Putting Children First

A Discussion Document on Mandatory Reporting

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A Discussion Document on Mandatory Reporting of Child Abuse

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W4. P45514. 2/96. 5,000. Cahill. (M18122). G.Spl.

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Foreword

The protection of children from abuse and neglect is a matter of major public concern. The Government is determined to put in place effective strategies and services to promote and protect the welfare of children. A sustained programme of improvements in child care and family support services is underway. Central to this programme is the implementation of the Child Care Act, 1991. Sixty-one of the seventy-nine sections of the Act are now in operation and the remaining sections will be brought into force before the end of 1996. The commencement of the Act has been underpinned by an investment programme of over **£35m** in additional personnel, services and accommodation.

My paramount concern is the interests of children. It has been suggested that mandatory reporting of child abuse should be introduced as a further initiative to facilitate early intervention to protect children. Mandatory reporting would involve placing designated professionals under a **legal** obligation to report known or suspected abuse to the authorities.

I am anxious to establish whether mandatory reporting would be a useful addition to the range of measures that currently exist to protect children from abuse. This Discussion Document highlights some of the major issues that would be involved in the introduction of mandatory reporting. I am inviting interested persons and bodies to make submissions on the issues raised in this Document and on any alternative strategies for reporting child abuse that might be effective in combating the evil of child abuse.

I am aware that this subject has been discussed in Northern Ireland and

would welcome the views of interested parties in the North arising from eir experiences. As part of the process of consultation, it is also my tention to provide opportunities for professionals and other interested arties to come together to discuss the issues involved.

hope that it will be possible to reach a consensus on how the best terests of the child can be protected in the arrangements we make for e reporting of child abuse. I invite all those whose responsibilities fect children to respond to this Document and to participate in the nsultative process. At the same time, I will continue to improve services to promote and protect the welfare of children in the fields of ealth, Education and Justice.

ustin Currie TD
inister of State at the Departments of
ealth, Education and Justice.

CHAPTER 1

Current Arrangements to Protect Children From Abuse

1.1 It is open to anyone to bring their suspicions or concerns about possible cases of child abuse to the attention of the authorities — the health boards or the Gardaí. Awareness of both the causes and extent of child abuse has grown considerably in recent years and the reporting of cases of child abuse has increased from 1,646 cases in 1987 to over 4,600 in 1994, an increase of over 180 percent. While no statutory duty to report cases of child abuse exists, it is clear that people recognise a responsibility to report cases of child abuse to the authorities. In the light of the increased awareness of the instances of child abuse, many organisations who are involved in the care of children, both on a national and local level, have drawn up guidelines for their members to deal with suspected cases of child abuse.

Department of Health Child Abuse Guidelines

1.2 The Department of Health **Child Abuse Guidelines**, published in 1987, contain detailed advice for staff working in health and social service agencies on the identification, investigation and management of suspected cases of child abuse. Under the Child Abuse Guidelines "any person who knows or suspects that a child is being harmed, or is at risk of harm, has a duty to convey his concern to the local health board".

1.3 Responsibility for monitoring and co-ordinating the management of child abuse cases rests with the health boards as part of their child care services provided within the community care programme. In fulfilling this responsibility health boards must:—

- ensure that arrangements are made to have all necessary information gathered concerning each case;
- consult with the appropriate personnel on the issues raised and determine the need for a case conference;
- where a decision not to hold a case conference is taken, record such a decision and the reasons for it;
- oversee the general management and co-ordination of cases and ensure that such action as is decided upon is carried out;
- maintain the lists of confirmed and suspected child abuse cases within their functional area; and
- ensure that there is adequate communication within the Community Care Team and with other agencies.

The Child Abuse Guidelines stress that inter-disciplinary and inter-agency work is an essential and integral element of the professional task of attempting to protect children from abuse.

Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí

1.4 A new procedure for the notification of suspected cases of abuse between the health boards and the Gardaí, launched in 1995, amends the Child Abuse Guidelines in relation to the interaction between health boards and the gardai in child protection matters. The procedure sets out that where a health board suspects that a child has been physically or sexually abused or wilfully neglected, the Gardaí must be formally notified immediately in accordance with prescribed procedures and a health board must not await confirmation of such abuse before notifying the Gardaí. A copy of the **Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí** is attached as an Appendix.

1.5 Where the Gardaí suspect that a child has been the victim of emotional, physical, or sexual abuse or neglect, whether wilful or unintentional, the health board must be formally notified immediately. It is not necessary for the Gardaí to have sufficient evidence to support a criminal prosecution before notifying the health board. However, it is not currently the practice that the Gardaí notify the health board in cases

of physical or sexual assaults against children which involve issues of law enforcement only, such as the assault of a child by a stranger, unless such cases give rise to child protection questions, for example, where the suspected abuser has ongoing contact with other children. In cases involving law enforcement only, the Gardaí currently contact the health services to provide for counselling and support services for the victim.

1.6 A central feature of the procedure is a standardised notification system between the agencies. The procedure also gives guidance on the consultations that should take place following such a notification.

Department of Education Procedures for Dealing with Allegations or Suspicions of Child Abuse

1.7 The Department of Education has issued procedures for dealing with allegations or suspicions of child abuse to both primary and post-primary schools. Under these procedures, a teacher who receives an allegation of child abuse, or who is suspicious that a child is being abused, is required to report the matter to another teacher, normally the principal. If the teachers are satisfied that there are reasonable grounds for the suspicion or allegation, the Chairperson of the Board of Management/School Manager/Chief Executive Officer of the Vocational Educational Committee is advised. The Chairperson/Manager/Chief Executive Officer, together with the teacher, then report the matter to the local health board.

