSS "Working Together" HMSO 1988.
- (3) Ibid.
- (4) Ibid.
- (5) Schechter, MD & Roberge, L (1976) "Sexual Exploitation" in "Child Abuse and Neglect: The Family and the Community". Helfer, R.E. & Kempe, CH (ed.) Ballinger, Cambridge, Mass.
- (6) Steele, B.F. & Alexander, H. "Long Term Effects of Sexual Abuse in Childhood" in "Sexually Abused Children and their Families", Mrazek, P.B. & Kempe, CH (ed.) Pergamon Press, New York 1981 p. 224.
- (7) Walker, L. "Battered Women" Harper & Row, New York 1979.
- (8) Browne, A. "When battered women kill" in "Abuse and Victimization across the Life Span", Straus, M. (ed.) John Hopkins University Press, Baltimore 1987.
- (9) Davies, S. "Domestic Violence — A Police Approach" in "Safety for Women Conference", The Stationery Office, Dublin 1993 p. 28.
- (10) Mrazek, P.B. "The Nature of Incest: A Review of Contributing Factors" in "Sexually Abused Children and their Families", Mrazek, P.B. & Kempe, CH (ed) Pergamon Press, New York 1981 p. 100.
- (11) Kempe, RS & Kempe, CH "The Common Secret: Sexual Abuse of Children & Adolescents" W.H. Freeman, New York 1984 p. 49.
- (12) Mrazek, P.B. op cit. pp. 97-100.
- (13) Mrazek, P.B. op. cit. p. 99.

- (14) Kempe, RS & Kempe, CH op. cit. p. 53.
- (15) Ibid p. 50.
- (16) Ibid p. 50.
- (17) Ibid p. 52.
- (18) Sgroi, S.M. Blick, L.C. & Porter, F.S. "A Conceptual Framework for Child Sexual Abuse: "Handbook of Clinical Intervention in Child Sexual Abuse" Sgroi, S.M. (ed) Lexington Books, Mass. 1982 pp. 28, 29.
- (19) Ibid p. 29.
- (20) Ibid p. 29.
- (21) I.C.C.L. "Report of Child Sexual Abuse Working Party" 1988 p. 36.
- (22) Groth, A.N. "The Incest Offender" in "Handbook of Clinical Intervention in Child Sexual Abuse" Lexington Books, Mass. 1982 p. 215.
- (23) Ibid pp. 216, 217
- (24) Sgroi, S.M. Blick, L.C. & Porter F.S. "A Conceptual Framework for Child Sexual Abuse" op cit. p. 27.
- (25) Groth, A.N. op cit. p. 218.
- (26) Groth, A.N. op cit. p. 225.
- (27) Finkelhor, D. "What do we know about Child Sexual abuse", Surviving Childhood Adversity Conference, Dublin, July 1992
- (28) Finkelhor, D. "Child Sexual Abuse: New Theory and Research", The Free Press, New York 1984 pp. 11, 12.
- (29) Gilligan, R. "Irish Child Care Services: Policy Practice and Provision", I.P.A., Dublin 1991 p. 64.
- (30) McKeown, K. et al "Child Sexual Abuse in the Eastern Health Board Region of Ireland in 1988", E.H.B. Dublin 1993.
- (31) Ibid p. xxv.
- (32) Ibid p. xxix.
- (33) Ibid Table 53, p. 76.
- (34) Ibid, Table 80A, p. 110.
- (35) Ibid, p. xxxviii.
- (36) Ibid, Figure 13 p. 134.

CHAPTER 7

The Family Story

Family Structure:

Mary: *Date of birth: 28/11/65*

Father: *Date of birth: 20/01/45; Unemployed*

Mother: *Date of birth: 10/11/42; Fulltime factory worker*

Sister: *Date of birth: November 1964; Died: 12/12/64*

Sister: *Date of birth: 24/02/68*

Mary's child: *Date of birth: 20/05/82*

Religion: *Wesleyan Methodists*

Nationality: *English*

Before Mary's Birth

Mary's parents married in January 1964 and their first child, a girl, was born in November, 1964. The baby was premature and required three-hourly feeding. At that stage, the family lived in a two storey farm cottage in England. On the night of 11th/12th December, her parents placed her in a carry cot beside the open fire in the living room on the ground floor. The parents then retired to their bedroom on the first floor. During the night mother got up to feed the baby. She went downstairs and tried to turn on all the lights but could not see anything. When she entered the living room, everything was smouldering. She went over to the cot "I picked her up and she was hot and I dropped her and when I dropped her I didn't notice that I didn't drop her back into the carry cot but on to the chair".

Father was alerted by mother's shouts. He ran to a neighbouring house and they contacted the fire brigade. Mother never saw her baby again. She now says "*I would have liked to see her, they said they put her back exactly as she was and I think I should have seen her.*" Mother cannot recall if her husband touched the baby in the house but she does know that he saw her body afterwards. The death certificate of this baby has been

provided to the investigation team by the U.K. authority. The cause of death was recorded as accidental.

After this tragic event the couple no longer wished to remain in the cottage and they returned to live nearby with the father's parents. During this time, the family's general practitioner was the main source of support to the couple. He knew both parents well as his professional relationship with them dated back through their childhood. Mother's recollection of her reaction to the loss of her baby is unclear other than "I think we kept it in. We didn't let it out".

The general practitioner advised the couple that they should have another baby as soon as possible and Mary was born a year later on 28th November, 1965.

Mary's first ten years

At this stage, Mary's mother and father were living with her father's parents. Within a year of Mary's birth, however, they had bought their own house in a nearby town. Mary's recollection of time spent in this house is not very clear. She has described herself as being "*happy enough*". If Mary and her younger sister misbehaved, she remembers her father shouting at them. Her mother figured for her as the dominant influence at this stage and she does not remember having a close relationship with her father. He had a number of jobs during this period, first on a building site and later driving a bread van. Her mother worked part-time as a cleaner in a local school.

Mary recalls frequent visits to her grandparents, particularly her father's parents. These appear to have been happy occasions. She says that she and her sister had friends but were not with them very much. "*After school we returned always to home*". In looking back on her childhood she describes herself as a tomboy. She remembers being "*told off*" for playing football rather than playing "*girls games*". Both sisters attended the local convent school.

The move to Ireland

According to the family members, the father had always wished to have his own farm. While living in town, he had rented some acres nearby on which he kept some animals. Mother talks about numerous attempts on their part to buy land in England but of being unable to do so. Mother and father travelled to Ireland on a number of occasions in search of land to purchase. Father, in particular, favoured a move to Belfast but mother was afraid to move there. On one of these trips, having arrived in Rosslare, without apparently having a precise destination in mind, they travelled through Wexford to Carlow and met a local estate agent. He showed them property which had just come on the market. It consisted of five acres and a prefab building and the couple purchased it immediately. As mother said "*We went out to see it and he says 'We'll buy it' and that was it*".

The family had no prior connection with their new locality or any particular part of Ireland. Mother says her grandmother was Irish but "*she left Ireland when she was eleven in the years of the Famine*". Mary and her sister knew that a move was planned but did

not know their destination. Mary suspects that a precipitating factor in the move was *"There were women in the house at the time and I thought he was having affairs"*.

The family moved to Ireland in the period between Christmas 1975 and New Year of 1976. Their new home was an isolated prefab which had *"no electricity, no water or toilet. Nothing"*. Until their electricity was connected, they had to use a camping gas cooker and they were loaned a gas heater from a neighbour. Their financial situation was very difficult at this stage: all the family members vividly remember living on pancakes during this time. Father could not get a job and was in receipt of Home Assistance of £6 per week. Within a very short period, mother attended a course organised by ANCO. Soon afterwards she commenced shift work as an operative in a factory some distance away and she has remained working there since then. Father had one brief period of employment in a local hotel as a night porter.

Some four years after they arrived in Ireland, the family moved from the prefab to a terraced house in a townland nearby. They retained ownership of the land. Although their new home was less isolated, Mary and her sister do not recall much interaction with neighbours or play with local children.

Mary and her sister had started in the local convent national school in January, 1976, where she spent two years before transferring to the secondary school. It would appear that Mary did not have any close friends in school and after the sisters came home each day there was no contact with classmates. In secondary school, she remembers spending time with *"lads of my own age, I could get on with. Played football and rugby... I had more in common with them. Most of them were farmers. You'd be talking about cows and that. Girls always want to be in washing their hair or putting on makeup"*. Mary had a special interest in animals. Her mother told us *"she's gifted with animals, she'd nearly make them talk to you"*.

The abuse

Mary recalls the first incident of sexual abuse by her father as occurring in late January, 1976, within weeks of their arrival in Ireland. *"I was eleven, and when I asked him he told me he was punishing me, I was bold..."*. The beatings first happened around the same time. Mary has given a history of frequent incidents of physical and sexual abuse which sometimes happened separately and sometimes together. *"All this was brand new. I thought when he did this to me 'what did I do wrong?'. The more I struggled, the more I got hit. So I would just lie there and got it over with. The less you struggled the less you got hit"*. Mary remembers asking her mother to intervene — *"There was once I told mother, daddy is after doing something wrong I told her. I don't know how to describe it. She said don't worry about it, I'll sort it out. It seemed to sort itself out for a couple of months, but then it started again"*.

Although many of these incidents followed alcohol intake by her father, Mary was also abused when her father was sober. Undoubtedly, the alcohol was an aggravating factor. *"The more he drank, the angrier he got...it would all come out when he was drunk"*. Her father drank whiskey and poitin and as his drinking increased, he visited the pub less often and drank at home. Mary describes her father as being prone to unpredictable outbursts and mood swings. This was very difficult for the children as they never knew what to

expect. She was also subject to verbal abuse by her father who called her a “*whore*”. The sexual abuse occurred when Mary was alone in the house with her father; her mother would be at work and her younger sister at school. Frequently, he insisted that she remain at home from school saying her help was needed on the land. On other occasions when the abuse happened, both her mother and her sister were shopping.

Physical injuries inflicted on Mary by her father included “*black eyes, cuts and bruises and I had broken ribs, broken fingers, stuff like that*”. They culminated in a very severe eye injury in December, 1991, and the final physical assault which led to her hospitalisation and the subsequent court case. At her father’s insistence, she attended different general practitioners for the treatment of these injuries. “*Daddy didn’t want them putting two and two together. If I went to the same doctor all the time, the doctor would realise the injuries could not be all from one source*”. On presentation to doctors or at the hospital, Mary, on her father’s prompting, had an explanation which was prepared in advance at home. “*He would tell you what exactly to say if he didn’t go and if he went with you, he would make up the story*”.

Apart from receiving minimal information from her mother about menstruation, Mary received no formal sex education either at home or in school. When the abuse commenced, she had no understanding of what was happening to her and thought it was as a result of having done something wrong.

Pregnancy and Birth

At Christmas, 1981, Mary attended a general practitioner because her stomach has swollen. She had no idea why this might be so and the doctor told her it was “*too much wind after Christmas*”. Soon after, she and her mother attended another doctor who told her that she was pregnant. She was approximately four months pregnant at this stage. On the journey home from the doctor’s, her mother asked “*Is it your Daddy, child ?*” and I just said “*yes*” and she said “*I’ll sort this out*”. She ceased attending school at this stage.

Her child was born in 20th May, 1982. Mary reports that in the period between confirmation of the pregnancy and the birth, her father did not interfere sexually with her. He did continue to physically beat her. Approximately seven days after her son’s birth, her father resumed intercourse with her. Her father was drinking very heavily at this stage and although abusive to his wife and children, was very fond of her child: “*he was the doting grandfather*”. Prior to the birth, father had said that if she had a daughter, she was to place her for adoption but that if it was a boy, he would adopt the baby as he always wanted to have a son.

Mary continued to live at home with her son. Although she had not completed her education, she did not attend any training course or work outside the home. Her mother was still working in the factory and absent from home for long periods of time. Her younger sister had left the family home. Her father insisted that she “*go on the pill*” and her mother accompanied her on the visit to the doctor who prescribed the contraceptive.

Mary was in receipt of the Lone Parent Allowance. When she went to collect this each

Thursday her father waited outside the post office and took the money from her: *"One Thursday I asked him for a fiver and I got a black eye from him"*. Pocket money was received from her mother.

Any contact with classmates did not appear to survive her departure from school. With neighbours, only minimal contact was maintained. She did trust, and relate to, one older neighbour and also liked and relied on a family who lived a number of miles away. She chose the father of this family as godfather to her child. She had no contact with her own extended family except for occasional visits to her paternal grandmother who lived in England.

Mary ran away from home three times. On one occasion she went alone to her paternal grandmother in England; her father arrived three days later and took her home. In 1985, she moved with her child to a hostel in Dublin. This was arranged by the health board's local social worker. They stayed there for three weeks and she recalls it as being a happy time for her. Her parents discovered her whereabouts from the local gardaí and her father arrived at the hostel unannounced. She reports that due to his constant harassment of residents and staff in the hostel she was asked to leave (her mother states that it was she who collected Mary from the hostel and makes no reference to the father travelling to the hostel). In any event Mary and her child returned home, and her father promised he would no longer physically or sexually assault her. The promise that the abuse would cease was broken within three to four months and the abuse was to continue for another six years.

In early December, 1991, Mary was again severely physically assaulted by her father. He had been drinking very heavily that day; he hit her over the eye and her nose and top lip were swollen. When he had left the house she telephoned the gardaí from home. A local garda visited by which stage her father had returned to the house. In his presence, she and her mother were asked if they wished to make a statement but as her mother told our investigation *"We thought we probably would have got worse once he'd gone and we didn't want to talk ourselves into any bother"*. Her father went to bed on the garda's suggestion and this concluded the incident.

At Christmas, 1991, Mary and her father went to visit his mother in England. Her father drank heavily during the Christmas period and on December 26th, following a row with his mother about his drinking, he decided to leave for Ireland with Mary. As it was a Bank Holiday, there was no transport available. Mary carried her father's bags for him. She slipped and he kicked her in the face with his boot, severely damaging her eye. They had to walk a very long distance to the nearest hospital and while walking her father continued to berate and kick her. At the hospital her father explained the injuries as being the result of a mugging. Mary received five stitches and was discharged from hospital. After returning to Ireland the following day, she was referred to an eye consultant.

For Mary, this was a crucial turning point: *"Years before going through all this since I was fifteen or sixteen, I always felt my spirit was broken. The body was something else whereas myself as a person looked out through the window of my eyes. That's how it was for years. I felt*

my spirit was broken. But now when he blinded me: — Who gave him the right to do it ? And I was just so angry”.

About two weeks later, in mid January 1992, Mary was again physically assaulted by her father. She ran out of the house, hid from her father and sought help from neighbours. These neighbours brought her to the general practitioner and she was admitted to hospital. The relevant legal and health authorities were notified. Following discharge from hospital, Mary and her child moved to a refuge for battered women and their children. They have not returned to the family home.

Mary's Sister

Like her older sister, Mary, she was born in England. By the time of her birth, the family had moved into the house in town. Due to her relative youth, she does not have many memories of this time, but she recalls frequent visits to her paternal grandparents. When asked about happy memories of that period, she specifically remembers these visits. She remembers having the usual rows with Mary, but she also said they spent more time together rather than playing with other children. She remembers much more contact with her mother than her father and has no memory of her father hitting her at this period. If she had to be chastised, it was her mother who punished her. She attended the local school in England. There appears to be no significant events that she can recall from that period.

She (sister) was seven when the family moved to Ireland. With Mary, she was enrolled in the local national school. The major difference she remembers from this time is that her father was present more often than her mother. The beatings by her father commenced after their arrival in Ireland. *“One day myself and Mary were off on bikes. And we had hens and the fox came and took two of them. When we came back he strapped us... he made you take down your trousers and bend down... there used to be metal on the belt and if that caught you it would hurt.”* On another occasion she describes helping her father clear ditches in cold weather: *“We were getting cold and hungry.... He wouldn't take any notice.... He made me take off my clothes and stand in the field for an hour or so. I'd have my vest on and he told me not to complain about the cold”.* On another occasion she recalls being hit on the side of the head with a turnip.

She (sister) enjoyed going to school as it offered escape from the situation at home. She had friends in school but she was unable to continue these friendships outside school hours. She and Mary were not allowed out to play and spent a lot of their free time helping their father on the land: *“They (neighbours) all thought we were queer because we would never mix. We would always be on our own... We would see them out playing and wish we could do that”.*

Beginning in early adolescence, she (sister) ran away from home on a number of occasions. Each time her father came and brought her back again. Once, the father engaged the assistance of the gardaí in bringing her home. Soon after the birth of Mary's child in 1982 she (sister) was beaten by her father with a hand carpet sweeper. This broke on her back as he hit her and she also sustained a head injury. She was brought to the local doctor to be stitched. *“My mother came with me but he had her well told”.* Her

father had decided in advance that the doctor was to be told that she had hit her head on a cupboard.

On her third attempt at escape, when she was about fifteen years old, she (sister) left home never to return. She went to live with neighbours: *"She welcomed me into her home and was very good to me.... I could see the difference between the two"*. When asked if she had been sexually abused by her father, she said *"No. That's why I used to laugh about it. I was only a punchbag"*. Mary had told her that her father had tried to have intercourse with her: she had not been aware that her father was also the father of Mary's child.

After moving to live with neighbours, she (sister) had absolutely no contact with any of her family until the gardaí contacted her with a view to obtaining her statement in relation to charges against her father: *"You would hear rumours but no contact. Not until I went and met my Mam"*.

She subsequently married. Neither of her parents attended her wedding. She and her husband have three children. She is a happy and confident young woman who is very committed to the upbringing and welfare of her children.

Father

As Mary's father was not interviewed, our only source of information pertaining to him comes from our interviews with family members.

He was born in a rural area in England. He was an only child. On leaving school he worked on a farm. His father, who had been in a nursing home for some time suffering from dementia, died in 1988. He would have preferred to have arranged care for his father with his family in Ireland. His mother, who is now aged 82, is still alive and living in England.

Mother

She was also born in a rural area of England, the eldest of three children. Her mother died in 1977 and her father died in 1989. She recalls her childhood as being a happy time. On leaving school, she went to work on a farm. In 1962, when she was aged 20, she met her future husband. Their courtship was a happy time: *"They were all good times then"*. At this time he occasionally drank beer, but not spirits.

