Final Report

Review Inquiry on any matter pertaining to Child Protection Issues touching on or concerning Dr. A

January 2008
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1. Terms of Reference

(a) The Review Inquiry Team will compile:-

(i) A documentation and information chronology of what information was in the possession of the Health Service Executive from sources such as An Garda Siochana, the Departments of State and the Athlone Institute of Technology in regard to any matter pertaining to child protection issues touching on or concerning Dr. A

(ii) A description of the legal context in relation to the assembling, evaluating and use of this category of information*

(iii) A description of the existing administrative processes for the collection, evaluation and use of this category of information.

(iv) A brief comparison of the Irish system with comparable foreign states, i.e., (England and Wales, United States, Canada, New Zealand and Australia).

(v) Short recommendations for improvements to (a) the legal context and (b) the administrative context.

(b) For the purpose of the conduct of the review inquiry, the Terms of Reference Guidelines will be furnished to all of the witnesses who may be called.

(c) The Review Inquiry Team will prepare and furnish a report to the Assistant National Director of Primary, Community and Continuing Care in Dublin/Mid Leinster.

*In this context category of information means information provided to the Health Service Executive pursuant to its statutory function.
2. Methodology

2.1. The following methodology will be adopted in the Review Inquiry and distributed to each interviewee

i. The Review Inquiry will have regard to the principles underpinning Review Inquiries as set out in Children First, National Guidelines for the Protection of Children and the Health Boards Executive Guidelines on conducting Inquiries.

ii. The Review Inquiry will be non adversarial, its workings will be informal but will fully observe fair procedures and principles of natural justice appropriate to a fact finding domestic inquiry process.

iii. The Review Inquiry Team will examine all relevant correspondence/documentation and interview all relevant persons to establish a factual chronology of events/interactions relevant to the Terms of Reference.

iv. This examination will also extend to establishing legal, administrative and best practice approaches to dealing with circumstances comparable to those encompassed within the Terms of Reference. and will take place having regard to relevant Duty of Care considerations.

v. All relevant parties will be interviewed in respect of the subject matter of the Terms of Reference. These interviews will be conducted in the presence of a representative if requested by the interviewee. The Review Inquiry Team has no authority to award interviewee or representative fees or costs.
vi. Individuals who have been identified to the Review Inquiry Team as having in their possession, or knowledge of, material facts relevant to the subject matter of the Review Inquiry, will be interviewed. The Review Inquiry Team will also interview other persons who, in the opinion of the Review Inquiry Team, can assist in establishing the facts.

vii. The first series of interviews as described above will take place in August and September 2007 and will be notified to parties identified for interview. Final interviews with parties who may be adversely affected by any findings emerging from the Review Inquiry process, will be conducted at the earliest date following the first series of interviews. The final interviews will give an opportunity to those parties to address issues arising from the first set of interviews and to make concluding statements.

viii. Notes of each meeting will be taken and circulated to any affected party prior to the final meeting.

ix. Prior to findings being concluded, matters of fact emerging from the Review Inquiry will be distributed to any affected parties for comment/confirmation. Where preliminary conclusions have been arrived at which may have adverse implications for any of the parties, these will be also distributed in draft form to any person adversely affected to provide any additional information or challenge any aspect of the evidence prior to finalisation.

x. The Review Inquiry Team reserves the right to issue preliminary findings and /or interim reports to the Assistant National Director of PCCC, HSE.
xi. A final report of the Review Inquiry will issue to Assistant National Director of PCCC, HSE within a period of four weeks from the date of the final Interview.

xii. Confidentiality will be maintained as far as practicable. The parties will be expected to respect the privacy of those involved by refraining from discussing the allegations with other work colleagues or any other person outside of their immediate representative structure.

xiii. The Review Inquiry Team is made up of

- Mr. Conal Devine, Management Consultant
- Mr. Eoin Rush, Social Work and Child Protection Consultant