Medical Council Ethical Guidelines

1.8 The Medical Council, the regulatory body of the medical profession, revised its Ethical Guidelines in 1994 as they relate to patient/doctor confidentiality. While the new guidelines stress that confidentiality is a "time honoured principle of medical ethics", four circumstances are listed where confidentiality may be breached:—

- 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
- when necessary to safeguard the welfare of *another individual* or patient.

'he amendment italicised means that a doctor may report to the appro-riate authority information given to him or her by a patient about the buse of a child so that the welfare of the child may be safeguarded.

:hild Sexual Abuse: Framework for a Church Response

.9 The **Report of the Irish Catholic Bishops' Advisory Committee on :hild Sexual Abuse by Priests and Religious (1996)** recognises that the :hurch, as part of the community, shares the responsibility for ensuring iat children are protected from abuse in all its forms. The purpose of ie Advisory Committee's report is to provide information and guidance 'hich would assist Church authorities to make an appropriate and effec-ve response to the problem of child sexual abuse by priests and eligious. The report recommends that each diocese and each religious ongregation should adopt a protocol for responding effectively to com-laints of child sexual abuse by priests and religious.

.10 The report recommends that each bishop or religious superior hould appoint a Delegate (and deputy-Delegate to operate in the Del-gate's absence) to oversee and implement the adopted protocol and to ave such additional responsibilities in relation to child sexual abuse as iay be required. Every complaint of child sexual abuse against a priest r religious which is received, whether by a bishop or religious superior, priest or other person, should be communicated to the appropriate)elegate. Knowledge or suspicions that abuse has taken place should be iade without delay by the Delegate to the senior ranking garda/police fficer for the area in which the abuse is alleged to have occurred. Where he suspected victim is a child, or where a complaint by an adult gives ise to child protection questions, the designated person within the ppropriate health board (Republic of Ireland) and health and social ervices board (Northern Ireland) should also be informed. The report ecommends that undertakings of absolute confidentiality should not be iven, but rather that the information should be expressly received 'ithin the terms of this reporting policy and on the basis that only those 'ho need to know will be told. However, the recommended reporting olicy does not apply to the relationship between penitent and confessor s under the Code of Canon Law the seal of the confessional is con-idered inviolable.

Misprision of Felony

1.11 Misprision of felony lies in the concealment or in procuring the concealment of a felony known to have been committed. Under the criminal law a person who knowingly conceals a felon or the fact that a felony has taken place could be found to be an accessory after the fact and liable to conviction.

1.12 Since most sexual offences are classified as felonies, the offence of misprision may arise where a person has knowledge of such abuse but fails to report it to the authorities. Misprision of felony is, however, subject to limitations based on a claim of right made in good faith based on privileged relationships.

1.13 The law relating to felonies is currently under review in the context of legislative proposals currently being prepared by the Minister for Justice to abolish all distinctions between felonies and misdemeanours.

HAPTER 2

andatory Reporting

Both the Law Reform Commission[1] and the Kilkenny Incest Inves-ıtion Team[2] addressed the issue of mandatory reporting in their ɔective reports. Amongst the advantages highlighted in the reports :e that mandatory reporting would:—

- be a clear declaration by society that child abuse is a matter for social concern and a broad social response;
- lead to the discovery by the authorities of some cases of child abuse which otherwise would not come to their notice;
- empower professionals, who otherwise might be reluctant to do so, to report abuse;
- secure consistency in the management of the disclosure of child abuse; and
- provide a better basis for research on the incidence and prevalence of child abuse.

Amongst the disadvantages highlighted in the reports were that ndatory reporting could:—

- lead to an over-reporting of cases of child abuse;
- lead to scarce resources being wasted on investigating cases which are never substantiated;
- deter victims from disclosing abuse;

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aw Reform Commission, *Report on Child Sexual Abuse* (LRC 32-1990).
.eport of the Kilkenny Incest Investigation Team (May, 1993).

- undermine the therapeutic relationship between professionals and their clients; and
- not guarantee that all abuse would be reported.

2.3 Having considered these factors, both the Law Reform Commission and the Kilkenny Incest Investigation Team recommended that, on balance, mandatory reporting should be introduced. The separate recommendations of both reports are listed here.

The Law Reform Commission

2.4 The Law Reform Commission recommended wide ranging changes in the law in relation to child sexual abuse, including the introduction of mandatory reporting. In accordance with their terms of reference, the Law Reform Commission's recommendations were restricted to the mandatory reporting of *child sexual abuse*. However, the Commission agreed with suggestions that other forms of abuse should also be covered by a mandatory reporting law. The following is a summary of their recommendations concerning mandatory reporting:—

- doctors, health workers, social workers (professional and voluntary) and teachers should be under a legal obligation to report cases of child sexual abuse;
- the obligation to report should arise when the mandated reporter *knows* or has *good reason* to believe that child sexual abuse has occurred;
- suspicion that a child may at some future time be subjected to sexual abuse should not give rise to a mandatory obligation to report;
- reports should be made to the health boards and it should also be open to a mandated reporter to submit his/her report to the Gardaí;
- reporting should be the personal responsibility of a designated professional;
- express statutory immunity from legal proceedings should be given to any person who bona fide and with due care reports a suspicion of child sexual abuse; and
- an appropriate summary offence should be created for failure to

report with a maximum penalty of six months imprisonment and/or fine of £1000.

he Kilkenny Incest Investigation Team

5 The Kilkenny Incest Investigation Team, which recommended ajor improvements in the child care services, called for the introduction mandatory reporting of *all forms of child abuse*. In relation to manda-ry reporting, the principal recommendations may be summarised as llows:—

- mandatory reporting should apply to all forms of child abuse;
- there should be a clear definition of abuse for the purposes of the mandatory reporting law to be provided in guidelines to designated personnel;
- doctors, nurses, social workers, psychologists, community welfare officers, child care workers, teachers, probation officers and other professionals responsible for the care of children should be subject to the legislation;
- reports should be made to the health boards which in turn should be required to notify all cases and suspicions of child abuse to the Gardaí;
- there should be a legal responsibility on the Gardaí to inform the health boards of any cases of reported or suspected abuse known to the Gardaí;
- immunity from legal proceedings should be granted to designated persons who make a report, provided they do so in good faith and in accordance with guidelines set down;
- persons other than those "designated" should also receive immunity, provided they report in good faith;
- designated personnel should be required to caution clients about their reporting obligation; and
- failure by designated persons to report should become an offence.