The couple married two years later. Initially he continued to work on the land and they set up their first home in a farm cottage. She (mother) went to work in a draper's shop until the birth of their first child in November, 1964. After moving to the town he abandoned farm work and went to work in a variety of jobs based in the town. These involved long hours and absences from home.

Mother's experience of childbirth was unusual: her labour was very short and all the children were born before she arrived at the hospital. She had a minor heart attack at the time of the birth of her youngest daughter and was advised by her doctor not to have any more children. She was prescribed the contraceptive pill. Because of the death

of her first born child the first five weeks of each subsequent baby's life were a worrying period for her.

After coming to Ireland, she (mother) became the sole wage earner in the household and drove the family car. As mentioned above, she was a factory operative who worked shifts. She confirms her daughters' accounts of little or no contact with neighbours. The family did not have callers to the house: *"They would, further up the road. But they didn't come down our way...I always assumed they never liked us but I found out since that's not true"*. Mother's recollection differed from Mary's in that it was not until Mary's pregnancy was confirmed that she became aware of the sexual abuse which was happening in her family: *"When Mary got pregnant, that was the first. I never knew anything was going on before that...He maybe gave them a clatter if they didn't do what they were told. But you probably wouldn't take a lot of notice because when I went to work I did shifts"*. When asked if she knew about the children's injuries she responded *"No. Because I was coming back late and I would not turn the light on and when I'd check on them and they could be down under the covers and you wouldn't see anything then"*.

When she did notice injuries, she (mother) believed the explanations which were given to her. She expresses surprise at learning of the sexual abuse of Mary by her father and the resulting pregnancy. She spoke to both Mary and her father: *"Would you believe, I can't remember exactly what I said. I laid it on the line to them that couldn't happen any more"*. She did not think there was anything else she could do or that there was anyone she could talk to about the situation. With regard to how questions regarding the baby's paternity might be answered at the maternity hospital, mother says: *"We decided for a while we wouldn't say who the father was and see what happened afterwards"*.

As mentioned earlier, on one occasion Mary was placed in a hostel in Dublin. When her parents traced her and persuaded her to return home, Mary told her mother *"she didn't want to be living like that again. He promised it wouldn't happen again and I asked her afterwards and she said no, it was not happening at that stage. But it did start again"*.

Mother talks of being beaten by her husband: *"You could get a clatter an odd time here and there. It could be the legs, or the body or the hands, or the face which hurt most"*. On one occasion, she and her husband were requested to visit a local general practitioner, following Mary's disclosure to him that her father was sexually abusing her. Both parents met the doctor but as the doctor confronted her husband with this information, he walked out and returned home. She went to work.

In 1992, following Mary's admission to hospital and subsequent confirmation of physical and sexual assaults, father was questioned by the gardaí for a number of hours. On return home, mother remembers giving him something to eat after which he went to bed. *"He got over that and he never said a lot about it after that"*.

Her husband travelled to England on three occasions, staying with a cousin. She borrowed money to finance his journeys as she was ill and out of work at this time. After returning to Ireland, her husband returned to the family home where he stayed for ten weeks, never leaving the house. *"If they knew he was back he would be arrested"*.

Mary was aware of her father's return and she informed the gardaí. Her husband is now in prison where she visits him once or twice a month. She sends him money weekly for cigarettes.

CHAPTER 8

Case History — Mary's Contact with Health Services

Introduction

Mary's contact with the health services spanned the period 1975 — 1992. We have divided this into three sections as follows:

(i) 1975 — November, 1981 — Childhood

This covers the period up to when Mary reached age sixteen years. This was the period during which it was open to the South Eastern Health Board, under the Children Act, 1908, to take legal action to protect her had the Board knowledge of her being abused.

(ii) November, 1981 — 1983 — Early Adult

This period covers Mary's life between the ages of sixteen years and eighteen years. Given the full implementation of the Child Care Act, 1991, a health board could protect a young person up to the age of eighteen years through the provision of a care order and/or supervision order. This section is further divided into:

- (i) the period of her pregnancy and confinement;
- (ii) post confinement.

(iii) November, 1983 — March, 1992

This period relates to when Mary was over 18 years of age and includes:

- (i) A review of the six years from 1984 — 1990;
- (ii) The final period December 1991 — March 1992 when disclosures led to effective action.

SECTION 1

1975 — November, 1981

From the time of their arrival in December, 1975 to November, 1981 Mary attended the local general practice on twelve occasions. Nine of these visits were for injury related problems. These included abrasions, swelling, strains and scalds. Many were deemed to be of a minor nature.

On three of these occasions — August 1976, August 1979 and November 1981, she was referred to St. Luke's General Hospital, Kilkenny for x-rays of her knee, finger and arm. These were reported as normal.

Mary had a school medical examination in 1976. Her consent form highlighted poor vision and enuresis. Assessment of her vision indicated that she was 6/60 in her right eye and 6/24 in her left eye — indicating poor visual acuity. This deficit was virtually corrected with glasses (6/9 in both eyes).

In 1980, as a second year student, Mary was referred by her school guidance counsellor to an educational psychologist as she seemed to be having great difficulty making friends, was isolated by her class-mates and tended to tell lies leading apparently to further isolation. With remedial help from her teacher, she was placed towards the top of a weaker class at the school. Her attendance was quite irregular for a long time and she missed a number of weeks at one stage. The psychologist first met Mary on 18th November, 1980.

SECTION 2

November 1981 — May 1982

The school psychologist met Mary and her family in December 1981, February 1982 and April 1982. In her report dated 17th May, 1982, the psychologist noted that "*Mary seems a girl who does have emotional difficulties and needs which are not being met*" and recommended that she be:

1. Referred to the National Rehabilitation Board for suitable training and work placement; and/or
2. Referral to area social worker/psychologist if (1) is not available, to act as a support for this family.

In the period of November 1981 to May 1982 Mary attended her local general practice on four occasions and saw three different doctors on these visits. Her pregnancy was suspected on the third visit in January 1982 and was confirmed in February, 1982. She was referred to St. Luke's Hospital, Kilkenny for ante natal care. Mary first attended St. Luke's Hospital, Kilkenny on 29th March, 1982. She presented as sixteen years old and unmarried, and was accompanied by her mother. Her examination is reported as "*very normal*", with no other significant comment.

On May 10th, 1982, Mary attended for her second ante natal clinic, again accompanied

by her mother. Pregnancy was estimated at 34-36 weeks and no abnormalities were noted.

On the 20th May, 1982, she was referred by her general practitioner to St. Luke's Hospital in spontaneous labour. The hospital medical records note that she had a normal delivery of a healthy male infant and that she was keeping her baby.

Mary and her baby were discharged home from St. Luke's Hospital on May 25th, 1982 and the birth of the infant was notified to her local area public health nurse. A discharge letter was forwarded to her general practitioner.

May, 1982 — November, 1983

The first visit to the family home by the local public health nurse was on the 27th May, 1982 and it was noted that the baby was making good progress. Mary was advised on feeding, hygiene and general child care management.

In early June, on receipt of the report from the educational psychologist, the National Rehabilitation Board (NRB) referred the case to the Social Work Department, South Eastern Health Board, Co. Clinic, Kilkenny. At this stage the NRB advised that Mary did not qualify for placement within its work placement/training programme. The Health Board was advised to recontact the NRB offices after a social worker assessed her case to consider if any further assistance might be available.

The case was assigned to a student social worker with child-care experience who was on professional placement with the Board. He first called to Mary on the 18th June, 1982. She was alone in the house with the baby at the time. The baby was about three weeks old and his report noted that she presented as a friendly, outgoing, talkative young girl who seemed happy with the situation at home and the way her parents had accepted the baby at home. She told him that the father of the baby was a married man with two children who lived in the area and who no longer had any contact with her. She had a new boyfriend, a local boy of her own age.

At this stage Mary had applied for the unmarried mother's allowance and was in the meantime receiving £15 per week supplementary welfare allowance.

The home conditions were noted as being very poor and as far as the social worker could ascertain, Mary's immediate needs were of a material nature such as blankets etc. for the baby. He got in touch with the Social Service Centre to arrange these for her. In their discussion, she indicated that she intended staying home to look after the baby and did not want to go back to school or get a job. According to her there was great support for her and the baby at home.

The social worker's assessment on this initial visit was that he felt that he should also meet Mary's parents, as Mary's assessment of the situation, particularly the support from her family, seemed a little ambiguous. While he identified her immediate needs as material, he also identified a need for ongoing emotional support and counselling.

On the 14th June, 1982, Mary was revisited by the public health nurse and the file report noted that the home conditions and hygiene standards were poor. The infant, as a matter of routine, was listed for monitoring by the public health nurse as "*at risk*" due to mother's age, her unmarried status and environmental conditions.

On the 18th June, 1982, Mary brought her child to her local general practitioner for his "*six weeks check up*". On the same day, the public health nurse called to her and advised her on the introduction of solid feeds. The public health nurse's record also noted that she asked the social worker attached to the local office of the Ossory Social Services to visit Mary. The team interviewed the social worker attached to the office of Ossory Social Services at this time and she did not recall visiting the family. The Ossory Social Services had close working relationships with the social work department of the South Eastern Health Board and the normal practice at the time was to discuss referrals. Where the case was being handled by the health board staff, the social worker of the Ossory Social Services would not take on the case.

A further follow up surveillance visit was made by the public health nurse on 22nd June, 1982.

On the 23rd June, 1982, the social worker visited Mary for the second time and the purpose of the visit was to explore with Mary her feelings about being home with the baby and how things were working out since she brought the baby home. During the course of the interview Mary spoke about her relationship with her father which it was noted "*seems to be a very important and significant one*". She spoke of her father's violent reaction when he discovered she was pregnant by a married man. He had beaten her with the poker and he only stopped when she shouted at him that it might be a son. Her father's reaction to this was to stop beating her. He began to cry and agreed that if the baby was a boy she could bring him home but if it was a girl he would throw her out.

The report of the social worker further noted that Mary's relationship with her father was highly significant and she described how she cried when he did not visit her in hospital and that she was discharged early from hospital because "*she missed her daddy so much*". The report raised questions about the role she was playing in the family, the family relationships in general, and her negative feelings towards her mother, including questions of boundaries, limits and expectations. Also it questioned how she was permitted to have an affair with a married man locally for two years, occasionally staying out all night, while in other ways her father was very authoritarian. This pointed to inconsistencies in the family structure.

During the social worker's visit on the 23rd June, 1982, Mary's mother arrived home from work. She presented as a strong forceful woman, who, "*although quite friendly, had an air of intimidation about her*".

On the 5th July, 1982 the social worker revisited the family. Mary was alone in the house although she said that her boyfriend, whom she had met the previous night, had just left. Her father and sister were at the farm and her mother was at work. She was now receiving £42.00 p.w. unmarried mother's allowance, but said that her mother

took this from her for keeping her and the baby. She did not mind this as she didn't need any money and if she did, *"her daddy would give it to her"*. During this visit she indicated that her relationship with her sister was very bad and getting worse and that her sister presented a very negative reaction to her baby. The social worker report noted *"there appears among other family dynamics, to be very strong sibling rivalry, with both sisters competing strongly for various effective roles within the family"*.

On the 20th July, 1982, the social worker again visited Mary. She was alone in the house with the baby and she indicated that her relationship with her sister had worsened. At this stage the social worker indicated that he wished to speak to the whole family.

On the 3rd August, 1982 the social worker revisited the family. On this visit the entire family was in the house, though the father was in bed asleep. A further visit was arranged for August 16th, 1982. The report noted that Mary's mother was very keen to have this meeting but Mary was reluctant and tried to make *"feeble excuses"* as to why the meeting should not go ahead, though she denied trying to block the meeting. The report of the meeting also noted that Mary's relationship with her sister seemed different to the one she described. There appeared to be friendly banter between the girls and the atmosphere in the house seemed to be carefree. The report concluded *"I am not sure if Mary has been telling me lies, but she certainly hasn't been telling me the whole story"*.

On the 7th August, 1982 Mary was visited by the public health nurse. The child's developmental progress was satisfactory and she was advised on hygiene, bottle sterilisation and child immunisations.

On the 9th August Mary attended her GP complaining of a pain in her leg. A week later, 16th August, 1982, Mary attended the medical out-patient department at St. Luke's Hospital, complaining of pain in her left leg, from her ankle to her thigh. On examination she was found to be limping and there was paraesthesia over the left leg. There is no history of injury noted in the file. She was referred by the consultant physician to the Richmond Hospital Dublin.

On the same night 16th August, 1982, the social worker met the entire family in their home. The atmosphere in the house was described as very pleasant and the family presented as being very warm and caring and, although unsure as to what was going to happen, they were willing to use the social worker to help them to talk to each other.

On this occasion Mary's sister spoke of her feelings towards the baby and that she was not getting any attention since the baby arrived. Mary spoke of her preference for her father over her mother and the family touched on the fact that there was a lot of role confusion in the house but did not explore this in any depth.

During the meeting the social worker discussed the possibility of another social worker calling and continuing to work with them and the family were willing to co-operate.

On the 26th August, 1982 Mary was admitted to the Richmond Hospital. She was discharged on the 2nd September, 1982 and her discharge letter stated that there was no

history of injury. The diagnosis given in the letter of discharge was hysterical conversion syndrome.

During his placement with the South Eastern Health Board the student social worker was under the supervision of the senior social worker. He returned the file to him on completion of his placement. Shortly after he had left the Board, Mary made a number of phonecalls to the social work department requesting to speak to the male social worker who had previously called to her. She was advised that he was no longer employed in the department and she was offered a referral to the area social worker which she declined.

On the 7th December, 1982, Mary was visited by the public health nurse as part of her routine follow-up surveillance of the baby. The record of this visit noted that her mother and father were present at this time. The father was very hostile and aggressive towards the public health nurse's visit and did not see the need for it.

There are no notes on the file to indicate social work contact with Mary during this period. However, it transpired during our interview with the senior social worker that he remembered contact with the family in the late 1982/early 1983. The senior social worker recalled receiving a note from Mary requesting that a social worker call to the home to discuss her parents adopting her son, who was now about six months old. The senior social worker recalls visiting the home on two occasions and a number of telephone contacts in this regard.

On the first of these visits to the family home Mary, her child and her mother were alone in the house. In their discussions Mary advised the senior social worker that she wanted to talk about having her baby adopted. She wanted to know if she would have any say where he would be placed as her parents wanted to adopt the child. She then asked if the fact that her father was the father of her child would help in her parents adopting him.

The senior social worker clarified what she was saying and she confirmed that her father was the father of her child. This statement was made in the presence of Mary's mother who confirmed that she knew what had been happening. In discussing the matter further both Mary and her mother also confirmed the violence in the home by the father against Mary, her mother and sister. This was the first revelation of incest to a staff member of the South Eastern Health Board.

At this stage Mary and her mother were advised that adoption in such circumstances would be inappropriate. The senior social worker asked them to consider their own position and advised them that they did not have to continue living in their present abusive circumstances. He advised them that they could go to the gardaí and make a complaint, go to a solicitor and apply to the Courts for a barring order or leave the family home. Neither Mary nor her mother were willing at this stage to consider these options. Mary and her mother asked the senior social worker if he would do something to help them and he advised them that unless the baby was under threat or at risk that he had no statutory powers to intervene. Mary and her mother assured him that the baby was not at risk and in fact that the father "*doted on the child*". The senior social

worker did agree to help Mary and her mother to make a decision and to support them in following through this decision. He also agreed to come back to speak to Mary's father and a second visit to the family was arranged. Between visits the senior social worker called to the Kilkenny Garda Station to check the legal position of Mary and her mother but did not advise the gardaí of the details of the particular case. He was informed by the gardaí that they would only take action in a case of domestic violence if a member of the household was willing to make a complaint and they also referred to the difficulties in successfully prosecuting cases of incest through the offices of the Director of Public Prosecutions.

On his second visit to the family home Mary's mother informed the senior social worker that her husband was not at home and that he was refusing to meet him. Again the senior social worker outlined the options available to them and offered to accompany Mary's mother to the garda station to make a complaint. Mary's mother was unable to make this decision. The senior social worker then told Mary that she would have to make her own decision and he arranged for her to call to his office to meet him.

When Mary called to the office of the senior social worker her biggest concern was of being removed from the house and being separated from her baby. She was assured by the senior social worker that this would not happen and he tried to get her to recognise what was happening in the house, that she need not tolerate it and that she should leave. During this meeting Mary spoke again of the physical violence in the house but made no reference to the sexual violence. She was also asked by the senior social worker if she would prefer to discuss the matter with a female social worker and she declined. In the discussion with Mary, the senior social worker advised Mary that she should leave the family home and raised some options with her, i.e., a hostel in Dublin or a flat in Kilkenny, and he agreed to investigate the possibility of hostel accommodation in Dublin.

At the end of their meeting Mary told the senior social worker that she did not want him to call to her at the house and they agreed for him to telephone her at particular times.

The remaining contact between Mary and the senior social worker was by telephone. The senior social worker got the information on the hostel in Dublin but Mary was not willing to consider it even as an interim move. The senior social worker telephoned her on two or three more occasions to encourage her to leave.

During one of these telephone conversations Mary told the senior social worker that she was going to stay in a flat in Dublin with a friend, to see if she would like Dublin. Her final contact with the senior social worker was when she returned home from Dublin having decided that she did not like it there. She told the senior social worker that she had decided to stay at home as things had improved and were much better. At this, she was advised that if circumstances changed she could contact the social work department again. This was in or about Winter 1982/early Spring 1983.

In his final analysis the senior social worker recalled that the key issue for Mary at this

time was *“her baby and not being separated from him”* and his primary focus was to encourage and support Mary to leave the family home with her son.

There are no written records of these contacts in the social work file. In our interviews with the senior social worker he recalled receiving the written note from Mary requesting a visit and he further recalled writing up case notes for the file. Despite intensive searches these notes have not been found.

There are no records of child welfare visits by the PHN in 1983. On the 10th March, 1983, Mary’s baby was not brought for his scheduled developmental assessment at nine months. Mary stopped attending her local GP with whom she was a registered General Medical Services (medical card) patient and began attending a GP in Carlow without changing her GMS registration.