2.2. **Schedule of Meetings of Review Inquiry Team**

- 26 July 2007
- 27 July 2007
- 28 August 2007
- 29 August 2007
- 7 September 2007
- 19 September 2007
- 28 September 2007
- 25 October 2007
- 9 November 2007
- 28 December 2007
- 25 January 2008
3. Introduction and Background

3.1. Circumstances giving rise to the Review Inquiry

3.1.1. The HSE, through its involvement with the Midland Regional Drugs Task Force, facilitated the carrying out of a research project relating to drug use in Athlone and Portlaoise. Dr. A, Centre for Child and Youth Care Learning, Athlone Institute of Technology, was commissioned to undertake the study, assisted by one of his students, Ms. MHB 5, who was also a Health Promotion Officer (Substance Abuse) with the Midland Health Board.

3.1.2. The research project proposal was presented to the Midlands Regional Drugs Task Force and was funded through the use of funds which had been allocated for the appointment of a Regional Co-ordinator post but which were unexpended due to that post being unfilled. The research project provided for three international study visits, one of which included a visit to Amsterdam.

3.1.3. Mr. MHB 1, who was effectively acting in the role of Regional Co-ordinator while continuing to hold a senior management position in Health Promotion, in the Midland Health Board, identified Detective Sergeant GS 1, an Athlone based Garda with experience of policing drug abusers, as an appropriate person to accompany Dr. A on the study visit to Amsterdam.

3.1.4. In the course of the study visit to Amsterdam, on the night of 24 June 2004 an incident occurred in the hotel in which both Dr. A and Detective Sergeant GS 1 were staying. The incident involved Dr. A and a number of young girls who were part of an American school touring party who were also staying in the same hotel. Those incidents were reported by the young girls to hotel staff who summoned the police. The police detained Dr. A for questioning. Detective Sergeant GS 1, who was not involved in the incident, was also questioned by Dutch Police.

3.1.5. Both Detective Sergeant GS1 and Dr. A subsequently contacted Mr. MHB 1 by telephone and apprised him of the circumstances surrounding Dr. A’s arrest. The detail of the information provided to Mr. MHB 1 and Mr. MHB 1’s subsequent contacts with other personnel and any steps taken by Health Board staff, in light of information provided regarding Dr. A’s arrest, is for consideration in this Review Inquiry.
3.1.6. Both Dr. A and Detective Sergeant GS 1 separately returned to Ireland and raised separately with Mr. MHB 1, the detail of these interactions is for consideration in this Review Inquiry.

3.1.7. Dr. A continued the research project and undertook a further study visit in October 2004 to Canada, accompanied by Ms. MHB 5 and another female member of the Health Promotion Staff, Midland Health Board.

3.1.8. The Minister of State, Addiction Services, formally launched Dr. A's research project, Darkness on the Edge of Town in January 2005.

3.1.9. Mr. MHB 1 continued to have contact with Dr. A in 2004 and 2005, these contacts are for consideration in this Review.

3.1.10. Dr. A was served with a summons from the Dutch Authorities by An Garda Síochána on 9 September 2005. Dr. A was tried by the Dutch Courts and was convicted of the following offences. Judgement was delivered on 27 September 2005.

"On or around 24 June 2004 in Amsterdam (forced (named person 1)) by performing the criminal act intended by the defendant through violence or (an) other act(s) of violence and/or other threats of violence, to perform and/or to endure one or more lewd act(s) and of standing with bared lower part of the body beside the bed of (named person 1) and/or bending down over (named person 1) with his penis in his hand and/or saying “suck me baby” and/or attempting to bring the head of (named person 1) to his crotch”.

And

“On or around 24 June 2004, forcing (named person 2), by performing the criminal act intended by the defendant, through violence or (an) other act(s) of violence and/or threats of violence or (an) other act(s) of violence, to perform and/or to endure one or more lewd act(s) and of lying down in bed with (named person 2) with the front of his trousers opened, and/or grabbing (named person 2) by the wrist(s) and/or hand(s) in order to prevent her from leaving the bed and/or forcing her to endure that he, the defendant, was lying down against her with the front of his trousers opened.”