.6 Both reports stressed the importance of a clear definition of the buse to be reported. The Law Reform Commission considered that if

it proved impossible to arrive at a reasonably clear statutory definition of reportable circumstances, then the case for mandatory reporting was considerably weakened. The definition proposed by the Law Reform Commission covered sexual abuse only, reflecting the Commission's terms of reference. The Kilkenny Team did not recommend a definition but proposed that one be provided in guidelines to designated personnel.

2.7 Although the Law Reform Commission and the Kilkenny Team both recommended the introduction of mandatory reporting, their recommendations as to the actual form of mandatory reporting to be introduced differed in important respects.

The main differences are as follows:—

- The Law Reform Commission's recommendations, reflecting its terms of reference, concerned the introduction of mandatory reporting of child sexual abuse, while the Kilkenny Team recommended that all child abuse be the subject of mandatory reporting.
- The Kilkenny Team recommended that a wider group of professionals should be obliged to report abuse than the Law Reform Commission.
- The Law Reform Commission recommended that the obligation to report should arise when the mandated reporter *knows* or has *good reason* to believe that abuse has occurred. The Kilkenny Team envisaged that *suspicions* of child abuse should be reported.
- The Kilkenny Team recommended that health boards should be legally obliged to notify the Gardaí of cases and suspicions of child abuse. No such legal obligation was recommended by the Law Reform Commission.

2.8 At this juncture it may be worthwhile to examine the situation as it currently exists in other countries, some of which have introduced mandatory reporting, and others which have either not introduced it, or have decided against it, for varying reasons.

HAPTER 3

eporting of Child Abuse in other ountries

l The introduction of a system of mandatory reporting of child abuse s been considered in a number of countries worldwide. Some countries ve introduced Mandatory Reporting as part of their strategies to ckle the problem of child abuse; others have actively rejected it in vour of other approaches which were thought to better serve the needs children. What follows is a brief outline of the situation in relation to ndatory reporting in a selection of countries and a detailed examinon of the case of the United States of America, where mandatory porting was introduced in the 1960s. As part of its role in informing consultative process, the Child Care Policy Unit in the Department Health is continuing to gather information in relation to mandatory porting in other countries.

A recent report prepared for the International Society for the Prention of Child Abuse and Neglect[3] studied the situation regarding the porting of child abuse in thirty countries. Of European countries studl, Finland, France, Italy, Norway and Sweden had a system of mandary reporting in operation. In these countries, while the levels of public areness as to the extent and causes of child abuse were only rated to "low" to "moderate", awareness was found to be increasing. owever, in the European context, increased awareness of the problem child abuse was not confined to countries which had a system of ndatory reporting; Germany, England and the Netherlands do not

[3] The National Committee for Prevention of Child Abuse (USA) *World Perspectives on Child buse: An International Resource Book* (Chicago, 1992).

have mandatory reporting, yet levels of awareness of child abuse were found to be "high" and increasing still further.

United Kingdom

3.3 There is no system of mandatory reporting in Northern Ireland, Scotland or England and Wales. In 1985, a Review of Child Care Law by an interdepartmental working party in England recommended that any proposal for a compulsory reporting law should be rejected. It was felt that mandatory reporting might "be counter-productive and increase the risks to children overall, first by weakening the individual's (professional's) sense of personal responsibility and secondly, in casting the shadow of near automatic reporting over their (the professionals') work, by raising barriers between clients and professionals and also between professionals involved in the same case".[4]

The Netherlands, Belgium and Germany

3.4 The Netherlands has a voluntary system of reporting child abuse based on the Confidential Doctor's Bureau. Anyone suspecting that a child is being maltreated can contact the confidential doctors for advice on how to handle the situation or to refer the case to professionals, whereupon the confidential doctor verifies the request and organises the most adequate assistance amongst existing services. Belgium and Germany have similar systems with certain adjustments.

Australia

3.5 In 1977 a mandatory reporting system was introduced in the state of New South Wales in Australia aimed primarily at medical practitioners. Other states in Australia have systems of voluntary reporting but with the addition that the person reporting is protected from civil liability.

The United States

3.6 In the United States of America, mandatory reporting has been in operation in some states since the 1960s. In 1974, Congress passed the

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[4]Review of Child Care Law: Report to Ministers of an Interdepartmental Working Party (Published by the Government as a Consultative Document, Her Majesty's Stationery Office, London, 1985).

hild Abuse Prevention and Treatment Act (CAPTA), the first federal gislation specifically dealing with child maltreatment. Under the Act, order to receive reimbursement from the federal government for ser-ces, states were required to have mandated reporting laws, to investi-ıte reports of suspected abuse or neglect and to show that administrat-e procedures were in place "to deal effectively with child abuse and eglect". The mandate to report was introduced because physicians were n uncertain ground in breaching confidentiality to make reports of sus-ected child abuse. The original objective of mandatory reporting laws as to promote reporting by physicians of serious physical abuse. Over ıe years, there has been a considerable expansion in the number of rofessions included as mandated reporters and in the number of mal-eatment categories identified as reportable.