On the 6th September, 1983, now aged seventeen years, Mary was seen at the surgical out-patient department, St. Luke’s Hospital, Kilkenny on referral from a Carlow general practitioner for the removal of a plantar wart. She was admitted to hospital on 21st September, 1983 and the wart was excised. The consent for this operation was signed by her mother. She was discharged on the 22nd September, 1983. She was visited on a number of occasions by the local public health nurse for dressings and attended at the Out-patient Department on 11th October, 1983.

In the Summer/Autumn 1983 Mary’s sister ran away from home to live with a neighbouring family. She had run away on two previous occasions but on each occasion had been persuaded by her parents and the gardaí to return home. She continued to live with this family until she married and had no further contact with her parents or her sister for eight years.

SECTION 3

January — December, 1984

On the 1st May, 1984, aged 18, Mary attended at the Out-patient Department, St. Luke’s Hospital, Kilkenny and was admitted on the 10th May, 1984, for an appendicectomy. Nothing significant is recorded on the medical record and consent for the operation was signed by her mother.

On the 5th September, 1984 Mary was visited by the public health nurse who had received complaints that her child was not being well cared for. The record of the visit noted that the child was examined and there were no marks or bruises, though the child appeared clingy. During the visit her mother and father arrived home and seemed to relate well to the child but the public health nurse noted that *“some of the attention may have been put on”*.

During the same visit Mary told the public health nurse that she was pregnant and was very worried and was not sure if she would get married. She had not told her parents. The public health nurse record noted *“not sure if it is true or not. Does not appear to be pregnant”*.

Mary was revisited on the 18th September, 1984, 12th October, 1984 and 16th October, 1984 by a locum public health nurse at the request of the area public health nurse who was on leave. On the 16th October, 1984 Mary's father was in the house. He was hostile and aggressive toward the public health nurse and he told her not to return. She and her son were in the house at this time but did not meet the public health nurse. After the visit the public health nurse wrote to the superintendent public health nurse for advice.

January — December, 1985

The public health nurse visited the house in March 1985, June 1985 and 17th August, 1985, but did not meet Mary or see her son. The record of the June visit shows that the house was occupied but the public health nurse was not admitted and she rang the social worker about the case.

The file of the social worker noted a telephone call in March, 1985 from a solicitor in Carlow, in the presence of Mary and a male friend, enquiring about the possibility of leaving her son in the care of her parents. The record further noted that this was not pursued and she returned home to live with her parents.

On the 31st May, 1985, now aged 19, Mary was referred by her general practitioner to the Casualty Department, St. Luke's Hospital, Kilkenny presenting as having fallen on her left arm and injuring it while playing football. A provisional diagnosis of a fractured scaphoid was made. She was x-rayed, put in a plaster and was called for a review. The x-ray reported as normal and no further attendance is recorded.

The file of the social worker recorded that she tried to make contact with Mary throughout the Summer of 1985 following referrals from both the public health nurse and a neighbour expressing concern at the rumours they had heard. The report noted that the social worker met her on one occasion in June, 1985, outside her house and Mary said she would not invite her in as her father would never agree to her discussing her problems. The report of this meeting contains her allegation that *"her father was cruel to her, that he continually raped her and took her unmarried mother's allowance"*.

The report continued *"It was very difficult to know how real any of this was and how much of it was a combination of Mary's fantasy and imagination. I emphasised to her that she should consider doing something about her situation. I asked her to think about this and that I would see her about these allegations again. I told her that I was unwilling to be dragged into a situation of listening to her stories and then not being allowed or placed in a position to do anything about it. Consequently I arranged to meet her in Carlow the following week. This was to coincide with Mary's visit to her general practitioner in Carlow"*. The diary of the social worker showed that the appointment was scheduled for 5th July, 1985 but that Mary did not turn up for this appointment.

On the 21st August, 1985, Mary was referred by her general practitioner to the Casualty Department, St. Luke's Hospital. The history noted on the referral form was of *"a blow to the face on the 17th August, 1985, and a cement block dropped on the toe on the 19th August, 1985"*. The history noted on the casualty record was that of assault, with the patient

allegedly kicked on the face and on the left foot. Nasal and foot x-rays were requested and were noted as normal.

On the 23rd August, 1985, the public health nurse visited the house and spoke to Mary. Mary's father, who was also present, prevented her from seeing Mary's child. He used threatening behaviour towards her and told her not to visit her again. The public health nurse recorded that she rang the superintendent public health nurse and the social worker about this incident on that date and again spoke to both of them about the case on the 26th August, 1985.

On the 4th September, 1985, the public health nurse located Mary living in the prefabricated former family home. She would not let the public health nurse into the house and when she asked to see her son she told her that he was with friends some miles away. She told the public health nurse that she was on bad terms with her father and mother.

On the same day, 4th September, 1985, a case conference was arranged at the South Eastern Health Board, Co. Clinic, Kilkenny, to discuss the case of a child from the same area. Following this case conference the local public health nurse, senior public health nurse, area social worker, acting senior social worker and senior area medical officer discussed the case of Mary and her child. There are no minutes of this meeting but the public health nurse file noted *"concluded it is necessary to find truth of Mary's allegations against her father. Get Garda to keep a watch if necessary and see for ourselves if someone is being battered"*.

A record in the nurse's file for the following date, 5th September, 1985, noted *"spoke to Garda about family. Will keep an eye on the house"*.

The public health nurse called to the family home and farm on the 10th September, 1985, 18th September, 1985, 6th October, 1985, and 8th October, 1985, but got no replies. The PHN record of the 6th October, 1985, noted that she had called to a family who were friends of Mary's and had also telephoned the social worker. The social worker had told the PHN that Mary had been to the social work office making a lot of allegations against her father. The record of the PHN of the 6th October, 1985 also noted that the gardai were involved. There is no record of Mary's visit to the social worker's office in the social work files.

The record of the public health nurse of the 8th October, 1985, noted that she called to the gardai to see if they knew anything. On 4th November, 1985 the local public health nurse received a telephone call from a friend of Mary's to say that Mary and her son were missing from the family home. The public health nurse telephoned the area social worker and called to the family home where she received no reply.

On the same day, 4th November, 1985, Mary called to the social worker's office in Carlow accompanied by her son and a male friend and advised the social worker that she was being sexually abused by her father and that this had been on-going since she was 10 years old. She told the social worker that she had left home on the previous

Saturday night following an argument with her father and was staying with friends in Carlow.

On the night before she had left home a general practitioner, whom Mary had attended a few days earlier with bruises on her right wrist and upper arm, had met Mary's father and mother. It had been Mary's first consultation with this general practice and she was not a registered General Medical Services patient with this doctor. Mary told the investigation team that she had complained to the doctor of physical and sexual abuse by her father and suggested that this was ongoing. In our interview with the general practitioner, he informed us that Mary complained to him primarily about the physical abuse and he decided, with her approval, to confront her father directly on the complaints *"to try to frighten him as it were, to admonish him"*. After a number of telephone calls he wrote to Mary's parents asking them to attend his surgery. When he confronted Mary's father about these allegations he walked out without comment. According to Mary her father had been angered and this had led to the argument on Saturday night.

On the 5th November, 1985, the social worker from the Carlow office contacted the public health nurse and this general practitioner to discuss the case. Later on that afternoon Mary called to the Carlow social worker's office and told the social worker that her father, accompanied by a garda, had called to the house she was staying at the previous night and, as a result, she no longer felt that she could stay there. The social worker arranged overnight accommodation for her and her son in Carlow and arranged a placement in a Dublin hostel for her and her son for the following day.

Mary and her son travelled to the hostel in Dublin on 6th November, 1985, and she was advised to contact the Rape Crisis Centre, Dublin, or the Eastern Health Board.

On 11th and 12th November, 1985 the social worker at the Carlow office telephoned her in Dublin. Mary advised her that neither herself nor her son had settled in Dublin and that she intended to return to Carlow to look for accommodation.

On 11th November, 1985 Mary's mother called to the social worker's office in Kilkenny (not the same social worker as in Carlow) and told the social worker that Mary had left home the previous week with her son and that she had been in contact with the gardaí about Mary's whereabouts. She also indicated that she wished to see Mary and that if she did not wish to return home, she would not mind, but that she wanted Mary's son returned home. She also alleged that Mary told lies and was not caring properly for her son.

On 21st November, 1985, the social worker attached to the Co. Clinic, Kilkenny received a telephone call from a garda in Kilkenny. He had been contacted by a garda colleague from Mary's local area who had been advised by the general practitioner concerning her allegations about her father. The record on the social worker's file noted *"As Mary was in Dublin it was agreed that there was nothing to be done"*.

On 22nd November, 1985, Mary left the Dublin hostel and returned to her parents' home. The Carlow social worker's file noted *"It would seem that she was intimidated into this move. Contact has been re-established with ---- Social Worker, Kilkenny"*.

The file of the Carlow social worker was closed in November, 1985. However, the case notes were not forwarded to the social worker in Kilkenny.

During our interview with Mary and her mother, they both discussed the circumstances under which she left the Dublin hostel. Mary advised us that she was quite happy in the hostel and had no complaints about it. However, her position became intolerable as her father had traced her to the hostel and he maintained a vigil outside it in an effort to make contact with her. She described how he was abusive to other occupants of the hostel and as a result she could not remain there and had to return home.

Her mother's account of the circumstances is different. She advised us that she traced Mary to the hostel in Dublin through the gardaí, whom she had notified that Mary had run away with her son. Mary's mother recalled contacting her and driving to the Dublin hostel, with a neighbour, to collect Mary and to bring her home.

On the day that Mary left the Dublin hostel, 22nd November, 1985, her mother telephoned the social worker in Kilkenny to make an appointment for the following day. Mary, her son and her mother called to the social workers office on 23rd November, 1985 as arranged. The purpose of the meeting, as the family saw it and as noted in the social worker's file, was — *"For me (Social Worker) to draw up an agreement whereby Mary could leave her son in her parents' care and visit him at weekends etc. At this point she said that she had a job in Carlow"*

The notes in the file continue: — *"I (Social Worker) pointed out that all of this was irrelevant for me and that it seemed quite ludicrous for Mary to consider leaving her son in a household intolerable for her. I also pointed out that seeing that her mother works full-time, that her son would be in a worse position than at present. I asked Mary to consider again her own position and suggested that it seemed only logical for her to leave and to take her son"*.

The conclusion of the meeting as noted in the file was: *"Mary was to consider what she wanted and what was best for her — their idea of an agreement was scotched"*.

The following week, 28th November, 1985, Mary telephoned the social worker in Kilkenny saying that the situation was still the same and she was seeking *"an alternative"*. The social worker undertook to investigate her request and she subsequently contacted a hostel in Dublin and one in Waterford. The hostel in Dublin advised that they would take Mary back if there was no other option for her.

The social worker's file noted that on the following day, 29th November, 1985, she contacted a garda in Kilkenny who advised that if Mary was *"being kept home reluctantly, she could make a complaint directly to the Gardaí, who would then deal with it"*.

There is no evidence on the file that any further contact was made with Mary by the social worker advising her of the availability of the hostel in Dublin or to contact the gardaí. There are, however, notes in the social worker's desk diary of appointments with her on the 8th and 10th January, 1986 to the effect that these meetings took place. The social worker in her evidence recalls these meetings and that she outlined the options available to Mary.

On 29th November, 1985, the Director Community Care/Medical Officer of Health received a letter from a medical officer of the Eastern Health Board advising that Mary had left the Dublin hostel to return home. The letter refers to the fact that Mary's father was the father of her child and indicated that she would benefit from social work and other support, and the letter requested that the case be followed up. There is no record of the response of the D.C.C./M.O.H. to this letter.

January — December, 1986

During 1986 the public health nurse called to Mary at her family home on three occasions. On the first of these visits in January there was no reply. In February, 1986, the PHN met Mary and recorded that both she and her son were fine.

On 12th May, 1986, Mary was referred by her general practitioner to the Casualty Department, St. Luke's Hospital, complaining of pain in her left ankle for three days. She gave no history of trauma on this referral. X-rays were normal and she was discharged and advised to re-attend if necessary. There was no further attendance in connection with this referral.

On 17th December, 1986 the PHN again called to the house and met her and was not invited in. Her son was in school at the time and her father was out. The record of the visit noted that Mary told the PHN that her father did not want the PHN calling.

January — December 1987

On 21st March, 1987, Mary (aged 21) was referred to the Casualty Department, St. Luke's Hospital, complaining of right-sided abdominal pain for two days and a brown offensive discharge PV. A differential diagnosis of pelvic inflammatory disease or an ectopic pregnancy was suggested. She was admitted from casualty to the gynaecology ward. No history of miscarriages was documented. A cervical erosion was noted, which bled to touch. A provisional diagnosis of urinary tract infection was made.

Mary continued to have tenderness in the right loin area and her antibiotics were changed on the following day. As she did not improve, a consultation with a consultant surgeon was requested. X-rays were taken and a urine test confirmed an infection. On examination he found tenderness over her right kidney and a provisional diagnosis of pyelonephritis was made. Repeated pregnancy tests were carried out and these were all negative.

Mary was discharged on 31st March, 1987, and was to be followed up at the Surgical and Gynaecological Out-patient Department clinics. A discharge letter was forwarded to her general practitioner.

On 8th May, 1987, Mary attended at the Out-patient Department, St. Luke's Hospital, with severe right-sided pain since the previous night. On examination she was tender on the right loin area and hypochondrial area. She was admitted to the gynaecology ward. She had urine and liver function tests. A high vaginal swab was also taken following which she was treated with antibiotics.

On 16th May, 1987, a medical consultation was sought. All blood tests carried out were negative and Mary now gave a history of colic intermittent pain. A diagnosis of irritable bowel syndrome was made. Mary was discharged on 16th May, 1987.

On 28th May, 1987 Mary, attended at the gynaecology clinic with right-sided abdominal pain and hypochondrial pain. A chest x-ray and urine tests were normal. She was given painkillers and discharged.

In June, 1987, a public health nurse called to the house but got no reply. The notes of the visit record that somebody was in the house but failed to answer.

On 3rd September, 1987, a smear test showed inflammatory cells and a repeated swab at the gynaecology clinic was suggested, followed by a repeat smear, in six to twelve months. On 18th December, 1987, Mary attended the gynaecology clinic where a diagnosis of chronic cervicitis was made. She was put on antibiotics and an appointment was made for a D&C and cautery of her cervical erosion.

January — December 1988

On 19th January, 1988, Mary (aged 22) was admitted to St. Luke's Hospital, Kilkenny, for a D&C. Her family history noted nothing significant. On examination she was found to be tender in the left inguinal area. A D&C and a cautery of small cervical erosion was carried out and nothing remarkable was found. She was discharged and the curettings were subsequently reported as normal.

In the discharge letter of the consultant to Mary's general practitioner, the consultant states that Mary asked to be sterilised. His letter notes that this was most unusual as she was only aged 22 years and was said to be contemplating getting married in the near future. He noted that, the general practitioner "*knew her background a little more*" and he felt sure she would visit him regarding this. There are no GP records of follow-up consultations in this regard.

On 10th August, 1988, a repeat smear test was taken and was shown to be normal.

January — December 1989

There is no record of contact between Mary and the public health nurse or social work department or hospital services during 1989.

In February, 1989, consent for a school medical inspection of Mary's child was refused. On examination of this refusal notice, the team noted that it had been signed by Mary's father. There was no follow-up or referral of this refusal notice by the school nurse to the local area public health nurse.

Mary attended another general practitioner, who was a new doctor in the practice in Carlow, on three occasions during 1989. Two of these visits were for routine medical problems. One attendance, in July 1989, was for a right ankle injury, which was of a

minor nature, and was explained to the general practitioner as resulting from a trip and a fall.

January — December 1990

In early May, 1990, Mary attended her general practitioner in Carlow for an injury to her left foot and some bruising of the shin. Again this was a minor injury and Mary explained to the general practitioner that one of the animals on the farm had stepped on it.

On 19th May, 1990, Mary, aged 24, was referred to St. Luke's Hospital, Kilkenny, for an x-ray of her left hand by a different doctor in the same practice in Carlow. The history given on the referral form was "*stood on knuckle*". The x-ray was reported to be normal.

On 20th May, 1990 Mary attended Casualty Department, St. Luke's Hospital, and the history noted on the casualty record was that of injury to her left index finger three days previously. On examination she was found not to be able to extend her finger and there was a loss of sensation. A history of parathenia to the finger and previous cuts to this finger were noted. The finger was strapped and she was to be reviewed at the out-patient clinic. On 25th May, 1990, Mary attended the out-patient clinic and decreasing movement was found to be present in her finger. Mary was referred to St. James' Hospital, Dublin and the history given in the letter of referral was that of "*a cow kicking her*".

January — December 1991

In February, 1991, consent for a school medical examination of Mary's son was again refused. The refusal form was signed by Mary's father. There was no referral of this refusal by the school nurse to the local area public health nurse.

On 4th February, 1991, Mary, aged 25, was referred by her general practitioner to the gynaecology clinic with PV bleeding. Mary did not attend the clinic appointment given and was not offered a further appointment.

On 9th April, 1991, Mary was admitted to St. Luke's Hospital with acute urinary retention. A history of urinary tract infection was noted. On examination of her nervous system, a residual weakness of her left leg was found but it was noted that previous investigations on this leg had been inconclusive. A radiological examination of her kidneys was carried out and distension of both renal calyces and ureters was noted. Mary was referred to Beaumont Hospital for a neurological consultation. A provisional diagnosis of a uropathic bladder was made. Mary did not attend follow-up appointments.

On 23rd May, 1991, the public health nurse met Mary in a laneway to the family farm. On this occasion, Mary and her father were attending the sheep and Mary came to the public health nurse's car at the gate. The public health nurse spoke to Mary about her son and during the conversation Mary conveyed that she was afraid of her father and had something terrible to report. However, Mary's father came out of the shed and at

this Mary said that she could not say any more. The public health nurse made an appointment to meet Mary in a local town on the following day. However, Mary failed to keep this appointment.

Mary and her father travelled to his mother in the UK for Christmas 1991. During this visit Mary's father became very drunk on one occasion and following an argument with his mother he ordered Mary to pack their bags for both of them to return home.

On the journey, Mary's father assaulted her, kicking her repeatedly on the back of the legs and in the face. They attended the Casualty Department of a UK hospital and Mary's father told the casualty staff that they had been mugged and robbed. She received stitches and was apparently informed that her eyesight would recover in a few days.

On 31st December, 1991, on their return home, Mary attended her general practitioner with severe bruising to her right eye. She told the general practitioner that her father had assaulted her. The GP informed the team that, he urged her to make a complaint to the gardaí or to contact a social worker but she declined.

Mary was referred immediately by ambulance to the Casualty Department, Waterford Regional Hospital with a letter from the GP indicating she had been in an accident. She told casualty staff that she had been mugged in England. She received treatment for her injured eye and an appointment was made for a CT Scan for the 2nd January, 1992.

January — December 1992

On January 2nd, 1992, Mary attended Waterford Regional Hospital for a cranial and orbital scan. She was also seen by a consultant ophthalmologist on this occasion. She told him that she had been mugged and he advised her of the seriousness of her eye injury and that he would be willing to provide a report for the police in the U.K.

She attended on the 7th January, 1992, for a repeat CT and was again seen by the consultant ophthalmologist. The repeat CT showed a fracture of the floor of the orbit with herniation of the orbital contents into the right maxillary sinus. Her symptoms also suggested an optic canal haematoma. On this occasion Mary told the consultant that her injuries resulted from an assault by a family member. This information was not recorded on her medical record. Mary was advised that visual prognosis for her eye was not good. She was offered an out-patient appointment for the 28th January, 1992, but did not attend.

Late on the night of the 16th January, 1992, Mary was brought by a friend to the home of a general practitioner in the Carlow practice she attended. She was brought by the GP to Carlow District Hospital where her wounds were sutured and she was given an anti tetanus injection. The GP referred Mary to the Casualty Department, St. Luke's Hospital and she telephoned details of the injuries and how they occurred to the hospital and advised that the gardaí were to be notified. The general practitioner's letter of referral outlined a history of injury to her eye which had left her almost blind in that eye and also noted that the patient was attending Beaumont Hospital regarding her

urinary retention. Bruising of her upper arm and back were noted as well as lacerations to her head, right upper arm and right middle finger.

In the Casualty Department, St. Luke's Hospital, Mary gave a history of on-going assault by her father for approximately fifteen years. The record noted that Mary advised that her father had been drunk that evening and on returning home had stripped her and beaten her with his belt and hand. He had also hit her on the head with a bottle. She had experienced loss of consciousness and was complaining of severe headaches. She also gave a history of sexual abuse by her father in the previous years but denied any sexual abuse on this occasion.

On examination, bruising and lacerations were noted as was the loss of vision in her right eye. Skull, cervical, finger and chest x-rays were carried out. All x-rays were normal except for a fracture to her middle finger, which was strapped. Her injuries were photographed and a list of action points were set out by the admissions officer which included referral to the social worker and DCC/MOH. The general practitioner was to be contacted to provide a full history of the case. The record also noted that Mary's father was not to be informed of her admission to the hospital. The gardaí were contacted and neurological observations were carried out.

On the following day, 17th January, 1992, Mary was interviewed by a social worker and a garda. The nursing notes recorded that Mary was not anxious for garda intervention.

Later on that day Mary was again interviewed by the social worker who at this time had arranged accommodation for her and her child. She was also interviewed on this occasion by a ban garda.

On 21st January, 1992 Mary was discharged from St. Luke's Hospital, in the company of a social worker from the County Clinic, Kilkenny to hostel accommodation in Waterford. Mary and the social worker picked up Mary's child from his school en route.

At this stage Mary did not advise the school principal of the identity of the social worker or the arrangements made as it was her first visit to her locality since the assault of the 15th January and she was afraid of being seen by her father. The gardaí subsequently advised the school principal that the child would not be returning to school.

She left the hostel on 4th March, 1992, and has lived in independent accommodation since then. She made a formal complaint to the gardaí of the physical and sexual abuse inflicted upon her by her father who was subsequently prosecuted by the Director of Public Prosecutions.

Mary was offered a further appointment by the Eye Department, Waterford Regional Hospital on the 24th March, 1992. She cancelled this appointment. A report was issued to the referring general practitioner on the 9th April, 1992. She was offered another out-patient appointment on the 5th May, 1992 which she also failed to keep.

Mary and her son continue to receive counselling and support services from the South Eastern Health Board.

CHAPTER 9

Analysis and Conclusions

In this chapter, having surveyed and considered all the evidence available to us from Mary and her family, from the health services personnel and from the contemporaneous written records, we set out in summary form what appear to be the key elements in Mary's contacts with the health services from the time she and her family arrived in Ireland in 1975 until she finally left the family home in early 1992. For the sake of convenience and clarity we have divided our analysis into a number of sections which correspond to the relevant periods of time in Mary's life.

At the end of each section we comment on the response of the health services to Mary's contacts with these services in all their aspects. Finally we comment on the dynamics within the family which in part have influenced the response of the health services to Mary.

This is the first occasion in which all her contacts with the health services have been brought together for analysis. Such indepth analysis of a persons total contact with the health services over a prolonged period has not to our knowledge been carried out previously in the Irish health services.

While our terms of reference empower us to carry out an investigation "*insofar as the health services are concerned*" it is clear both from the contemporaneous written records and from oral evidence given to us that there were a number of contacts with the Garda Síochána during the history of the case. These arose both from informal referrals to members of the Garda Síochána by health board personnel and from occasions when the gardaí acted on behalf of Mary's parents or on one occasion Mary herself.

The investigation team were not given the opportunity to hear evidence from the gardaí actually involved in the case. By agreement with the Garda Síochána we heard evidence from Deputy Commissioner Thomas O'Reilly which has proved extremely helpful in framing the recommendations contained in Part II of our report. We feel, however that our account of the history of the case would be incomplete without some reference to the various contacts with the Garda Síochána and we include a summary of those contacts at the end of our analysis.

At the conclusion of the chapter we summarise our findings for the purpose of Part I of this report and endeavour to answer the question put by our terms of reference as to why action to halt the abuse was not taken earlier.

DECEMBER 1975 TO NOVEMBER 1981

From the time of her arrival in Ireland in December 1975 to November 1981 Mary was a child under 16. She spent one and a half years at national school and three and a half years at secondary school. Her mother gave approval to a school medical examination in November 1976 and this examination was carried out in December of that year. In giving her consent her mother made reference to bed wetting and vision problems. Her sight was tested and no further intervention was indicated. There was no record of any investigation of the enuresis.

During that time Mary attended the local General Practice on twelve occasions, nine of which were for injury related problems. They averaged two to three per year and included abrasions, swellings, sprains and scalds. Most of these injuries were deemed by the GP's to be of a minor nature and if queried plausible explanations were given.

During that time she was referred by her general practitioner to the X-Ray Department of the local hospital on three occasions

- August 1976 she was referred for x-ray of her knee
- August 1979 the x-ray was for an injury to her finger with a query re foreign body
- November 1981 she was referred for x-ray for a strain injury to her arm.

While at secondary school Mary was referred by the School Guidance Counsellor to the Department of Education's School Psychologist in November 1980. Her first interview with the Psychologist was on the 18th November, 1980. Mary, then a second year student seemed to be having great difficulty making friends, was isolated by class mates and tended to tell lies, which in turn tended to isolate her even further.

One of the school teachers in evidence said *"looking back I can remember the black eyes, the broken arm or whatever and she always came back at the end of these kind of injuries and she always had an explanation. Today if a child had a broken arm or you ask him/her what happened, they will say "I fell off the bicycle" or something else like that but you got with Mary down to the last plaster."* Mary gave highly detailed and plausible stories to the school teachers as to the cause of any of her injuries or accidents when asked.

These are the only recorded instances of Mary's contact with the health services while she was under sixteen. Mary was never referred to the health services nor did she present herself to them or to her teachers as a victim of physical or sexual abuse.

It is important to note that this was the period during which it was open to the health board to apply for a Fit Person Order under the Children Act 1908. This power ceased when Mary reached her sixteenth birthday. The general awareness of child abuse as an

issue would not have been high at that point. Specific guidelines in relation to child abuse only became available in January 1980. These had an emphasis on the battered baby syndrome, the pre school child. The extent of the circulation of those guidelines within the health board and to people outside is questionable. No reference to child sexual abuse was included in these guidelines.

While two to three visits would have been made each year to the general practitioner for injuries, many of these would have been for minor complaints and all would have had plausible explanations. While she attended the one practice during this time she in fact attended three different doctors. She subsequently gave evidence that stories would have been prepared in advanced, by the family, if explanations were sought and her father ensured that they never visited the one general practitioner more than twice or three times. On each of these occasions we understand she was accompanied by her mother. The impression given to the doctor was that the mother was the dominant personality in the family and that she was "in charge."

A once off school medical and three x-rays over a five year period which were essentially normal would not necessarily give rise to a high level of suspicion of non accidental injury or child sexual abuse. Furthermore, twelve visits to a GP over a period of five and a half years for various medical conditions and minor injuries might not necessarily give cause for concern. Although she did see different doctors the practice kept an excellent single record and each visit was fully documented. This does however highlight the need for more relevant and probing questions to be asked by general practitioners and school authorities when a child presents with repeated injuries, however trivial they may appear. While the level of awareness of child abuse has increased we are concerned that the same position would apply at present unless a more proactive approach is taken to the whole area of child abuse. We will be addressing this further in Part II of our report.

Having interviewed a number of staff of the secondary school involved we were impressed by the current level of awareness and involvement with their pupils and their liaison with the social work services within the health board. It would be fair to assume that this level of knowledge and awareness did not exist prior to 1981. We would not be confident that the level of progress achieved in this school would reflect the national picture.

From the health board's point of view there was no evidence of referral for child abuse being made and not acted upon during the period while Mary was a child up to November 1981.

NOVEMBER 1981 TO MAY 1982.

This covers the period of Mary's sixteenth birthday to the birth of her child.

In November, 1981 Mary reached the age of sixteen years and therefore could no longer be taken into care under the Children Act, 1908. Between then and February 1982 she attended the general practitioner on four occasions mostly related to the early signs and

symptoms of pregnancy. Again this was to the one practice but she saw three different doctors. Her pregnancy was confirmed in February 1982.

On the 29th March, 1982 she first attended the ante natal clinic at St. Luke's Hospital, Kilkenny accompanied by her mother. From then until her confinement she was under the combined ante natal care of her general practitioner and the hospital consultant. Her second ante natal clinic appointment at St. Luke's Hospital was on the 10th May, 1982 and she was again accompanied by her mother. From a health point of view, her pregnancy was normal.

On the 20th May, 1982 she was referred by her general practitioner to St. Luke's Hospital in spontaneous labour. The hospital records note that she had a normal delivery. She was discharged on the 25th May. The birth was notified to the public health nurse and a discharge letter was sent to her general practitioner. Both the birth notification and the discharge letter note that she was keeping her baby.

During this period the educational psychologist visited the family on three occasions culminating in a final report dated the 17th May, 1982. The recommendations were:

- (1) referral to the National Rehabilitation Board for suitable training and work placement and/or
- (2) referral to area social work/psychologists if (1) is not available, to act as a support for this family.

Mary did not attend school after January 1982. We are aware that the school principal visited the family home at this time and encouraged Mary to return to school following the birth of her child. He met Mary and her mother at the door and was not invited into the home.

The consultant obstetrician in his evidence indicated that a confinement at sixteen, although unusual, was not unique. Also the signs presented to him by Mary and her mother was that she enjoyed good family support. Mary on recalling the confinement also noted that three of the four mothers on her ward at the time were single parents. The local general practitioner confirmed that teenage pregnancies were not uncommon particularly in this area. The social worker's records would also indicate a relatively high number of unmarried mothers in this area.

At all times during this period Mary presented as having a high level of family support. The absence of such support would normally be seen as an indicator of concern in the case of a teenage pregnancy. No referral was made to a social worker.

The issue of paternity was not raised with Mary but she herself informed us that she told other women in her ward while she was in hospital that her boyfriend was in England. Her parents had decided, that if queried in the hospital about paternity, they would not say who the father was, and see what happened afterwards. If Mary was specifically queried on this matter, she was to say "I don't want to tell you".

It has been reported in the media that Mary had met a social worker in the hospital and

that pressure had been put on her to place the baby for adoption. Mary in her own evidence to us has clearly stated that this did not occur. In common with many hospitals of its size there was no social worker specifically attached to the hospital. The health board's social workers had no involvement in the adoption service which, in this area, is provided by the Ossory Adoption Society which is a registered adoption society under the Adoption Acts.

We are aware that to have unlawful carnal knowledge of a girl under the age of seventeen is a criminal offence (generally referred to as "statutory rape"). In order to institute a prosecution for this offence a formal complaint would have to be made to the gardaí by the victim. It appears no such complaint was made.

No referral was made to the social work services by the hospital at that time. It is a tenable point of view that all under age pregnancies (i.e. under seventeen) should be referred to the social work department. However, one must bear in mind the very high number of such pregnancies and the demands that this would make on limited resources. One could also question that where family support is available, as in this case, and there is no great risk to mother and child, social work intervention could be viewed as being intrusive. As noted above, the hospital had notified both the GP and the PHN of the birth as is normal practice. The hospital were aware that mother and baby would be visited by the public health nurse within days of her return home and for an ongoing period thereafter.

The investigation team would share the concern of society in general about the increasing number of underage pregnancies. This is not just an issue for the health and social services but for society at large and the solution must include providing programmes relating to life skills and sex education in schools, youth clubs etc.

MAY 1982 TO NOVEMBER 1983

Mother and baby were discharged from hospital on the 25th May and the public health nurse visited two days later. During the first seven months of the baby's life, the PHN visited on seven occasions. The frequency of the visits was more than usual and is accounted for by the mother's age, her unmarried status and problems with hygiene standards in the home. There was no concern for the child's general care and welfare. It is noted that on the last visit in 1982 Mary's parents were present and her father was very hostile and did not see the need for visitation by the nurse. There are no records of public health nurse visits to the child in 1983. The public health nurse did call to Mary on seven occasions in September and October 1983 as a follow up to the treatment she received at St. Luke's Hospital for removal of warts. Mary's child did not attend for scheduled nine month developmental assessment in March 1983. There was no follow up of that non attendance.

A referral to the social work department from the National Rehabilitation Board was received in June 1982. There were six social work visits to Mary in her home between the 18th June, 1982 and the 16th August 1982. The paternity of the child was explained by Mary as being a married man living in the locality. The detail of these visits is

recorded in Chapter 8. Mary did refer to an assault by her father when he learned of her pregnancy.

The senior social worker recalled contact with Mary and her mother in the winter 1982/spring 1983. There are no written records available of these contacts. This was the first time that Mary informed the health services that her father was the father of her child.

Between August 1982 and mid October 1982 Mary attended her family doctor on eight occasions. During that time she was referred to the outpatient department at St. Luke's Hospital and a referral was made from there to the Richmond Hospital. A diagnosis of hysterical conversion syndrome was made in the Richmond Hospital. No history of injury is noted in any records or correspondence for this period.

Sometime between December 1982 and September 1983 Mary changed doctors and began attending a General Practice in Carlow rather than her local general practitioner with whom she was registered as a GMS (medical card) patient.

A number of key features which occurred during this period should be noted. Her younger sister finally left home. The diagnosis of hysterical conversion syndrome was made to which no significance was subsequently attached. Between August and November 1983 her mother had a phantom pregnancy. There was a change of doctor as noted above. The senior social worker's involvement in this case arose from a written note from Mary to the social worker seeking information with regard to the possible adoption of her child by her parents. While the public health nurse visited Mary in 1983 in relation to her own health there was no follow up visit to the baby and there was a period of nine months where neither mother nor baby were visited by the public health nurse. The failure of the child to attend the development assessment during this period was not followed up. There is no record of any inter disciplinary liaison in regard to this family during this period.

The more significant issues arising during this time were the first references to violence and to incest by Mary to the senior social worker. No detailed exploration of the incest or family violence was made at this time. The record of this information is not on the social work files. The senior social worker gave evidence that he would normally discuss such information with the area social worker and the Director of Community Care & Medical Officer of Health. The DCC/MOH when interviewed had no recollection of the case and there were no separate records or files maintained by the DCC/MOH. The area social worker had no recollection either and neither was there evidence that the case was allocated to the area social worker.

The senior social worker recalls suggesting a number of options to Mary and her mother in relation to the violence. These were leaving the family home, seeking a barring order or making a formal complaint to the gardai. We accept that the senior social worker's powers in relation to adults were limited to persuasion and the offering of options. While the evidence was that the child was physically well cared for and was well bonded with Mary, the child was nevertheless living in a household where both violence and

incest had occurred. This would now be considered an appropriate point for the senior social worker to request a case conference to consider the position and welfare of the child.

This must be viewed in the context of the period when incest would be a taboo subject which was seldom if ever discussed. The only guidelines that existed were in connection with non accidental injuries to small children. There was no system of inter disciplinary liaison. There was pressure on resources including high case loads. The system of working was one where problems were dealt with on a one to one basis with a mono-disciplinary approach. In reviewing the situation the investigation team believe that the management roles of the DCC/MOH and the senior social worker were not fully developed at the time and that this weakness was further heightened by lack of resources and personality issues. All these factors contributed to a failure to clarify and respond to the significant information then available.

It should be noted that if the full provisions of the Child Care Act, 1991 had been in force at this period Mary would have come within the definition of a "child" until November, 1983 when she reached the age of eighteen. The health board would therefore have been able to intervene to obtain either a care order or a supervision order in respect of Mary. These powers were not available at the time and are still not available until the relevant sections of the Act are implemented.

NOVEMBER 1983 TO DECEMBER 1985

In September, 1984 the Public Health Nurse received a complaint that the child was not being well cared for and she visited the family home. There was hostility from Mary's father to the visit. Mary indicated to the PHN that she was pregnant although the PHN doubted this.

There were four further attempts in 1984 by the PHN to see the child which were unsuccessful due to the absence of the child from the home; the child being asleep; and to the PHN being refused access. The PHN notified the superintendent public health nurse and sought advice.

In 1985 there were six visits by the PHN up to the date of the case review in September. All of these visits were unsuccessful from a child care point of view. The hostility of the father was a feature of some of these visits, allied to non admission to the home. Following the case review in September the PHN made four visits up to early October. Subsequently, the PHN records telephone contacts with the social workers up to and including the time of Mary's departure to a Dublin Hostel.

The last visit by the PHN in this period was in December, 1985 when Mary had returned home. On this occasion she saw the child and he was fine.