.7 Under the Child Abuse Prevention and Treatment Act, 1974, child buse and neglect was defined as "the physical or mental injury, sexual buse or exploitation, negligent treatment, or maltreatment of a child nder the age of eighteen, by a person who is responsible for the child's /elfare under circumstances which indicate that the child's health or /elfare is harmed or threatened thereby". The various state reporting aws commonly include definitions of physical abuse, neglect, emotional buse and sexual abuse.

.8 The list of mandated reporters varies from state to state. Most tates identify the following categories or professionals or occupational roups as required to report:—

- medical professionals, such as physicians, nurses and dentists;
- mental health professionals such as psychologists, therapists or counsellors;
- educators such as teachers and administrators;
- child care providers such as staff in day care centres, pre-schools and family day care; foster parents and residential/institutional care personnel;
- social service providers such as social workers and social services personnel; and
- law enforcement personnel.

3.9 Some states require the clergy to report suspected child maltreatment. The rights of client-professional confidentiality (with the exception of the attorney/child relationship) are usually waived in child abuse and neglect reporting. Therefore, professionals are expected to report suspected child maltreatment even if their knowledge of the incident comes from a client.

3.10 Additionally, most state reporting laws include a provision that any person having knowledge of abuse or neglect may report. The same legal protection from law suits or criminal prosecutions are provided to individuals mandated and permitted to report.

3.11 States require the reporting of suspected child abuse and neglect. The law may specify reporting of "suspected" incidents or include the phrase "reason to believe". This very broad standard is designed to include as many cases as possible to identify those children who have been harmed and to prevent them from experiencing any further harm.

3.12 Reporting laws contain provisions to protect reporters from civil lawsuits and criminal prosecution resulting from filing a report. This immunity is provided as long as the report is made in "good faith". Determining whether child abuse or neglect is substantiated ("some creditable evidence exists") is the responsibility of the Child Protection Service (CPS) agency and the courts. As long as the reporter has a basis to "suspect" that maltreatment has occurred, it is assumed that the report has been made in "good faith", and therefore the reporter is immune from criminal or civil liability. Under most circumstances, CPS workers who investigate complaints are granted similar immunity from suits.

3.13 All statutes include a clause concerning the wilful failure to report suspected child abuse. Such wilful failure to report may subject the mandated reporter to criminal penalties, and in some states to civil liability and monetary damages if a child is injured after a mandated reporter has failed to report.

3.14 Over the past thirty years, the number of reported child abuse cases has increased from 150,000 in 1963 to 2.9 million in 1992 (Federal Government's National Centre on Child Abuse and Neglect). With a substantiation rate of forty percent (Besharov, 1990), that constitutes

proximately 1,160,000 children who were identified as having been altreated. On the basis of an estimated annual incidence of approxiately 1.5 million maltreated children (National Centre on Child Abuse d Neglect, 1988) this suggests that there are almost 340,000 children o are being maltreated annually and who are not the subject of ports.

15 The breakdown of substantiated child abuse cases in 1994 is shown low (National Centre for Prevention of Child Abuse). Child sexual use accounted for eleven percent of abuse cases, compared with fortyne percent of children who were victims of neglect and twenty-one rcent who were physically abused.

Emotional Abuse	Other Abuse	Physical Abuse	Sexual Abuse	Neglect
3%	16%	21%	11%	49%

npact of Mandatory Reporting in the USA

16 A comprehensive review of the effects of mandatory reporting in e USA is not available either at federal or state level. Nevertheless, a nsiderable amount of research has been carried out on the impact of andatory reporting. While mandatory reporting is generally considered have had a positive effect in terms of child welfare, there are extensive iticisms of particular aspects of mandatory reporting laws and pressure reform the existing system.

17 The main positive effect of mandatory reporting laws is considered be the huge increase in the number of child abuse cases reported. reater protection has been given to children at risk by bringing oubled families to the attention of child protection agencies. In ldition it is considered that it has forced professionals to educate themlves about abuse and has given them a rationale to report cases, even ough they may find it difficult.

18 The main criticisms of mandatory reporting may be summarised follows:—

- Mandatory reporting has led to an explosion in child abuse reports. However, the increase in the number of reported cases

has not been matched by a commensurate increase in the number of substantiated cases. The number of unsubstantiated cases has risen from thirty-five percent in 1976 to sixty-five percent in 1992.

- Many critics feel that the increase in the volume of reports has resulted in the child protection system becoming "swamped" to the extent that it is now in danger of collapse.
- It is argued that a disproportionate share of resources is being spent on investigations rather than on services for children and their families. The majority of cases investigated by child protection agencies receive no additional services.
- The definition of child abuse is considered to be too broad and vague, resulting in many less serious and unfounded cases being reported. There are problems in identifying the really serious cases of abuse.
- Mandatory reporting laws have not led to the complete identification of all endangered children. Children still "slip through the net".
- Some states refuse to deal with particular types of abuse such as custody cases or extra-familial abuse.
- Insufficient funding has been provided for training of mandated reporters and in putting in place the infrastructure for providing the follow-up to reports of abuse.
- A 1993 cost benefit analysis concluded that the costs of mandatory reporting laws outweighed the benefits. This study recommended a number of policy changes including narrowing the definitions of child abuse and supporting families by improving income maintenance and general social services.

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CHAPTER 4

Issues to be Addressed in Relation to Mandatory Reporting

The following are some of the major issues that would need to be addressed before a decision could be reached on the feasibility of introducing mandatory reporting. In preparing submissions, interested parties are invited to comment on the following points or on any other issue which they deem to be of relevance.