While normally there would be one visit to a child between the ages three and four in this case there were a significant number of visits, the majority of which were unsuccessful. The hostility of Mary's father to the visits was also a key issue.

Mary was admitted to St. Luke's Hospital on the 10th May, 1984 for an appendicectomy. Just over a year later on 31st May, 1985 she was referred to casualty with an injury to her forearm which she explained as having occurred while playing football.

On the 21st August, 1985 she was referred to St. Luke's General Hospital for x-ray — the history given in the referral was of a blow to the face and a cement block having dropped on her toe. In casualty on this date she gave a history of assault involving being kicked in the face and on the left foot.

The medical records and subsequent evidence do not indicate that the discrepancy between the referral note and the history given in the casualty department was picked up. Details of the assault do not appear to have been probed.

We note from the hospital records that Mary was referred to the hospital by a number of doctors from the practice she had begun attending in 1983. While she was the holder of a medical card she was not registered with this practice. There was a notable absence of any detailed GP record of consultations during this period. However, two doctors recalled *"that their brief involvement with the family at this time was trivial"*. *"They were never seen with suspicious injuries and never once mentioned violence or abuse"*.

We do note that Mary paid one visit to another doctor in the same town and disclosed abuse to him. This doctor in his evidence said that Mary disclosed primarily physical violence but Mary and her mother clearly state that she also disclosed sexual abuse.

In March, 1985 there was a telephone call to the social workers office in Kilkenny seeking advice regarding the possibility of Mary leaving the child in the care of her parents. This was the first contact with social workers since late 1982/early 1983.

The case was re-opened by the social worker in June, 1985 following a referral from a concerned neighbour and the public health nurse. When Mary met the social worker she alleged that she had been physically and sexually assaulted by her father. The next contact with the social work services was in Carlow when Mary presented on the 4th November, 1985 as a homeless person having moved out of the family home. She again repeated the allegation of violence and rape and arrangements were made for her to go to a hostel in Dublin.

Subsequent to her return home from Dublin in November, 1985 further contact was established with the Kilkenny social workers office and other offers of accommodation were made.

On two occasions, on contact with social workers, she reported physical violence and sexual abuse. Although moved to a place of safety she did, under pressure from her parents, return home.

On the 4th September, 1985 there was an informal case review involving internal health board personnel only. It dealt with the child and the family generally. While there are records on individual staff diaries of such a meeting there is no minute of this case review and no record of key decisions taken apart from that recorded in the PHNs notes

“concluded it is necessary to find the truth of Mary’s allegations against her father. Get Garda to keep a watch if necessary and see for ourselves if someone is being battered”.

During this time health board staff were working under the 1983 Department of Health guidelines on procedures for the identification, investigation and management of non-accidental injury to children, which again dealt with physical injury to children. These guidelines contain only one brief reference to sexual abuse. This is solely in the context of physical injury resulting from such abuse.

Up to early November, 1985 when arrangements were made for her to go to the hostel in Dublin many of those who had dealt with this case experienced an element of doubt in regard to the credibility of the allegations being made. This doubt was equally noticeable on the part of the social worker and public health nurse more immediately involved with her.

During this period there is evidence of some level of interdisciplinary co-operation within the community care team, chiefly between the social worker and the public health nurse. This contact would appear to have been informal and often inconclusive. We note that a case review was held on the 4th September, 1985. There was no liaison between community care staff and the hospital or between the various general practitioners and the other people involved apart from one phone-call from the Carlow social worker to a GP after Mary had gone to the hostel in Dublin.

This would have been an ideal opportunity for the DCC/MOH to initiate a formal case conference to discuss all the issues and plan appropriate action.

Mary attended St. Luke’s Hospital on the 31st May and the 21st August, 1985 with injuries. While the injury on the 31st May was explained as an injury sustained while playing football there is a clear indication in the contact of the 21st August that the injuries were the result of “assault”. There was a failure to probe the history of assault.

The family doctor to whom she paid just one visit followed up on her visit to him by inviting the father in to meet him for the purpose of admonishing him. This was not untypical of the isolated way in which medical personnel dealt with such issues at that time and still do in some cases. The reasons given for this type of approach by medical personnel include that they are dealing with adults who are capable of making choices and that their obligation of confidentiality to patients is an overriding consideration in the doctor-patient relationship.

During this time Mary was aged between 18 and 20 and was therefore an adult. In general throughout the country social work services were mainly directed towards children, at least in part because the health board has statutory powers in this area and because scarce resources did not allow for anything other than statutory obligations to be addressed. When Mary did present to the Carlow social work office in November, 1985 as a homeless person and repeated her allegations of assault the response of the social work service was both immediate and effective.

We note that on the 29th November, 1985 a letter from an Area Medical Officer of the Eastern Health Board was sent to the DCC/MOH in Kilkenny stating amongst other

things that the child was the product of incest and expressing concern. There is no evidence that action was taken on foot of this letter. There were no DCC/MOH files on this case.

JANUARY 1986-DECEMBER 1990

Between January, 1986 and June, 1987 there were four PHN visits to the home, only two of which were effective. In February, 1986 she records that "*Mary seems more settled at home*" and that "*the child is fine*". A school medical examination of Mary's child was refused in February, 1989. This refusal was signed by her father. It was not followed up. The local PHN was not made aware of the refusal.

The social worker's diary indicates that she made contact with Mary on two occasions in January, 1986. No further contacts are recorded and there are no notes of these two contacts.

In the period to March, 1989 no records are available in regard to her contacts with GP's. Our knowledge of contacts with GP's depends on the hospital records.

The history of her contacts with the health services are given in Chapter 8. The key points of her hospital contacts during this time relate to her gynaecological problems and to an accident in May, 1990 when her left hand was injured. Between March, 1987 and August, 1988 she had seven contacts with the gynaecological department of the hospital, of which three resulted in inpatient admission and four were dealt with in the outpatients department. These contacts culminated in a request for sterilisation in January, 1988. This was referred back to her general practitioner by her consultant.

In March, 1989 she attended a new doctor in the same Carlow practice which she had begun attending in 1983. She was still not registered as a G.M.S. patient with this practice. Between March, 1989 and the end of 1990 she paid three visits to this doctor. Two of these visits related to injuries, one to her ankle and one to her leg/bruising of her foot, for which she gave plausible explanations.

The significant factor in this period are the number of injuries for which she attended her GP and the hospital. There is no index of suspicion in relation to their non accidental status and no inter linkages were made between casualty notes or between casualty and the inpatient and outpatient attendances at the hospital.

The team felt that it was unusual for a woman in her early twenties to have so many repeated contacts for gynaecological problems. Significantly, the reasons for her request for sterilisation do not appear to have been probed despite the fact that this was a most unusual request and the consultant did make specific reference to this in his discharge letter to the GP.

JANUARY 1991 TO MARCH 1992

In February, 1991 a request for a school medical examination of Mary's child was again refused. The refusal was, as with the 1989 refusal, signed by her father. The local PHN was again unaware of this refusal.

The last contact with the PHN was in May, 1991 at the family farm when there was an urgent inference of trouble in the home when Mary spoke to the PHN. Arrangements were made for them to meet locally the following day. Mary failed to keep this appointment.

There were at least four attendances at the GP practice between January, 1991 and March, 1992. Although these were to the same practice she saw two members of the practice. One of these visits related to urinary retention. She was subsequently admitted to St. Luke's Hospital in April, 1991 and referred to a neurologist in Beaumont Hospital where a diagnosis of uropathic bladder was made. The other two visits to the GP practice related to injuries as a result of assault. In December, 1991 she presented with the eye injury received in the U.K. while on a visit to her grandmother. On this occasion she disclosed to the GP that the assault was carried out by her father. The GP stated that she was unwilling to take any action on her situation. She was referred to Waterford Regional Hospital by ambulance and attended there on three occasions for the treatment of her eye. During one of these visits she told the consultant ophthalmologist that her injury was the result of assault by a family member. This was not recorded.

The final contact was on the 16 January, 1992 when she presented at the home of the second GP in the practice following a serious assault by her father in the family home earlier that afternoon. This contact with the GP led to her admission to St. Luke's Hospital, the referral to the social workers and to the gardaí. Even at this stage she was reluctant to make a formal complaint to the gardaí.

On the 17 January, 1992 the hospital doctor referred the matter to the social worker who visited her on that date and made arrangements for her placement in a refuge with her child.

The key issues in this period were the severity of the last two assaults, and the disclosure by her to the GP on both occasions that the assaults had been inflicted by her father. The disclosure of the assault by a family member was also made to a hospital consultant. On the first occasion she was unwilling to act and was referred for treatment with a history of having been in an accident. On the second occasion she was equally unwilling to act but the GP contacted the hospital to insist that the gardaí be notified on this occasion.

The Adoption Issue

From time to time during the history of Mary's case the issue was raised by the family as to whether her child could be adopted by her parents or whether the child should be left in their custody and care.

Adoption matters in Kilkenny were not at any stage handled by the health board social workers. Adoption placements were and are handled by the Ossory Social Services through the Ossory Adoption Society now called Challenge. This society is a registered adoption society under the provisions of the Adoption Acts.

In Autumn/Winter, 1982 the senior social worker received a note from Mary raising the question of adoption for her child. He decided to visit the family. As outlined in Chapter 8 Mary was worried that if she placed her child for adoption whether she would have any say in where he would be placed. She then asked if the fact that her father was the father of her child would help in her parents adopting him. For obvious reasons at this stage the senior social worker advised Mary and her mother that adoption in such circumstances would not be appropriate.

In March, 1985 the social work records show that a solicitor from Carlow telephoned to say that Mary and a male friend were in his office requesting information about the possibility of leaving her son in the care of her parents. *"This however did not happen and Mary returned home"*.

On 22 November, 1985 Mary and her mother saw the social worker in Kilkenny. This meeting was arranged at the request of Mary's mother. Mary's own account of this meeting is that she felt that both her mother and the social worker were pressurising her into consenting to her parents adopting her child. She appears to have thought that the social worker had *"adoption papers"* ready for her to sign. The social worker stated in her record of the meeting at the time that the purpose of the visit of Mary and her mother in their view was *"for me to draw up an agreement whereby Mary would leave the child in her parents care and visit him at weekends etc."* This was after Mary's return from the hostel in Dublin and the social worker records that she severely discouraged this suggestion on account of conditions in Mary's family and on account of the fact that her mother worked full-time and was not really in a position to care for the child.

In her evidence to the team the social worker re-emphasised her attitude as set out in the record and pointed out that she had never had adoption consent forms since all these matters were in the province of the Ossory Adoption Society. We accept that this was in fact the course of events which took place at the meeting but suggest Mary may have been so pressurised by her parents on the adoption issue that her perception of the visit to the social worker and of what the social worker said to her may have been affected by this pressure.

Finally, when Mary removed her child from the local school and took him to the women's refuge in Waterford in 1992 the local gardaí contacted the South Eastern Health Board questioning the removal of the child on the grounds that he had been adopted by Mary's parents. The parents had informed the local Church of Ireland clergyman that they had adopted Mary's child. The team has ascertained that in fact no adoption order was ever made in respect of the child.

It is clear that Mary's parents wished to take over custody and care of Mary's child and to adopt him. It is reported throughout the records that they seemed to have been devoted to the child. The father is described as doting on him and saw him as the son that his wife did not give him. When Mary left home the mother indicated to the social worker that it was the child that she wanted returned rather than Mary. The child apparently saw Mary's mother as his mother and called her *Mummy*. The mother alleged that Mary was not fit to look after her child.

While at times Mary appeared to wish her parents to adopt or at least take over custody and care of her child this may well have been in response to pressure from her parents. At other times she was quite firm in her determination to keep him and care for him herself.

She was not in any way pressurised towards adoption by any social worker or other health professional. The only adoption that was suggested was adoption by her own parents and this was specifically rejected on two occasions by social workers. However, the fact that the suggestion re-arose at intervals during the history of the case illustrates the tensions within Mary's family and the struggle between her and her parents for possession of the child.

Contact with Gardai

From the records of the health services available to the investigation team we have established that there were contacts with the gardai at a number of points in regard to the family.

The PHN's notes record that she contacted the local gardai on the 5 September 1985 asking them to keep an eye on the home as there were concerns about the domestic violence. She followed this up with discussion with the gardai and a visit to the garda station on the 8 October, 1985. She called to the garda station on one other occasion subsequent to this. On each occasion she met different gardai.

On the 21 November, 1985 the social worker's record show that she was contacted by a garda. He in turn had been contacted by the gardai in Mary's local area. As Mary was no longer residing at home it was agreed that there was nothing to be done. Eight days later the social worker contacted the garda to inform him that Mary was now at home. He advised that if she was being kept at home against her will she could contact the gardai directly.

On the 17 January, 1992 the doctor at St. Luke's Hospital contacted the gardai. This resulted in an interview with Mary by the gardai.

We note from the evidence put before us and from the records available to us that there were a number of contacts between the family and the gardai over a period of years. Most of these were initiated by the family. These contacts included requests by the family for assistance in having the younger sister returned home prior to 1983. On the 4 November, 1985 after Mary had left home and was staying with friends in Carlow her father visited the house where she was staying in the company of the Carlow gardai.

When Mary went to the hostel in Dublin her parents reported her missing. They contacted the local gardai who established her whereabouts and informed the parents.

In December, 1991 Mary contacted the gardai from her home after she had been assaulted. This resulted in a visit to the home by the local gardai. At this stage neither Mary nor her mother made any statement or formal complaint.

On the 21st January, 1992 after Mary and her son had been taken to a refuge the gardai contacted the social worker. They in turn had been contacted by the local clergyman who advised them that Mary's parents had claimed that they had adopted Mary's son.

Area Profile

In the opinion of those we interviewed, the area in which this incident arose was different or atypical. It is described as a thickly populated rural area, though, in a sense it is not a rural community. A major industry which was the life blood of the community closed down a number of years ago. Now only a minority are in fulltime employment. The closure of the industry had a demoralising effect. We understand that this led to an increase in alcohol abuse and domestic violence. In contrast to other parts of rural Ireland only a small number are involved in farming. Very few would have had an opportunity for third level education. Among people over 50 years, few would have achieved second level education. There are two Churches which now form essentially one Christian community. There were a lot of inter related marriages. The community is also described as having many creative people with enormous talent. It is a community that is active in self development.

Family Dynamics

The analyses of contact with the health services indicated how knowledge, skills and attitude of health professionals can and do effect the response to families where physical and sexual abuse occurs. Equally there are behaviour patterns within the family which can influence how professionals respond and how the family react to such interviews.

The level of coercion and fear within such families can be a powerful influence on the way victims behave when abused. They may disclose abuse and then withdraw the allegation. Consequently professionals may often feel that their hands are tied and that they have no power to deal with the matter further. At other times disclosures may be accompanied by factual inconsistencies and/or emotional incongruity. This can lead to disbelief by the professionals and a questioning of the credibility of the victim making the disclosure. The pressure exercised by the abuser within the family can also result in failed appointments with health professionals, changing doctors and inconsistent stories being given as to the cause of injuries. All these factors makes it difficult for the full facts of the situation to come to light. The professional may view the family as being unwilling to take up the options offered to them or to accept professional advice. In the absence of legal power to intervene there may be a perception that the case does not come within the professionals role or service priority. It is understandable that in the circumstances some professionals may minimise the seriousness of the situation.

In the family where abuse has occurred there can be failure to recognise "normal" behaviour and relationships. Role reversal, especially between mothers and daughters, may become a feature of family dynamics. A situation of learned helplessness may prevail whereby victims appear unable to help themselves even when options are given. In certain cases victims may present as accepting of their situation and even possibly enjoying certain benefits of their abnormal roles.

Finally, hostility by an abuser may result in the direct intimidation of professionals. Threats may lead to refusal of access for routine services and insufficient follow ups. Such threats will be used to sabotage intervention by professionals.

Conclusions

In our comments in this chapter we have highlighted certain points where the reality of Mary's situation was not fully investigated or fully responded to by the health services. This must be seen against the background of her inability to reveal the true cause of her injury and the systematic approach adopted by the family to give plausible explanations for the injuries sustained by her in her early years.

What conclusions can we draw from the history of the case?

Firstly, it is clear that Mary sought and received services and assistance from the health services — doctors, hospitals, public health nurses, social workers — on many occasions. Despite this the central core of her problem — her physical and sexual abuse by her father — was never fully known, investigated, understood or resolved. A majority of those who dealt with Mary were not in a position to know the extent of the abuse or that there was any such abuse taking place. This report represents the first occasion on which the totality of her contacts with the health services has been documented.

There are a number of reasons why the physical and sexual abuse was never fully known or investigated. As is clear from the history of the case, each aspect of the health services dealt with the individual manifestations of Mary's abuse and her various illnesses entirely separately and without interdisciplinary communication and co-operation. General practitioners and hospital casualty personnel treated her injuries. There was no central recording system which could have collated and highlighted her repeated injuries and raised suspicions as to their non-accidental nature. Such a central recording system of all contacts with the health services is not a practical possibility while we rely on manual records. Constraints on the flow of information within the health care system, within hospitals and between hospitals, GP's and community care derive from a deeply held tradition of respect for the privacy of family related information, coupled with professional practices in relation to confidentiality especially where adults are concerned.

Because each injury was treated individually Mary's relatively plausible explanations were accepted on each occasion. Even when she attributed an injury to assault there is no record of any probing or investigation being carried out as to the nature and causes of the assault. Mary's own record of consulting a variety of general practitioners made the comprehensive recording of her injuries all the more difficult. In addition one practice did not have a complete record of all her attendances though she attended the practice frequently.

Mary was also treated over a period for hysterical conversion syndrome, uropathic bladder and repeated gynaecological problems which in the light of today's knowledge might have given rise to suspicions of possible sexual abuse. Knowledge of sexual abuse is more widespread now than it was in the early years of her contacts with the service.

Mary disclosed details of her abuse to three different disciplines within the health service.

Three GP's were to one extent or another aware of the abuse when Mary was an adult. In two instances they dealt with it unilaterally and in isolation from other professionals. One hospital consultant was also made aware of an assault on Mary by a family member.

Public health nurses were also aware of difficulties within the family. The effectiveness of the PHN system was hindered by the hostility of Mary's father, the failure to follow through on failed appointments for development assessments of the child and refusal of consent for school medical examinations.