4.1 Would the placing of a legal duty on certain professionals to report known or suspected cases of child abuse be the most effective way of ensuring that child abuse is reported to the authorities or would other means achieve the same end?

4.2 If mandatory reporting is favoured, what forms of abuse might be subject to a mandatory reporting law? Should mandatory reporting be limited to child sexual abuse or should it extend to other forms of child abuse, including physical abuse (non-accidental injury), emotional abuse and neglect? If there is to be mandatory reporting of neglect, should it extend to wilful neglect only or include unintentional neglect? In arriving at a satisfactory definition of the nature and scope of abuse to be covered, interested parties may wish to consider the definitions of physical, sexual and emotional abuse, as well as neglect, contained in the **Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí** and attached as an Appendix.

4.3 Any mandatory reporting law would have to be precise on whether a suspicion or knowledge should create a legal obligation for a professional to report. The Law Reform Commission recommended that the

)ligation should arise when the mandated reporter knows or has good ason to believe, while the Kilkenny Team considered that suspicion ould be sufficient. Interested parties are invited to comment on which ould be the more effective option.

4 One of the most difficult issues relates to the reporting of under-ge sexual activity. At present the age of consent to what may be termed sser forms of sexual activity is fifteen years. However, the age of con-nt to actual or attempted sexual intercourse, to buggery or to sexual ehaviour by a male with another male is seventeen years. Since the hild Care Act, 1991 defines a child as a person under eighteen unless arried, the question arises as to whether *all* underage sexual activity ould be subject to reporting. Some people may consider that consen-ual sexual activity between young people should not be subject to andatory reporting despite the fact that it is unlawful. The position in elation to pregnant girls under seventeen presents a particularly difficult ilemma. On the one hand such pregnancies are direct evidence that a rime has been committed by the male involved. However, the danger that if the pregnancies were to be subject to mandatory reporting, it ight deter young pregnant women from seeking medical attention or crease the pressure for them to seek an abortion.

.5 It has been suggested that mandatory reporting could damage the ust inherent in many professional relationships, such as doctor/patient nd teacher/pupil relationships and could place an unnecessary spotlight f attention on the victim who discloses abuse, rather than the per-etrator. Mandatory reporting could discourage some parents/guardians rom seeking professional attention for their children if they believe — ightly or wrongly — that the child's condition, no matter what the cause, night lead a professional to report automatically any suspicions of abuse o the health board or the Gardaí. Mandatory reporting could have erious implications for the confidentiality of many professional services f professionals were obliged to report cases of abuse that came to light n the course of professional consultations. Interested parties may wish o consider whether there are circumstances in which client/professional onfidentiality should not be breached.

1.6 Mandatory reporting could challenge the whole aim of our thera-eutic counselling services. If reporting were to lead to legal action, then ictims may have to confront their abuse and possibly even their abusers

with the attendant risk of trauma which such an encounter might provoke. The aim of therapeutic counselling is to support clients, not force confrontations. There may be situations where it is perceived to be in the best interests of the child not to report cases of child abuse, but to concentrate solely on the provision of therapeutic care.

4.7 Another issue to be addressed is whether mandatory reporting might apply to current child abuse only or to cases where an adult alleges abuse during his/her childhood, perhaps twenty or more years before. If cases where the victim is now an adult come to the attention of health board personnel or other designated reporters, should it be mandatory for such cases to be reported to the Gardaí, or should the consent of the victim be required? At present, the investigation of cases of child abuse disclosed by the victim as an adult is seen as primarily a matter for the Gardaí and the enforcement of the criminal law. In this regard, it is understood that the Gardaí are unable to proceed with a criminal investigation unless they receive a formal complaint from the victim. If mandatory reporting were to include abuse that happened many years previously, many victims in need of therapeutic counselling might not seek the help they require.

4.8 If mandatory reporting legislation were to be introduced should it apply only to cases of abuse that come to the attention of designated professionals subsequent to its introduction or should it have retrospective effect? If mandatory reporting were to have a retrospective application it could act as a disincentive for abusers to come forward and seek attention. There may also be the attendant risk that perpetrators who had previously disclosed abuse in good faith and sought counselling and assistance, may now feel betrayed if the confidentiality which they were promised was broken.

4.9 It may be that the legalistic approach inherent in mandatory reporting may not be the best way to proceed. It may lead to defensiveness in families, to the punishment of those perpetrators who come forward to admit their crimes and seek the assistance of counselling and other health services and thus encourage other perpetrators to remain silent. Although evidence from the United States is that mandatory reporting gave rise to an increase in the reporting of abuse, it could lead to an over-reaction by professionals who are designated as mandated reporters and drive the problem of child abuse underground. This would

be detrimental to the sense of openness and awareness which all public and voluntary agencies are trying to foster about the issue of child abuse.

4.10 To whom should reports of abuse be made? If it were to be the health boards, should the boards then be under a legal responsibility to notify all cases and suspicions to the Gardaí? Should there be a similar legal responsibility on Gardaí to notify all cases and suspicions to the health board. Another issue to be considered is whether the Gardaí might be required to notify health boards of all cases of past abuse or only those where child protection issues arise? Likewise, are there circumstances in which reports might be made to other agencies, such as the Medical Council, An Bord Altranais or the Dental Council?

4.11 Should mandatory reporting extend to the abuse of vulnerable persons other than children? Is there a case for giving adults with a mental handicap some of the same protection in law as is currently given to children in the Child Care Act, 1991? Arguments might also be made for including other vulnerable adults within the scope of mandatory reporting laws. In the case of adults, it would, of course, be necessary to distinguish between consensual and abusive relationships.

4.12 It can be argued that fear of legal proceedings operates as a disincentive to the reporting of suspicions of child abuse. The purpose of granting an immunity would be to encourage reporting by professionals. Interested parties may wish to consider whether those mandated to report should be given immunity from prosecution in respect of this statutory function. If professionals were given immunity from prosecution for reporting child abuse, without the introduction of mandatory reporting, would it achieve the same purpose? Protection could be given to professionals reporting abuse "in good faith" or protection could be given without limitation. However, the granting of an immunity without limitation could remove any restraint from an incautious reporter.

4.13 Allegations of child abuse, even if subsequently disproved, can have serious consequences for a person's reputation and good name. Even in the case of a report made with the utmost care and caution and in the best of faith, an allegation may prove to be unfounded. Should a person against whom allegations of abuse have been passed by a mandated reporter to the authorities be informed of this fact? Is it necessary

o consider providing some safeguards or an appeals process for persons ıgainst whom such allegations have been made?

1.14 Who might be mandated to report cases of child abuse? The Law Reform Commission recommended that doctors, health workers, social workers (both professional and voluntary) and teachers should be mandated to report known or suspected cases of abuse. The Kilkenny Incest Investigation Team recommended that the duty to report should be extended to doctors, nurses, psychologists, community welfare officers, child care workers, teachers, probation officers and other professionals responsible for the care of children.

4.15 What protection, if any, should be given to a person who is not a mandated reporter and who informs a mandated reporter of a suspicion or knowledge of abuse who in turn passes the information to the health board? Should the duty to report extend beyond those professionally involved with children? For example, should it extend to parents, families and friends? Should the duty to report be extended to non-professional persons in positions of trust or authority, such as scout leaders, youth club organisers, or child minders?

4.16 Should a mandated reporter have an entitlement to know the progress and/or outcome of an investigation? If mandatory reporting were to be introduced, should those who make reports be entitled to anonymity? For example, to protect reporters from possible victimisation, would there be a need for safeguards for employees who make reports which allege abuse by their supervisors or employers?

4.17 Should an authority designated to receive reports of abuse, such as a health board or the Gardaí, be entitled to inform a third party, such as a person's employer or a professional registration body, of information obtained via a report? Should a third party to whom information might be given by the Gardaí or a health board be able to use it in any future dealings with an individual concerned?

Summary

4.18 It is clear that there are many difficult issues to be resolved in relation to mandatory reporting. For many professionals working with children the fundamental issue is the quality of the response to the child's

needs after a report of abuse is received and not the nature of the obligation to report. If mandatory reporting were to be introduced in this country, it would be essential that the infrastructure and supports were in place to respond quickly to the increase in the reported cases of abuse which would occur. Interested parties may wish to consider whether developing our services to protect children from abuse, improving existing arrangements for the notification of child abuse and co-ordinating action in response to such abuse would better serve the interests of children than the introduction of mandatory reporting.

CHAPTER 5

Consultations

5.1 Comments are invited on the issues raised in **Putting Children First: A Discussion Document on Mandatory Reporting** and on any other matters which interested parties may consider relevant to the issue of mandatory reporting. Comments are also invited on alternative or complementary strategies or initiatives to improve reporting arrangements of child abuse. It is hoped that the consultations on the Discussion Document will lead to a consensus on how the arrangements for reporting child abuse can reflect the best interests of the child.

5.2 As part of the consultative process, it is the intention of the Minister of State, Mr. Austin Currie TD, to provide opportunities for interested parties to come together to discuss the issues raised in the Discussion Document. Further details will be announced at a later date.

5.3 Submissions on the Discussion Document should be forwarded to the Child Care Policy Unit, Department of Health, Hawkins House, Dublin 2 by the **30th April, 1996**. For administrative purposes, **five** copies of each submission should be forwarded and submissions should be in typed form. Any queries concerning points raised in this document may be addressed to the Child Care Policy Unit, Department of Health: Telephone 01-6714711 — ext. 2594. Fax. 01-6719530.

APPENDIX

Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí

April 1995

Contents

Introduction

1.1 Under the Child Abuse Guidelines issued by the Department of Health in 1987, a Health Board is expected to notify the Gardaí of any alleged case of child abuse where it is suspected that a crime has been committed. This can give rise to difficulties for Health Board staff who may not be in a position to determine whether an offence has been committed. A further problem with the current guidelines is that they do not specify when the Gardaí should refer cases to the Health Boards.

1.2 This document amends the 1987 Guidelines in relation to the circumstances in which the Health Boards and the Gardaí are to notify suspected cases of child abuse to each other and in relation to the consultations that should take place between both agencies following a notification.

1.3 Central to this document is a standard procedure for the notification of cases between the two agencies. This procedure, which is in line with a recommendation of the ***Report of the Kilkenny Incest Investigation***, is to be used where either agency suspects that child abuse has taken place.

1.4 Effective intervention on behalf of children who are in need of protection requires a co-ordinated approach on the part of the Health Boards and the Gardaí. Recognising and respecting their different roles and responsibilities in child abuse cases, this procedure is aimed at ensuring closer co-ordination between the key personnel involved in order to facilitate the twin objectives of protecting the welfare of the child and the full investigation of alleged offences.

Scope of Procedure

2.1 Parents, carers (i.e. persons who while not parents have actual responsibility for a child) or others can harm children either by direct acts or by failure to provide proper care, or both. This document is concerned with suspected physical, sexual or emotional abuse or neglect of children who are under the age of 18 years.

2.2 For the purposes of this document, abuse means one or more of the following:—

Physical Abuse

Physical injury to a child, including poisoning, where it is known or suspected that the injury was deliberately inflicted.