Social workers were equally aware of the abuse during this period. The social work services of the South Eastern Health Board saw the care and protection of children under sixteen as their absolute priority. This was in part because the service was under resourced and over stretched, and in part because social workers were aware that they had statutory powers to protect children under sixteen which were entirely lacking in the case of abused persons over sixteen years of age. There were eight social workers and one senior social worker for the whole Carlow/Kilkenny area. It should also be borne in mind that historically in the Kilkenny area the voluntary social service sector — Ossory Social Services — was very strong and received considerable subventions from the South Eastern Health Board. This enabled Ossory Social Services to employ a number of social workers and there appears to have been an informal division of labour during the period in question whereby the health board social workers dealt with children and the Ossory Social Services mainly dealt with the provision of services for adults and the mentally handicapped. The voluntary sector, however, was not geared to deal with cases of physical and sexual abuse.

There also appears to have been no contact between the general practitioner and hospital services on the one hand and the community care services on the other hand in regard to Mary's case. Public health nurses and social workers were aware of difficulties in the family and on one occasion in 1985 an informal case discussion was held among community care personnel. At no stage however was a full case conference held. This would have provided an opportunity to include a wider range of agencies and disciplines i.e. GP's, hospital personnel, gardaí and teachers to meet and share information and agree appropriate action. The general practitioner who dealt with Mary over those years had suspicions of abuse but he was unable to confirm them.

We consider also that the response of community care services, particularly in the Kilkenny area, seems to have been affected by weaknesses in management. We are aware of a high turnover in the post of DCC/MOH and senior social worker in Carlow/Kilkenny during this period. There is evidence that managerial roles and responsibilities were never fully developed. A number of appointments remained temporary for significant periods and there is no evidence of a coherent system of staff training and development.

We conclude that each individual responded to the best of his or her abilities to the presenting symptoms of Mary's abuse. There was however a lack of the necessary effective probing of the nature and causes of the problem which could have been achieved

both from an inter-disciplinary and inter agency approach and a better understanding on all sides of the nature of family violence and sexual abuse. This must be viewed in the context of the knowledge and limited legal powers available at the time and in the context of community attitudes. Violence and sexual abuse should not be seen as solely the concern of the health services. Other statutory and non statutory agencies and the community as a whole must share responsibility.

At the time Mary had her baby in 1982 the whole concept of child abuse was only beginning to be accepted as relevant to the health services and concentration was directed to the "battered baby syndrome". Historically child abuse and neglect was regarded as the province of the Irish Society for the Prevention of Cruelty to Children and its Inspectors. This, indeed, is reflected in the terms of the Children Act, 1908. The concept of child sexual abuse had scarcely surfaced and even discussion of incest was virtually taboo. The Department of Health's Guidelines on Child Abuse did not deal fully with sexual abuse until 1987 and even today many professionals have little or no training in recognising the signs and symptoms of child abuse.

On the evidence before us, many of the professionals involved in Mary's care are even now unfamiliar with the 1987 Guidelines. Some were unaware of their existence or had never seen them. However, it was clear that social workers, teachers and some medical and nursing personnel are now very familiar with the guidelines and with the danger signs of child sexual abuse. We are hopeful that today the early diagnosis of Mary's abuse as a young girl would have been much more likely.

With regard to physical violence within the family we believe that a major difficulty still exists in regard to the degree of ambivalence in the community as a whole to this type of violence. Quite a number of witnesses told us that domestic violence and the heavy drinking that often accompanies it was prevalent in the immediate area where Mary lived. This seemed to be accepted in a fatalistic way as a relatively normal part of life. There was and is a general reluctance to interfere in a "family matter" even when it was clear that assaults were occurring. Certain witnesses were of the view that physical violence was part of family life for some people and that women who were assaulted by their husbands "*gave as good as they got*". This attitude was by no means confined to the health services.

It is only in recent years that the Garda Síochána are receiving training that highlights the seriousness of domestic violence as a crime. Formerly they saw their role as simply that of peacemakers in such situations and were extremely reluctant to press charges. In many of the cases the victim is also reluctant and afraid to pursue the matter.

Ambivalence towards family violence goes right across the community and it is in this context also that one must view the failure to fully investigate the reasons for Mary's repeated injuries. As was noted to us during our investigation it is difficult to question injuries if the explanation given is consistent with the injuries being treated.

Finally the concentration of the limited community care resources of the South Eastern Health Board and other health boards on child care and protection work has meant that there are virtually no statutory services available to an abused person over 16 years of

age in many areas of the country. Such services as exist are provided by voluntary bodies such as Women's Aid and the Rape Crisis Centres, which are to some extent funded by the health boards. It is only since 1984 that a Women's Aid refuge has existed in the South Eastern Health Board area and that is in Waterford. A Rape Crisis Centre has opened in Kilkenny this year. This is in addition to those already in existence in Clonmel and Waterford. When Mary did take the step of leaving the family home with her child in 1985 the social worker in Carlow sought and found a hostel place for her in Dublin.

It is notable that when Mary finally was persuaded by a friend as well as her GP and the hospital staff to take the steps of making a formal complaint to the gardai about her abuse in early 1992 the health and social work services responded swiftly and adequately. A significant degree of change had taken place.

Mary suffered severe physical injuries, sexual and other abuse over a long number of years. In our examination of the role of the health services and other agencies we must not forget that the primary responsibility for Mary's abuse rests with her father. We note that Mary's mother was aware that her older daughter was being sexually and physically abused by her husband. Although her mother did make contact with the relevant authorities on occasions she did not make use of these services to protect her children.

During many of her early contacts with the health services Mary was accompanied by her mother and the impression given was that she enjoyed strong family support. In offering options to Mary people expected a coherent logical and rational response from her. Because of her status as a victim, albeit unknown to most of those with whom she was in contact, she was unable to make rational choices and reasonable responses.

Equally there is an expectation of the health services that they will act as a unified force in giving a coherent response. However, the health service is a conglomerate of specialities with increasing sub specialities. No professional has total responsibility for the total person.

We hope that the publicity attached to this case, the indepth nature of our investigation and the now known facts of the case with our analysis and conclusion will enable persons in such circumstances to take action sooner. We hope that health and other agencies will be alerted to the early signs of abuse and we have identified a number of additional factors which will enable professionals to recognise the warnings signals at an early stage.

PART II

Recommendations of Investigating Team

CHAPTER 10

Introduction to Part II

In undertaking the second part of the task outlined in our terms of reference which was *to make recommendations for the future investigation and management by the health services of cases of suspected child abuse*, the investigation team invited submissions from individuals, voluntary, professional and statutory bodies and organisations.

We received an excellent response to our invitation and we are indebted to all those who made submissions, for the time and trouble they took to do so and, for the comprehensive nature of their submissions. A list of those organisations who made submissions is attached in the Appendix. We also received submissions from DCC/MOH, senior social workers and from some individual staff members within the South Eastern Health Board.

A number of individuals and groups offered to meet with us in addition to making written submissions. While we fully appreciated their offers we regret that because of the time constraints we were unable to accept.

We did seek meetings with Ms. Maureen Gaffney and Professor William Duncan, who because of their background knowledge, professional qualifications and experience, would be helpful to us. We are indebted to them for their advice and assistance.

In making our recommendations the team had regard to the current Department of Health Child Abuse Guidelines and to the changes which have taken place since they were introduced. We also particularly took into account the provisions of the Child Care Act, 1991 and subsequent regulations made thereunder.

Much of the knowledge in regard to child abuse is still evolving and we carried out an extensive review of the literature in this area with the assistance of Ms. Ann Tierney, Librarian, South Eastern Health Board. We were however conscious, that within the time available, we could not deal with all the issues involved and we therefore concentrated on those which we felt merited priority.

We are aware that some of our recommendations will require further consideration and elaboration. Many will require additional financial support. Others will require a change

of policy, approach and attitude. All of them require an acknowledgement of the need for change if we are to improve the protection of children.

In framing our recommendations we have borne in mind certain principles which we feel should inform policy and practice in this area. These include:

- the rights of children
- parental involvement
- multi-disciplinary involvement
- inter-agency collaboration/cooperation
- the need for proper planning and evaluation of services
- the primacy of prevention
- the provision of treatment services
- the need to provide for a balance between child protection and the rights of parents.

We were also conscious that violence and sexual abuse, whether against children or adults, must not be seen as solely the concern of the health services. Other statutory and non statutory agencies and the community as a whole must share responsibility. The introduction of additional statutory provisions and new service developments will not in themselves protect persons from abuse. This must be a shared responsibility supported by society at large.

We hope that our recommendations will receive early and wide circulation so as to stimulate debate and bring about change in these areas.

CHAPTER 11

Recommendations

CHILD CARE ACT, 1991

Throughout our report we have referred to the importance of the legislative changes introduced in the Child Care Act, 1991. In the context of the investigation and management by the health services of cases of suspected child abuse, the provisions of Part III, Protection of Children in Emergencies, Part IV, Care Proceedings and Section 2, extending the definition of a child to include the sixteen to eighteen year old age group are of vital importance. The power of the court to require or direct medical or psychiatric examination, treatment or assessment of children would overcome key difficulties presently experienced. The introduction of supervision orders offers a method whereby a child may be protected in cases of suspected abuse without taking the traumatic and often damaging step of removing the child from the family home.

Section 3.(1) of the Act provides that *"it shall be the function of every health board to promote the welfare of children in its area who are not receiving adequate care and protection."* This represents a key change in the approach we adopt in dealing with child care. To date the health board resources had to be concentrated on intervening in cases of child abuse. With the implementation of Section 3 there is an obligation on the health board to identify actively those children who are not receiving adequate care and protection and put in place services to promote their welfare. The implications of this section has yet to be fully appreciated.

We are aware that as the Minister himself has stated nothing is achieved by implementing the necessary sections of the Act without providing the very considerable resources needed to operate them effectively. ***We cannot recommend too strongly the urgent need to provide the necessary resources and to implement the remaining sections of the Act and in particular Parts III, IV, V and VI which deal with the taking of children into care, court proceedings and the powers and duties of health boards in relation to children in their care.*** The implementation of these Parts of the Act will bring about a significant change in the focus and modus operandi of all those involved in child care. Prior to the introduction of the relevant sections it will be necessary to provide detailed briefings and, where necessary, training for those likely to be dealing with child care under the

new legislation. Training programmes must address individual discipline needs, in addition to multi-disciplinary training.

The willingness of the Government and the community as a whole to provide the necessary resources is a true measure of the degree of real public commitment to the protection of children and the promotion of their welfare. Public outcry about the circumstances of the Kilkenny Incest Case and other cases will achieve nothing without this commitment.

CONSTITUTIONAL CHANGE

In Chapter 5 of our report — Legal Framework — we have referred to the importance of Articles 41 and 42 of the Constitution and the effect which they have had both on the interpretation of the law and on the framing of legislation in regard to children. While we accept that the courts have on many occasions stressed that children are possessed of constitutional rights we are somewhat concerned that the “*natural and imprescriptible rights of the child*” are specifically referred to in only one sub article (Article 42.5) and then only in the context of the State supplying the place of parents who have failed in their duty.

We feel that the very high emphasis on the rights of the family in the Constitution may consciously or unconsciously be interpreted as giving a higher value to the rights of parents than to the rights of children. We believe that the Constitution should contain a specific and overt declaration of the rights of born children. ***We therefore recommend that consideration be given by the Government to the amendment of Articles 41 and 42 of the Constitution so as to include a statement of the constitutional rights of children. We do not ourselves feel competent to put forward a particular wording and we suggest that study might be made of international documents such as the United Nations Convention of the Rights of the Child.***

CHILD ABUSE PROCEDURES

The current child abuse guidelines “Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse” were issued in July 1987 by the Department of Health. They state “*responsibility for monitoring and co-ordinating the management of such cases rests with the Health Boards as part of the child care services provided within the Community Care Programme. The Director of Community Care and Medical Officer of Health (DCC & MOH) or person delegated by him has overall responsibility for the monitoring and co-ordination of cases of child abuse occurring in his area*”. The roles and responsibilities of other key personnel including hospital staff, general practitioners, social workers and public health nurses are also outlined in these guidelines. The guidelines promote interdisciplinary working and inter agency cooperation and it is recommended they be circulated to all health care staff, schools, gardaí and relevant voluntary organisations.

The investigation team understands that the current guidelines are not implemented uniformly within the eight health board regions. Knowledge and skill in relation to

child abuse have increased since 1987. Key service developments have occurred, and omissions in the current guidelines have been identified.

The guidelines provide that where there are reasonable grounds for suspecting child abuse, the Director of Community Care “*should report the matter to the Gardaí*”. **The current guidelines do not however have a statutory basis.**

Procedures in themselves, whether statutory or otherwise, are not a substitute for good practice and services must be responsive to local circumstances and resources must be available to ensure that intervention is effective. The investigation team supports the view that standards of good practice be developed and be updated through ongoing appraisal.

We recommend that the Minister for Health prepare revised procedures for the identification, investigation and management of child abuse to replace the current guidelines. These procedures should be given statutory effect under the provisions of Sections 68 and 69 of the Child Care Act, 1991.

We further recommend that revised procedures should include:

- ***a mandatory system of reporting***
- ***a standardised notification system***
- ***precise and workable definitions of physical abuse, emotional abuse, sexual abuse or neglect***
- ***guidelines on interviewing, history taking, indices of suspicion, incorporating recent theoretical developments in this area.***
- ***standardised criteria for the clarification of the outcome of investigation***
- ***written protocol on inter-professional and inter-agency collaboration, including a policy on access to records***
- ***protocols for the conduct of case conferences, with specific reference to the format, chairing and recording of minutes***
- ***protocol on parental participation***
- ***guidelines on case management, including***
 - ***recognition and investigation***
 - ***assessment and planning***
 - ***implementation and review***
- ***protocols for the maintenance of child abuse registers***

In preparing new procedures other crucial factors which influence their effectiveness must be considered. These include,

- the system of circulation of the procedures
- a systematic training programme for all personnel who may come in contact with child abuse

- the provision of administrative and secretarial services
- staff support and supervision.

No review of the implementation and effectiveness of the Child Abuse Guidelines issued in 1987 has been undertaken. ***We recommend that a regular system of evaluation of the procedures be established.***

It is insufficient to adopt Department of Health procedures in principle. All health care staff must have clearly written directions from their employer as to what their role and responsibilities are in relation to child abuse.

We recommend that there should be written agreed protocols for the investigation and management of child abuse within each health board. The roles and responsibilities of all staff should be outlined. There should be clear guidelines for inter programme collaboration between hospital and community care staff on matters concerning the identification, notification and follow up of child abuse.

The report on the future of public health medicine in Ireland if implemented will lead to the abolition of the post of D.C.C./M.O.H. and its replacement by a community care manager. As the responsibilities for managing child abuse are vested in the D.C.C./M.O.H. any re-organisation of services will have to take serious cognisance of these changes and designate a suitable alternative.

We recommend that the role and responsibility of the D.C.C./M.O.H. in regard to child abuse be appropriately assigned in the event of the abolition of that post. In view of the increased responsibilities assigned to health boards in the Child Care Act, 1991 and because of the increased reporting of cases of child abuse we recommend that consideration be given to the creation of a separate post of child protection co-ordinator within each community care area.

CHILD ABUSE REGISTERS

The 1987 Guidelines recommend that the DCC/MOH (or designated officer) should supervise the maintenance of lists of suspected and/or confirmed cases of child abuse. The investigation team is aware that the system of maintaining such lists varies widely across the eight health boards, and that there is some disagreement about their status/designation i.e. "lists" or "registers".

Registers can fulfil an important role in the protection of children. The register can assist in the investigation of cases by reference to previous concerns. Registers also provide epidemiological data for research and planning.

We recommend that standardised child abuse registers be maintained by the DCC/MOH in each community care area.

The investigation team concurs with the views expressed about the registers in the Law Reform Commission Report on Child Sexual Abuse. Prior to the introduction of such registers, certain safeguards and procedures must be agreed—

- **there must be a precise and standardised system of clarification of outcome**
- **parents and guardians should have the legal right to be informed of any entry, or change of entry to the register in relation to their child**
- **procedures for the removal of names should be established**
- **a system of regular review of data must be in place**
- **procedures must be established concerning the disclosure of information from the register**

To facilitate the speedy dissemination of information regarding children at risk we recommend the computerisation of the child abuse register. Access to this information should be provided to appropriate health care personnel, including hospital staff.

REPORTING OF CHILD ABUSE

As we have stated earlier there is no legal obligation on any person to report a suspected case of child abuse to gardai, health boards, or other statutory authority. The Department of Health Guidelines identify the DCC/MOH as the person to whom all cases are notified. There is no law requiring teachers, hospital staff or family doctors who have grounds to believe that a child may be subject to abuse to take steps to protect that child, or to report the matter to the DCC/MOH. The guidelines also state that at any stage where there are reasonable grounds for suspecting “child sexual abuse”, the DCC/MOH should report the matter to the gardai. The DCC/MOH is *not* statutorily bound to inform the gardai where he/she suspects the commission of an offence i.e. physical abuse, sexual abuse and incest. A garda is under no obligation to inform the DCC/MOH of any suspicion/report that he/she may have that a child has been or is being abused.

We believe, that as part of a range of measures designed to protect children, there should be a legal obligation on nominated professionals to report suspected cases of child abuse.

Mandatory Reporting

The team heard evidence and received submissions both *against and in favour of* mandatory reporting. Those against suggested that reporting does not ensure problems are effectively dealt with, that valuable resources could be tied up in pursuing vague or incomplete reports and that development of services should take precedence over a change in the law regarding reporting. Concern was expressed regarding doctor/patient confidentiality and the possible deterrence of victims from coming forward. It was suggested that current difficulties pertaining to the sharing of information could be largely overcome by training and the development of improved professional working relationships.

Arguments in favour of mandatory reporting however dominated and impressed the team. The true prevalence/current incidence of child abuse is not known and despite

prevention programmes, some children are likely to remain in situations of abuse out of fear, family pressure, guilt or shame. Mandatory reporting in the U.S.A. has resulted in an increased reporting of significant child abuse cases. Experience suggests that some professionals dealing with children may still prefer to turn a blind eye to the unpleasant reality of child abuse and studies show that professionals and voluntary agencies often refer children on an ad-hoc, discretionary and inconsistent basis — doubting their authority to do so and fearing personal or agency consequences in so doing. In making its decision the team considered that the overriding concern was to ensure the protection and safety of children and considered the benefits outweighed any negative influences.