Sexual Abuse

The use of children by others for sexual gratification. This can take many forms and includes rape and other sexual assaults, allowing children to view sexual acts or to be exposed to, or involved in, pornography, exhibitionism and other perverse activities.

Emotional Abuse

The adverse effect on the behaviour and emotional development of a child caused by persistent or severe emotional ill-treatment or rejection, or exposure to ongoing domestic violence.

Neglect

The persistent or severe neglect of a child, **whether wilful or unintentional**, which results in serious impairment of the child's health, development or welfare.

.3 In relation to **child sexual abuse**, it should be noted that, for the ›urposes of the criminal law, the age of consent to sexual activity is 17 ears. This means, for example, that sexual relationships between a 16 ear-old girl and her 17 year-old boyfriend is illegal, although it might ıot be regarded as constituting **child sexual abuse**.

Cases to be Notified by Health Boards to Gardaí

3.1 Where a Health Board suspects that a child has been **physically or sexually abused or wilfully neglected,** the Gardaí must be formally notified immediately in accordance with the procedure set out in paragraph **3.4** below.

3.2 The process of establishing whether grounds exist for suspecting **such abuse** may involve consulting relevant professional personnel within the Health Board and, where appropriate, in outside agencies. In appropriate cases advice and guidance in relation to the criminal law should be sought from the Gardaí. However, a Health Board **must not await confirmation** of such abuse (whether from a child abuse assessment unit or otherwise) before notifying the Gardaí.

3.3 It is not envisaged that the Health Boards should routinely notify suspected cases of **emotional abuse or unintentional neglect** to the Gardaí since the circumstances of such cases may not involve law enforcement issues. However, in case of doubt the Gardaí should be consulted.

3.4 The procedure for notifying the Gardaí of a suspected case of **physical or sexual abuse or wilful neglect** of a child is as follows:

- The Designated Officer (or an officer delegated by the Designated Officer) sends the Notification Form* (see Appendix A) to the local Garda Superintendent. A copy is retained on the child's file.

*Where more than one child is involved, a separate Notification Form should be sent in respect of each child.

- On receipt of the Notification Form the Garda Superintendent arranges to have a Garda assigned to the case and notifies the Designated Officer of the Garda's name and station.
- The Garda so assigned makes direct contact with the Social Worker (or other person) dealing with the case as soon as possible to obtain details of the case.

Informal Consultations

3.5 The above notification procedure should not preclude Health Board personnel from consulting the Gardaí on an informal basis where there is concern about a particular child but the available information does not appear to warrant the formal notification of the case. On the contrary, such contact is to be actively encouraged in order to protect the welfare of the child concerned.

Emergency Intervention

3.6 If, in an emergency, it is necessary for a Health Board to take immediate action to protect a child and there is no time to notify the Gardaí, the Notification Form should be forwarded as soon as circumstances permit.

Cases to be Notified by Gardaí to Health Boards

4.1 Where the Gardaí suspect that a child has been the victim of **emotional, physical or sexual abuse or neglect (whether wilful or unintentional),** the Health Board must be formally notified immediately. It is not necessary for the Gardaí to have sufficient evidence to support a criminal prosecution before notifying the Health Board.

4.2 It is **not** intended that the Gardaí should notify the Health Board of cases of physical or sexual assaults against children which involve issues of law enforcement only, such as the assault of a child by a stranger, unless such cases give rise to child protection questions; for example, where the suspected abuser has ongoing contact with other children. In cases involving law enforcement only, the Gardaí should continue to contact the Health Services where there is a need for appropriate counselling and other support services for victims of assaults.

4.3 The procedure for notifying the Health Board of a suspected case of **emotional, physical or sexual abuse or neglect** of a child is as follows:

- The Garda Superintendent (or a Member delegated by the Garda Superintendent) sends the Notification Form* (see Appendix B) to the Designated Officer. A copy is held by the Garda dealing with the matter and by the Garda Superintendent.
- The Designated Officer arranges to have a Social Worker (or other person, if appropriate) assigned to the case and notifies the Garda Superintendent of the name and location of that Social Worker.

*Where more than one child is involved, a separate Notification Form should be sent in respect of each child.

- The Social Worker so assigned makes direct contact with the Garda in charge of the case as soon as possible to obtain details of the case.

Informal Consultations

4.4 The above notification procedure should not preclude the Gardaí from consulting the Health Board on an informal basis where there is concern about a particular child but the available information does not appear to warrant the formal notification of the case. On the contrary, such contact is to be actively encouraged in order to protect the welfare of the child concerned.

Emergency Intervention

4.5 If, in an emergency, it is necessary for the Gardaí to take immediate action to protect a child and there is no time to notify the Health Board, the Notification Form should be forwarded as soon as circumstances permit.

Investigation of Cases

5.1 When the Social Worker and Garda assigned to the case have made contact, the initial task is to share the information already available to each agency about the case in order to establish the relevant factual circumstances of the child and the possible sources of harm or danger.

5.2 The next step is to agree a strategy for the investigation. Matters to be addressed by both agencies at this stage will include:

- **What action, if any, is necessary immediately to protect the child or other children in the household?**
- **Who will be responsible for such action?**
- **Arrangements for medical examination.**
- **Who is to be interviewed initially and in what sequence?**
- **Who will conduct these interviews?**

5.3 Both agencies should keep a written record of the decisions taken in relation to the case. If it is decided not to proceed, the reason for such decision, and by whom it was taken, should be recorded.

5.4 Personnel from both agencies should agree a plan for the case. If new information becomes available, the plan may need to be reassessed but there should be arrangements in place to ensure that all relevant personnel are aware of changes in the approach to the case.

5.5 In relation to the child and the parent(s), every possible effort should be made to ensure that:

- the child is not subjected to repeated interviews;
- repeated medical examination of the child is avoided;

- the parent(s) of the child are kept informed of developments in the case, except where this might place the child at further risk or impede the criminal investigation.

5.6 It is essential that enquiries by the Health Board and the Gardaí should be co-ordinated so as to ensure that:

- the welfare of the child is protected;
- everything possible is done to assist the criminal investigation (see paragraph 5.7 below);
- there is a free flow of information between agencies and personnel regarding the case;
- decisions and actions in an investigation follow consultation within and between agencies.

5.7 Where it is suspected that a crime has been committed, the Gardaí will have overall responsibility for the direction of the criminal investigation. It is the function of the Gardaí to interview and take any statements which will form part of the criminal investigation file.

Confidentiality

5.8 It is essential that all information exchanged between the Health Boards and the Gardaí in accordance with the procedures set out in this document is treated with the utmost confidentiality in order to safeguard the privacy of the children concerned and their families, and to avoid prejudicing any subsequent legal proceedings.

Ongoing Liaison

5.9 The Social Worker and Garda assigned to the case should keep in regular contact and inform each other of developments as they take place.

5.10 Both the Health Board and the Gardaí should notify each other of the progress of cases; for example, where the case has been referred to the Director of Public Prosecutions and the outcome of such referral.

Case Conferences

6.1 The case conference has a central role in the investigation of suspected cases of child abuse and in promoting inter-agency co-operation. It provides an opportunity for the key personnel concerned with the welfare of the child to exchange information and plan together.

6.2 While the case conference is central to child protection procedures, it is **not** a forum for a formal decision as to whether a particular person has abused a child. That is a matter for the Courts. Its purpose is to ensure an overall co-ordinated approach to the case that is objective, properly focused and multi-disciplinary.

6.3 Case conferences are convened by the Designated Officer. Where the Gardaí consider that a case conference is warranted, this should be made known to the Designated Officer as soon as possible.

6.4 In addition to the Social Worker, it is essential that the Garda involved in the investigation be present at the case conference.

6.5 The person to chair the case conference will be decided by the Designated Officer at the outset and with due regard to the skills needed to undertake this important task.

6.6 Since the 1987 Child Abuse Guidelines were published, the practice has developed in some Health Board areas of inviting the parent(s) of the child to participate at the case conference. To avoid any misunderstanding, a Health Board should inform the Gardaí where this is the practice in its area in advance of the convening of a case conference.

6.7 The case conference should include consideration of the impact of a prosecution on the victim. In relevant cases, this consideration should be included in the file submitted to the Director of Public Prosecutions.

Appendix A

SAMPLE FORM FOR USE BY HEALTH BOARD IN NOTIFYING CASE TO GARDA SÍOCHÁNA

CONFIDENTIAL

_____ HEALTH BOARD
_____ ADDRESS

To: Superintendent
Garda Síochána
Address _____ Ref. No _____

NOTIFICATION OF SUSPECTED CHILD ABUSE

Child's Name: _____
D.O.B.: _____ Sex: _____
Address: _____
Father's Name: _____ Mother's Name: _____

1. The above named child has come to notice as a possible victim of child abuse.
2. Form(s) of abuse suspected (see overleaf):
   - ❑ Neglect
   - ❑ Sexual
   - ❑ Physical
   - ❑ *Emotional

*All abuse involves an element of emotional ill-treatment; this category should be used where it is the main or sole form of abuse suspected.

3. Additional information _____

The Social Worker dealing with this matter is:
Name: _____
Tel: _____
Address: _____

Signed: _____
Designated Officer
Date: _____

Physical Abuse

Physical injury to a child, including poisoning, where it is known or suspected that the injury was deliberately inflicted.

Sexual Abuse*

The use of children by others for sexual gratification. This can take many forms and includes rape and other sexual assaults, allowing children to view sexual acts or to be exposed to, or involved in, pornography, exhibitionism and other perverse activities.

Emotional Abuse

The adverse effect on the behaviour and emotional development of a child caused by persistent or severe emotional ill-treatment or rejection, or exposure to ongoing domestic violence.

Neglect

The persistent or severe neglect of a child, **whether wilful or unintentional**, which results in serious impairment of the child's health, development or welfare.

*It should be noted that, for the purpose of the criminal law, the age of consent to sexual activity is 17 years.

Appendix B

SAMPLE FORM FOR USE BY GARDA SÍOCHÁNA IN NOTIFYING CASE TO HEALTH BOARD

CONFIDENTIAL

Garda Síochána
Address _____ Ref No. _____
_____

To: Designated Officer
_____ Health Board
Address _____

NOTIFICATION OF SUSPECTED CHILD ABUSE

Child's Name: _____
D.O.B.: _____ Sex: _____
Address: _____
Father's Name: _____ Mother's Name: _____

1. The above named child has come to notice as a possible victim of child abuse.
2. Form(s) of abuse suspected (see overleaf):

❑ Neglect	❑ Sexual
❑ Physical	❑ *Emotional

*All abuse involves an element of emotional ill-treatment; this category should be used where it is the main or sole form of abuse suspected.

3. Additional information _____

_____
_____
_____

The Garda dealing with this matter is:
Name: _____
Tel: _____
Address: _____
_____

Signed: _____
Garda Superintendent
Date: _____

Physical Abuse

Physical injury to a child, including poisoning, where it is known or suspected that the injury was deliberately inflicted.

Sexual Abuse*

The use of children by others for sexual gratification. This can take many forms and includes rape and other sexual assaults, allowing children to view sexual acts or to be exposed to, or involved in, pornography, exhibitionism and other perverse activities.

Emotional Abuse

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*It should be noted that, for the purpose of the criminal law, the age of consent to sexual activity is 17 years.