We therefore recommend that there should be mandatory reporting of all forms of child abuse by designated persons to the DCC/MOH (or other nominated person within health boards) These designated personnel should include doctors, nurses, social workers, psychologists, community welfare officers, child care workers, teachers, probation officers and other professionals responsible for the care of children.

A clear definition of what is to be reported should be provided in guidelines to such designated personnel i.e. observed abuse or its effects, disclosures or specific risk factors which give reasonable cause for concern.

There should be immunity from legal proceedings for such designated persons, who report suspicion of child abuse to an appropriate authority, provided they do so in good faith and in accordance with guidelines set down.

Failure by designated persons to report child abuse should become an offence.

All designated personnel should be required to caution clients about their reporting obligation under a mandatory reporting law.

Persons other than those “designated” should also be entitled to report abuse and receive the same immunity provided they do so in good faith.

As we have already recommended the health board should have a legal responsibility to notify all cases and suspicions to the gardaí — the most appropriate person to carry out this role should be the DCC/MOH. Likewise there should be a legal responsibility on the gardaí to inform the DCC/MOH of any cases of abuse reported or suspected by the gardaí.

It is recognised that for such reporting to be fully effective, those obliged to report must have confidence that their reports will be investigated and pursued quickly, fairly and effectively. Some of the requirements to enable this to happen are referred to later in our report. It must be stressed that if mandatory reporting is to be successful the resources to deal with such reports must be in place.

We have also received submissions relating to the disclosure of the name of the person reporting suspected or alleged child abuse and there are grounds to suggest that the immediate disclosure of the name of a person reporting may result in a reluctance to make a report in some cases.

We recommend that the confidentiality of persons who make reports should be protected, if requested, so long as this does not adversely affect the investigation of the case. The duty to protect the child from abuse must override the duty to respect family privacy or personal freedom.

While we acknowledge that the introduction of mandatory reporting will have significant resource implications we nevertheless feel that this recommendation is central to the proper identification, investigation and management of child abuse cases.

CONFIDENTIALITY

The issue of confidentiality is a difficult one for professionals and their clients. Clients who are subject to abuse do not find it easy to trust people and are sometimes worried that what they tell a professional may be told to other people. There are situations in child care and welfare where a narrow definition of confidentiality may become a barrier to effective communication and may result in a child remaining in an at risk situation.

We are aware that the issue of confidentiality arises in regard to inter-professional and inter-agency co-operation.

The withholding of information between professionals and between agencies is not acceptable where failure to disclose may have an influence on the future safety and welfare of the child.

The team discussed this issue with the medical and other professional persons who gave evidence to us and it is clear that there are many and varying interpretations of the limits of doctor/patient confidentiality and also of the confidentiality of other client/professional relationships. There is no unanimity regarding its interpretation or boundaries, both in dealing with victims and particularly where there are third party risks.

We note from the report of the Cleveland Inquiry the recommendation of the U.K. General Medical Council in 1987 that — “if a doctor has reason for believing that a child is physically abused, not only is it permissible for the doctor to disclose information to a third party, but it is the duty of the doctor to do so”.

In response to our invitation to make a submission, the President of the Medical Council drew our attention to its ethical guide under the heading of “confidentiality” where it was pointed out that confidentiality is a principle of medical ethics. “The Council, however, recognises that there are circumstances when exception may be made and these are

- *When required by a Judge in a Court of Law;*
- *When necessary to protect the interests of the patient;*
- *When necessary to protect the welfare of society”.*

The Medical Council in its submission to us recognises that exceptions to the rule of confidentiality may arise when necessary to protect the interests of the patient and when necessary to protect the welfare of society. It appears to us that as a broad outline this offers a good indication of the limits of confidentiality.

We recommend that the Medical Council should ensure that all doctors are circulated with ethical guidelines governing medical practice on a regular basis and that it should be made clear that, if a doctor has reasonable grounds for believing that a child is being abused, not only is it permissible for the doctor to disclose information to a third party, but it is the duty of the doctor to do so. Where a client admits to child abuse or discloses child abuse, clinical responsibility to that client cannot take precedence over a doctor's responsibility in relation to child protection and the client should be so advised.

Likewise if a child reveals abuse on a confidential or "secret" basis to a professional this confidentiality cannot be binding. The professional person involved — social worker, teacher, doctor, etc., — must make it clear to the child that absolute confidentiality cannot be guaranteed.

In this context we would refer to a judgment of Lady Justice Butler-Sloss, in the case of *Re M and anor* (minors) in the English Appeal Court. Lady Justice Butler-Sloss, who had great experience in the area of child abuse as Chairman of the Cleveland Inquiry, had this to say:—

"A promise was made by the social worker to M. that her confidences would not be disclosed to the foster parents I am well aware of the enormous difficulties for those placed in the position of being the recipients of confidences of children, particularly where fears and highly sensitive allegations are revealed and the child may be most reluctant to speak in the absence of promises. I would venture these comments on the problem. Once a serious allegation is made particularly one criminal in nature such as abuse it cannot be ignored especially by a social worker charged with responsibility for the child. In those circumstances the fact and contents of the allegation will eventually have to be revealed not only to the social workers but probably to the police, doctors and others to the Court if proceedings are taken and to the foster parents if any action at all is taken A child cannot be sheltered from the consequences of the information disclosed and the person to whom the confidences have been made or suggested must give the child a truthful description of the likely outcome. He or she cannot promise what cannot be delivered. Whatever assurances for instance of protection may be given to the child, he or she has to be told that at some stage (unless the allegation is ignored) the carers will have to be told. Any other approach would be unjust to the child as it would be to the adults concerned".

While in that case Lady Justice Butler-Sloss was dealing particularly with the revelation of the allegations to the child's foster parents the point she made is a general one which we feel is applicable in a general way.

Selective disclosure of information by professionals to one another is often inadequate. Some professionals may have unrealistic expectations of the powers of other professionals and of what the other agency may be able to achieve. There is a need to establish a shared understanding of the statutory responsibility of the various organisations and of the legal and other limitations imposed upon them.

We are of the view that responsibility for co-ordinating information from voluntary and statutory agencies involved with child care rests with each health board.

The issue of confidentiality is sometimes seen as one which is of concern to professional staff only. It is often overlooked by them, and by others, that a similar and equally onerous duty of confidentiality rests with administrative staff, some of whom will have to make decisions on child care issues while others will have to keep records of these. Indeed the duty of confidentiality extends to all employees of health agencies.

However, we wish to stress that the communication of information must be confined to those who have an obligation to receive it and third parties should not be privy to allegations unless it is necessary to involve them as matters unfold.

CASE CONFERENCES

The case conference has a pivotal role as a method of interdisciplinary contact, analysis and decision making.

We recommend that the DCC/MOH take all reasonable steps to facilitate the attendance of relevant persons at case conferences. There must also be an equal obligation on all those required to attend to facilitate the DCC/MOH in arranging the case conference.

The purpose of a case conference is to promote efficient co-ordination and communication between professionals so that they work in unison to promote the interests of the child. They serve a number of broad purposes including:—

- the bringing together of relevant professionals involved with the particular child so that they can pool information about the child and his/her circumstances so as to develop a clearer picture of the risks to the child
- the case conference will also reach decisions as to what action is to be taken and appoint a key worker to manage the case. A subsequent case conference will also be used to review the intervention decided upon
- it will pool information which may be used in legal proceedings and recommend that the child's name should/should not be included in the list of at risk children
- where a case is being referred to the Director of Public Prosecutions with a view to prosecution the case conference should formulate a view on the effect that this will have on the welfare of the child and this view should be transmitted to the DPP with the garda file.

The agenda and the purpose of the case conference should be set out in advance and circulated with the invitation to those who are expected to attend. All health professionals who have had previous dealings with the case should bring their records to the case conference and should have prepared a written summary of the case history for the initial conference. In an emergency case conference a verbal submission will suffice. This should be followed up with a written report as soon as possible.

Where a decision not to hold a case conference is made, that decision and the reasons therefor must be clearly recorded.

There should be a prepared agenda for all case conferences to be used as a checklist by the chairperson.

All participants at case conferences should carefully distinguish facts from opinion in their presentations to the conference.

Everyone attending a case conference should be given the opportunity to express a point of view at the conference. This is particularly important where some of the individuals attending could be much less experienced in attending case conferences and presenting their point of view. The chairing of case conferences requires particular skill in this regard.

It is important that minutes of case conferences set out clearly the conclusions reached, the recommendations made and the information on which they are based. The minutes should include an abbreviated record of the discussion noting the information received and the process which led to the final recommendations. The minutes should also indicate what further action is to be taken and who has responsibility for taking this action.

We recommend that accurate minutes are kept in regard to decisions reached at case conferences and that these are distributed to participants within a reasonable time and are properly corrected where appropriate. Appropriate secretarial services must be provided in this regard.

We recommend the attendance of parents/guardians at case conferences unless there are substantial grounds for their exclusion. Where parents or guardians are to be excluded they should be advised in writing of the reasons for their exclusion. This will require careful preparation and training for those involved.

The task of co-ordinating the response in cases of child abuse is, in fact, quite difficult. Each case conference is likely to have different representatives attending. For this reason the role of the DCC/MOH or his nominated deputy in chairing case conferences is crucial. Because of the importance of this task it must be effectively managed and not inappropriately delegated.

Because of the central importance attached to the task of chairing case conferences, we recommend that those likely to be charged with responsibility for chairing case conferences should be suitably trained for the task.

We are concerned that the role of chairperson of case conferences has never been properly defined and we believe that this role should be clarified to include

- ensuring that proper arrangements are made for the calling of the case conferences
- arranging for the minutes to be taken and circulated
- allowing all members of the conference sufficient time to present their information and opinions and a point of view, while recognising that it is important that contributions do not become repetitive or argumentative

- ensuring that the meeting keeps the interests of the child as its primary focus
- probing the information and opinions being proffered and, where necessary, challenging statements being made
- ensuring that a plan with immediate and long-term aims is formulated at the case conference
- ensuring that all those at the conference are clear on the decisions reached and who has responsibility for their implementation; deciding on when, and in what circumstances, the case conference may be reconvened
- the chair will remain the focal point for the circulation of information before and after the case conference and will remain a central point of contact in regard to the case until it is satisfactorily disposed of.

INTER-AGENCY CO-OPERATION

Senior managers must ensure the establishment of effective working relationships within the health care system and between the health board and other agencies. A process of continuous inter-agency review needs to be operational in each health board area and arrangements and time schedules for such reviews must be formally agreed between the agencies involved. *We recommend that responsibility for ensuring that inter-agency reviews are carried out should be assigned to the health board.*

The difficulties of inter disciplinary and inter agency co-operation are compounded where administrative and clerical support is unavailable and where the effort required in contacting persons in another agency and communicating with them is seen as disproportionate to the benefit from such co-operation. Adequate administrative resources must be provided to facilitate and support such inter-agency contact and co-ordination.

Liaison with Gardai

The team believe that there is room for a good deal of misunderstanding of principal and practice between health boards and the gardai in the area of child abuse. The role of the gardai is *“driven by the need to identify a culprit and collect evidence”* and they have an obligation to investigate all crime. If gardai are involved at an early stage of an investigation into child abuse, it is easier for them to accumulate relevant and admissible evidence and it is more likely that the alleged offender will be successfully prosecuted. In many cases however there will be insufficient evidence to warrant a full garda investigation. The question at present arises as to whether health boards should be the arbiter in deciding if and when to involve the gardai.

Health agencies concern is primarily with the victim and it has been expressed that “routine” involvement of gardai in all allegations of child abuse may deter victims coming for help. It may lead to parental non consent to interview or examination or support for intervention by the health services. Many health professionals believe that the operation of the criminal justice process can be insensitive to the needs of clients.

The DCC/MOH is not statutorily bound to inform the gardai where he/she suspects the commission of offence, such as indecent assault, on a child. There is at present no law requiring teachers, hospital staff or family doctors, who have grounds to believe that a child may be subject to abuse, to take any steps to protect that child or to report the matter to the DCC/MOH. A garda is under no obligation to inform the DCC/MOH of any suspicion he/she may have that a child has been, or is being, abused.

We recommend that the DCC/MOH should notify the Garda Superintendent of all allegations of child abuse. Each Superintendent should notify the DCC/MOH of all allegations of child abuse received by gardaí. We further recommend that a standardised format be used for initial reports on child abuse passing between the DCC/MOH and the gardaí.

Notwithstanding the differences of approach, the team believes that effective cooperation between both agencies is fundamental to the successful management of child abuse. In securing this co-operation, there must first be mutual recognition, understanding and acceptance of each other's roles. Policies and written protocols must be devised for effective inter agency communication, liaison and working at all levels within each organisation.

We recommend that

- ***formal contact be established between senior health board and garda management whose areas of geographical responsibility overlap***
- ***roles and responsibilities of each agency regarding all forms of child abuse be discussed and clarified***
- ***an agreed policy be derived for the effective inter agency communication, liaison and working at all levels in each organisation to meet the needs and responsibilities of each agency***
- ***written protocols for implementing this policy be devised and circulated to all relevant staff in each agency***
- ***arrangements be put in place for consultation between investigation personnel from both agencies prior to action on an investigation taking place***
- ***explicit criteria be agreed for cases that require joint investigation — all approaches to be agreed in advance and from which neither agency can pursue independent investigation.***

We recommend that the Garda Authorities, should designate one or more officers at regional level as contact persons in child protection cases. These officers could be attached to the Office of the Chief Superintendent and provide services to a number of garda districts. Such officers should be trained in matters relating to child abuse and protection. As designated contact persons such officer(s) should attend all relevant case conferences, accompanied by the officer dealing directly with the individual case.

The DCC/MOH should notify the Garda Superintendent of the outcome of the health board's investigation of any/or agreed cases of child abuse within his area. Each

Superintendent should advise the DCC/MOH in relation to the progress and outcome of garda investigations into cases of child abuse.

Where a file is to be sent by the Garda Authorities to the Director of Public Prosecutions we recommend that DCC/MOH be advised of this decision and that a report from the health board professionals be included in the file forwarded. This shall include a report to the DPP on the impact a prosecution may have on the welfare of the child.

In view of the possible adverse affect on child welfare of delays in decision making every effort should be made by the Office of the DPP to process files on child abuse cases speedily and as a matter of priority. The decision of the DPP should be conveyed to the health service personnel.

An annual review of the operation of the policy and protocol should be arranged to include relevant personnel from both agencies. Opportunities for joint training of staff, particularly those involving investigation, follow up and support should be actively pursued by both agencies. A system should be developed by each agency to advise the other of changes in key personnel.

Schools

Teachers have daily contact with children in term time and are in a position to see change and express concern.

The role of teachers in the identification, investigation and management of child abuse is therefore significant and must be recognised in the development of any comprehensive programme in this regard. In particular their role must be integrated with that of other professionals dealing with children and with child abuse in particular. There are a number of aspects to the role of the teacher and these include.

- to express concern about children who may be showing signs of abuse and reporting cases of suspected or alleged child abuse where there are reasonable grounds to support such action.
- to raise awareness amongst children of their rights to personal health, welfare and safety.
- to monitor children who are subject of investigation of child abuse or who are listed on a child abuse "at risk" register or who are in the care of the health board and to provide appropriate support to the child and to liaise with the health board on matters relating to the child's progress and management.

To carry out their role effectively, teachers and school principals at primary and post primary levels need to be able to recognise child abuse and know how and to whom to report when they are concerned. We recognise that teachers cannot be expected to diagnose and treat cases of child abuse.

The investigation team are aware that guidelines dealing with allegations or suspicions of child abuse have been issued by the Department of Education to all primary schools in November 1991 and to post primary schools in August 1992. Additionally a Child

Abuse Prevention Programme (CAPP) operates in primary schools and approximately 75% of primary teachers have now received one day training on this programme and arrangements are in place to extend this training to remaining teachers. We deal in greater detail with the CAPP programme, and other preventative strategies in schools, in our section on prevention.

The Department of Education is also involved in supporting the establishment, development and implementation of guidance services in second level schools, consistent with the ethos of schools and parents. These services provide a valuable role in dealing with child abuse.

From submissions received, and from our own experiences, we are aware that many teachers consider that they lack sufficient knowledge and skills to enable them to satisfy themselves that they have reasonable grounds for the suspicion that a child is being abused. This has resulted in the failure to report suspicions of child abuse in certain cases and in the provision of inadequate reports in some cases. In order to optimise the full potential of the contribution that can be made by teachers in the prevention of child abuse and in the protection and promotion of child health, welfare and safety, *we recommend that appropriate training on the identification, investigation and management of child abuse should be developed and introduced at pre service level for all teachers. In addition a programme of appropriate inservice training should be provided for all teachers. These programmes should be reviewed and updated at regular intervals and be provided on a rotating basis to include new staff on appointment and to update more experienced staff from time to time.*

In our recommendations we emphasise the multidisciplinary nature of providing an appropriate and effective response in relation to child abuse. With regard to schools *we recommend that guidelines issued by the Department of Education should be reviewed in consultation with the Department of Health on a regular basis. If changes or revisions of guidelines are proposed by either Department these should be carried out in consultation to ensure uniformity in approach in dealing with suspicions or allegations of child abuse. All such reviews or changes must be brought to the attention of all teachers, health services and other professionals dealing with child abuse.*

We further recommend that there should be formal liaison between health boards and schools at local level to align respective guidelines on child abuse into a joint protocol for effective action.

We have dealt with reporting of suspicions or allegations of child sexual abuse in our section dealing with the reporting of child abuse.

INTER COUNTRY CO-OPERATION

It is recognised that there is increasing travel between countries and especially between Ireland and the U.K.. Families or individual members may emigrate and return on many occasions within a few years. Effective child protection must include initiatives to link health and social service agencies more closely in this regard. *We recommend that a formal liaison between the Department of Health and the U.K. Departments of*

Health and of Social Services be established to explore opportunities to develop and support maximum inter agency cooperation in relation to children at risk.

RECORDING OF INFORMATION

We would wish to stress the importance of accurate recording of all key facts relating to each clients contact with the health services. The importance of their retention, storage and retrievability must also be taken into account and we recommend that these issues be comprehensively dealt with in the curriculum of training of all the professions. It is not necessary that notes should be typed, but standard recording sheets should be used. ***What is essential is that records are accurate, comprehensive, dated, signed, legible and available when necessary. All records must be contemporaneous.***

The problem within the health service essentially is how to get necessary and relevant information to professionals who need it at the right time and in the right location. In addition to the central filing of records, their accessibility is also a key factor.

General Practitioners' records can be divided among a number of locations. While the main record will normally be kept in the surgery, a separate record may be kept in the doctor's private residence if a patient calls to see the doctor after normal surgery hours. This problem can be compounded where there are several partners in the practice and where a central recording system is not in operation. In these circumstances a patient may call to the same practice on several occasions without individual members of the practice being aware of this unless the patient chooses to inform them or unless they seek to elicit this information. In cases of non-accidental injury to children or adults and cases of child sexual abuse, the problems may remain hidden for much longer than is necessary by the absence of a central record.

The GP has a pivotal role to play in referring patients to hospital services. The GP will normally be aware of the status of a child, either as a confirmed or suspected child abuse victim. In referring such cases to hospitals it is important that this information be conveyed to the hospital. A problem arises where a child is brought directly to the Accident and Emergency Department or is referred to hospital by a doctor who is not the regular family doctor. This can apply particularly where there are relief services in operation which do not have access to the family doctor's records.

We recommend that guidelines be prepared regarding the retention by family doctors of written records of all attendances and that in group or practices where there is more than one centre of practice that one central record is maintained.

Hospital records are often voluminous. Many hospitals store the records for each department separately and without linkages. Medical and surgical records may be stored separately from gynaecology and from psychiatric in-patient records. Out-patient as well as accident and emergency records may be stored separately from each other and from the in-patient records. Likewise results of x-ray and pathology examinations may be kept separately, particularly where the request for the test comes directly from a GP and a report issues directly to him/her.

We recommend that linkages be established for all hospital attendances. They should be kept in summary form and should preferably be computerised. This would enable all attendances at the hospital to be reviewed at the time of each attendance. The summary list should contain information regarding the presenting symptoms, diagnosis, causation and any special precautions which need to be taken in regard to an individual person.

The history of injuries can be an important feature in diagnosing the presenting injury and for this reason staff in the Accident and Emergency (A & E) Department should have available the complete history of the hospital records of each person referred to A & E.

No clear guidelines exist regarding the length of time for which records maintained by Community Care staff should be retained.

We recommend that common guidelines be prepared in regard to the retention of the files of social workers, public health nurses and other professional staff who deal with child care.

We recommend that records should be accessible to professional workers who need them. This is particularly so in relation to new staff taking over a case and also to staff providing cover while a colleague is on leave. Efficient record keeping and effective personal contact between professionals should go hand in hand. In order to ensure the proper management of child abuse cases agency policies should promote the maximum amount of information/record sharing between personnel and departments. This would encourage a holistic approach to cases and would help to eliminate the possibility of contradictory or conflicting stories being told to individual workers.

It must be emphasised that the records do not belong to the person who makes the entries into these records. They are in the ownership of the employing authority.

We would stress that all agencies including voluntary agencies dealing with children should have a policy of co-operating with the DCC/MOH and his/her staff in making records and information available in promoting the welfare of children.

Where child abuse victims move from one area to another, the records should be transferred to the new area. In some cases personal contact between the team who have had responsibility for the care of the child should be established with the team who will be assuming this responsibility in the new area.

Where the transfer of a case file might be impractical or unworkable, it is recommended that there should be a summary of the known information supplied to the new area when the case is transferred.

PREVENTION

Prevention programmes are an intrinsic element of a comprehensive, integrated approach to the problem of child abuse. Prevention in the community is about setting standards of acceptable behaviour between adults and children and between children and children.

We recommend funding for the promotion of:

- *primary prevention programmes for children and young people*
- *family support services*
- *public education programmes*

Primary Prevention Programmes for Children and Young People

The Child Abuse Prevention Programme (CAPP) was introduced on a pilot basis in twelve schools in the Dublin area in 1989/1990. It was implemented in all primary schools in the Eastern Health Board area in 1991/1992 school year, and is now being extended to all primary schools throughout the country.

The aim of the programme, known as the “Stay Safe Programme”, is “to assist all concerned in dealing with or preventing child abuse, including sexual abuse and bullying, and to address the problem of child abuse at the level of primary prevention” (Department of Education).

The overall response to the programme has been positive. The programme increases community awareness, involves parents and imparts safety skills to children. As a joint Department of Education/Health Boards/Department of Health initiative it has promoted liaison between schools and health board personnel at local level.

We recommend the introduction of the CAPP in all classes at primary school level and recommend that a child abuse prevention programme be devised and introduced into second level schools at the earliest possible date.

We endorse the recommendations of the Second Commission on the Status of Women in relation to the introduction of age appropriate life skills programmes in primary and second level schools. These programmes should cover such issues as relationships, parenting, sex education, nutrition, hygiene.

A number of children do not attend school regularly, or opt out at an early age. Some of these would be considered to be at risk. The investigation team is aware that a number of community based youth projects have prepared prevention programmes for these young people. The knowledge and skills gained should be shared and ongoing programmes for this potentially vulnerable group should be promoted.

Family Support Services

Parenting is an onerous task. Frequently parents have to cope under considerable pressure, sometimes alone. During the last few years there has been some increase in the number and type of family support services available e.g. family resource centres, community mothers schemes, home makers schemes and womens self development courses. *We recommend the extension of these community based schemes and suggest that family support services for men should be promoted as their participation in such programmes is low.*

Public Education Programme

The prevention of child abuse is the shared responsibility of the entire community. It is essential to raise public awareness of the extent of the problem and the professional help currently available to victims and their families. Responses following television and radio programmes and newspaper articles suggest that most people believe that there are few services available to which people can turn. ***We recommend that education programmes should be devised by the Health Promotion Unit, Department of Health, to increase society's awareness and knowledge of child abuse.***

TREATMENT

It was clear from many of the submissions made to us that great strides have been made in recent years in the validation of allegations of child sexual abuse. It is equally clear that, while the process of validation has improved considerably, there has been no significant development of treatment facilities for victims of abuse. ***We recommend that appropriate treatment resources and facilities be developed in each health board area to deal with the victims of child abuse.***

Treatment of a family where intra familial abuse has occurred can require a high resource input if that family is ever to have a chance to function as a normal family. Treatment for the victim goes beyond securing and normalising the child's environment. It is now accepted that the effects of abuse should be probed in more detail and assertiveness training offered as further self protection. Individual and peer group therapy services should be readily available. More specialised treatment may be required for the traumatised child who exhibits psychological or psychiatric symptoms.

Treatment for the family may also require counselling and support for

- the non abusing parent(s)
- counselling and support for siblings
- counselling and support for husband/wife relationships

Furthermore, family therapy may also be required to assist the family to come to terms with the disruption of the family unit.

We recommend that health boards should employ a comprehensive range of expertise in the provision of diagnostic, treatment and support services for children and families and that these be available in each area. This includes child and adult psychiatrists, psychologists, social workers, nurses, family and play therapists.

Health boards should provide suitable and appropriate accommodation for the investigation and management of child abuse, including facilities for observation, video/tape recording, secretarial back up and play equipment.

Health boards should also be obliged to evaluate the effectiveness of their intervention programmes and share this information with other agencies.

There is almost a total lack of facilities for the perpetrators of child abuse. *We recommend that a treatment service be made available for perpetrators of child abuse and research be carried out into the most appropriate forms of treatment. We also recommend that inter-agency co-operation between the various sections of the Department of Justice i.e. prisons, gardaí, courts and court welfare services and of the health services be developed to facilitate a co-ordinated approach. Furthermore where a perpetrator has commenced a treatment programme while in custody a continuation of this programme should be available on release.*

TRAINING AND SUPERVISION

Child abuse is a complex, challenging and emotionally charged area of work. The work can evoke feelings of anger, distress and revulsion. Workers may be faced with conflicting evidence, retraction of statements, disbelief and denial. Many workers will be subjected to intimidation, violence, threatening behaviour and language.

The work is time consuming and intense. Those involved will be exposed to the pain and distress of the abused. Working in the field of child abuse requires considerable knowledge, skill, sensitivity and clarity.

Information may not always be correctly interpreted. There is a tendency to use coded messages when referring to sexual matters. Information may be disregarded if the source is not felt to be reliable. Information may be known and still disregarded if a different problem has been identified and is receiving attention.

Training must be provided for all those working in the area of child abuse. Some professionals would not have received training in child abuse during their formal training. Many professionals have had to arrange training for themselves without agency support.

We recommend that the health boards provide a systematic training programme for all professionals working in the area of child abuse.

Training programmes should focus on knowledge, skills, attitudes and values. The programme must be available at a number of levels — induction courses, inservice training, external courses, inter-disciplinary and inter-agency training. *We recommend that health boards should designate budgets specifically for training in child protection and child abuse.*

Regular professional consultation and supervision are also essential for those working in child abuse. Supervision facilitates learning, provides an opportunity to plan and evaluate and supports workers. Supervision also promotes good standards of practice to the benefit of the public. *We recommend that newly qualified staff should have additional support and supervision when working in this area.*

The nature of intervention in these cases is such that it often causes workers to become isolated, vulnerable and stressed. Employing agencies need to have an understanding of the ongoing complexities of the work and should provide appropriate support systems

and structures to ensure that both clients needs are met and that workers do not become casualties.

Child abuse within the context of the health services is an issue for the health board as a whole. It follows that structures and management styles affect responses to child abuse within the agency. Leadership from the most senior level, clarity of purpose and expectations, feedback and affirmation are essential.

DOMESTIC VIOLENCE

As with children, victims of adult abuse, need to know that violence against them is unacceptable and that services are available which are presented in a personal and non bureaucratic way. Adult victims also need to know that these services are appropriate to their needs.

We are aware that one major Dublin hospital is engaged with Women's Aid in a pilot project in relation to the management of persons who present to the hospital following family assault.

We recognise the excellent work done by organisations such as Women's Aid and the Rape Crisis Centres in providing refuges and counselling for victims of domestic and sexual violence. These services are however strictly limited and overstretched due to a lack of resources.

We believe that services for victims of domestic violence are urgently required and *we recommend that*

- *health boards should provide directly or in association with voluntary agencies a minimum number of refuge places within their geographical area for victims of domestic violence. Refuges should have back up facilities including access to professional counselling, information and advice on entitlements and on practical help available to victims of abuse.*
- *health boards should provide directly or in association with voluntary agencies, counselling support services for adult survivors of child abuse and incest.*
- *particular attention should be paid to the need to provide specialised services for adolescents who are victims of abuse.*
- *health boards should provide a free phone service to facilitate contact and the provision of information and counselling for victims of domestic violence.*
- *protocols should be developed for use by general practitioners, hospital and other health care staff for dealing with cases of domestic violence presenting for treatment or care.*
- *these protocols should include arrangements for the notification of such cases to the gardai and subsequent co-operation and liaison between health care and garda personnel.*

- *health care, gardaí and staff of voluntary organisations dealing with victims of domestic violence should receive adequate training in the recognition, investigation and recording of cases of domestic violence.*
- *a community and professional education programme should be provided to dispel current ambiguity and tolerance regarding domestic violence and to highlight the services available to victims of such violence.*
- *we recognise that support groups for men overcoming violence are now evolving. These groups should be supported and encouraged by health boards.*

Barring Orders

In Chapter 5 we have noted the limitations of the barring order under the Family Law (Protection of Spouses and Children) Act 1981 as a remedy in domestic violence cases. The problem of domestic violence is widespread and acute. For example in 1987 the Garda Síochána reported about 500 “family row” calls a month in the Dublin Metropolitan Area seeking their help. Hostels/refuges in Dublin, Cork, Limerick and Galway report admitting 496 families leaving situations of domestic violence in 1987.

The Second Commission on the Status of Women considered this question in their Report published in January 1993 and recommended that the Family Law (Protection of Spouses and Children) Act 1981 should be amended as follows:—

“Protection orders should be available as a remedy in their own right when barring orders are not available. This would provide a measure of protection for a woman cohabitee who is living with a man in premises owned by him.

Barring orders are at present available only to married couples, they should also be available to a cohabitee where the person seeking the order is the owner or tenant of the property; a woman who owns her own house or is a named tenant should be able to eject a violent partner.

Protection orders should be available as a remedy in all cases of domestic violence e.g. cohabitation, mother/son, brother/sister, relationships etc..

In crisis situations the Garda Síochána should be empowered to initiate an ex parte application for a protection order; at present it is only the spouse who can initiate such an order; this should be available for all cases of domestic violence, not just violence between spouses”.

The Commission also recommends that the question of extending the constitutional definition of the family should be referred to the Law Reform Commission for examination.

We support these recommendations for the amendment of the law and in addition recommend that barring orders should be available in certain cases of family relationships other than spouses or cohabitees.

Where the welfare of the child is concerned as in a case of child abuse, it may be very difficult, both psychologically and otherwise, for the mother of the child to seek a barring order.

We recommend that in such cases a health board should have the statutory authority to apply to the court for the barring or protection order. Such an application should not be made unless and until a full case conference has been held on the case which the parents have been given the opportunity to attend. It should not be made without the explicit authority of the DCC/MOH.

We are also aware of practical difficulties experienced by health care and other professionals in protecting victims of abuse from contact with their abusers. Sometimes this includes intimidatory contact by offenders and persons against whom legal proceedings are in consideration. ***In this regard we recommend that gardaí or health boards should be enabled to apply for an order to prohibit a person from further contact with an abused victim.***

We feel that this approach is preferable in certain circumstances to the issue of a care order for the protection of a child in that it further supports the principle of maintaining the child within its natural family unit.

PERSONS WITH MENTAL HANDICAP

While the particular circumstances of persons with mental handicap is not specifically included in our terms of reference we feel that it would be appropriate to make some reference to the protection of persons with mental handicap from abuse and in particular from sexual abuse.

The health services have a high degree of involvement in the provision of services for the mentally handicapped and a commitment to the protection of mentally handicapped persons.

The trend today is towards persons with mental handicap living in the community and leading lives as full and normal as their handicap permits. The general expectation of those with mental handicap, that they should be treated as adults and not as children, is a factor which should be constantly borne in mind when measures designed for their protection are under consideration. However, it may well be that sexual relations with mentally handicapped persons are of an exploitative and abusive nature and that the mentally handicapped person is unable fully to protect herself or himself in these situations.

Recommendations in this area have been made by the Law Reform Commission in their report on Sexual Offences Against The Mentally Handicapped (LRC 33-1990) and we support their recommendation that ***in general terms it should be an offence to engage in unlawful sexual intercourse with persons suffering from mental handicap to such a degree that the person is incapable of guarding himself or herself against exploitation.***

While a person with a mental handicap may have the chronological age of an adult they can have the mental age of a child. There is a strong case for giving them some of the same protection in law as is currently given to children in the Child Care Act, 1991.

There is an urgent need to develop guidelines on procedures for the identification, investigation and management of sexual abuse of people with disabilities as recommended by the National Rehabilitation Board in 1992. ***We recommend that appropriate guidelines should be prepared by the Department of Health and issued to health agencies and other organisations dealing with people with disabilities.***

The foregoing is the report of our investigation into the Kilkenny Incest Case carried out in accordance with our terms of reference.

Signed:

Catherine McGuinness SC

Brid Clarke

Martin Hynes

Sheelah Ryan

14 May 1993

APPENDIX

List of Persons/Organisations who made Submissions

Chief Executive Officer, Eastern Health Board, Dr. Steevens' Hospital, Dublin 8.
Chief Executive Officer, Midland Health Board, Arden Road, Tullamore, Co. Offaly.
Chief Executive Officer, Mid-Western Health Board, 31/33 Catherine St., Limerick.
Chief Executive Officer, North Eastern Health Board, Kells, Co. Meath.
Chief Executive Officer, North Western Health Board, Manorhamilton, Co. Leitrim.
Chief Executive Officer, Western Health Board, Merlin Park Hospital, Galway.
Accused Parents' Aid Group, 71 Basin Lane, James St., Dublin 8.
Association of Secondary Teachers of Ireland, 36 Lower Baggot Street, Dublin 2.
Mr. Mark Doyle, FRCSI, Consultant in Accident & Emergency Medicine, Waterford Regional Hospital, Waterford.
The Dublin Rape Crisis Centre, 70 Lower Leeson St., Dublin 2.
Dr. Harry Ferguson, Department of Social Studies, University of Dublin, Dublin 2.
Mr. R. Gilligan, Department of Social Studies, University of Dublin, Dublin 2.
IMPACT, Health and Welfare Division, 9 Gardiner Place, Dublin 1.
Institute of Guidance Counsellors, Gonzaga College SJ, Sandford Road, Dublin 6.
Irish Association of Social Workers, 114-116 Pearse St., Dublin 2.
The Irish Association of Care Workers, PO Box 1729, Dublin 3.
The Irish College of General Practitioners, Corrigan House, Fenian Street, Dublin 2.
The Medical Council, 8 Lower Hatch Street, Dublin 8.
The Irish Medical Organisation, 10 Fitzwilliam Place, Dublin 2.
The National Rehabilitation Board, 75 John Street, Kilkenny.
The Irish National Teachers Organisation, 35 Parnell Square, Dublin 1.
The Irish Nurses Organisation, 11 Fitzwilliam Close, Dublin 2.
Kilkenny Women's Studies Group, c/o City Vocational School, Ormonde Rd., Kilkenny.

Mr. Patrick K. Plunkett, FRCS (Ed) FRCS (Glas), Consultant in Accident & Emergency Medicine, St. James' Hospital, Dublin 8.
Professor FW Powell, Department of Social Administration and Social Work, University College, Cork.
The Psychological Society of Ireland, 13 Adelaide Road, Dublin 2.
Resident Managers Association, c/o Mt. St. Vincent's Child Care Centre, O'Connell Avenue, Limerick.
Royal College of Surgeons of Ireland, 123 St. Stephen's Green, Dublin 2.
Support Network Group for Professionals in Child Care, c/o Our Lady's Hospital for Sick Children, Crumlin, Dublin.
Teachers Union of Ireland, 73 Orwell Road, Rathgar, Dublin 6.
Women's Aid, PO Box 791, Dublin 7.