Dr. A was sentenced to a prison term of 3 months suspended for two years and fined €2,000.
3.1.11. Alleged interactions between Mr. MHB 1 and Dr. A in September and October 2005 are for consideration by the Review Inquiry.

3.1.12. On Friday 13 July 2007 media outlets published and broadcast details of the conviction of Dr. A in respect of the June 2004 incidents in Amsterdam. Over the succeeding days, issues relating to Dr. A’s use of certain teaching materials in Waterford Institute of Technology showing examples of injuries consistent with child sexual abuse were also raised via the media.

3.1.13. On Friday 13 July 2007 the National Director for Primary, Community, and Continuing Care (PCCC) HSE issued queries to all HSE LHO Managers and Assistant National Directors to determine whether Dr. A had been employed in the HSE in any capacity.


3.2. Statutory and Duty of Care Obligations in respect of Child Protection

3.2.1. The Health Service Executive has a statutory duty under the Child Care Act 1991 to promote and protect the welfare of children up to the age of 18 years. This amended the historic statutory basis for child protection as provided for under the Children Act 1908.

3.2.2. The Department of Health published guidelines on procedures for the identification, investigation, and management of child abuse in July 1987. The guidelines stated “Child abuse cases involve both child care and law enforcement issues and what is discovered may be relevant to decisions which have to be taken by both agencies.”

3.2.3. Additional guidelines specifically focussing on the respective roles of the Health Boards and the Gardai were published in April 1995 having regard to the recommendations of the “Report of the Kilkenny Incest Investigation”. The guidelines related to physical, sexual, and emotional abuse and neglect of children under the age of eighteen years. The guidelines provide for mutual formal notification as between Health and Gardai and vice versa where there are grounds for suspecting child abuse utilising formal notification forms. The guidelines stated that such formal notification would not normally be used in cases
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. The guidelines also provide for contacts between Gardai and the Health Boards on an informal basis where there is concern about a particular child but the available information does not appear to warrant the formal investigation of the case.

3.2.4. A multi-disciplinary working group including Government Departments, An Garda Síochána and the Health Boards was established in 1998 to review all existing child protection guidelines. That process led to the publication of the National Guidelines for the Protection and Welfare of Children "Children First" in 1999. Among the primary objectives of Children First was to consolidate inter-agency co-operation based on clarity of responsibility, co-ordination of information and partnership arrangements between disciplines and agencies. The guidelines stipulate that Health Board staff are obliged to treat seriously all child protection concerns, whatever their source. The Children First guidelines relating to An Garda Síochána – Health Board notification protocols stipulate mutual formal reporting of suspected child abuse and joint actions to be undertaken in the investigation of suspected abuse.

3.2.5. The Children First guidelines are stated as being directed at Health Board personnel, An Garda Síochána, other public agencies, voluntary and community organisations, and private citizens.

3.2.6. In addition to the statutory provisions and State policy on child protection as articulated in the Children First guidelines, there are broader duty of care responsibilities across all statutory and non-statutory agencies. Central to the concept of duty of care is the principle of reasonableness. The agency, whether statutory or non-statutory, must act with reasonable foresight so as to avoid injury or damage to potential service users and to the wider public. Allied to the concept of duty of care is the standard of care. The standard of care in the instances being explored in this Review Inquiry refers to the quality and professionalism of the response reasonably expected and the care given by the various agencies that had knowledge of child protection matters as they related to Dr. A.

3.2.7. The Children First guidelines define sexual abuse as occurring when a child i.e. a young person under 18 years, is used by another person for his or her gratification or sexual arousal or that of others. Examples of child sexual abuse include
the exposure of the sexual organs or any sexual act intentionally performed in the presence of the child.

4. Process Chronology

4.1. 17 July 2007

4.1.1. C. Devine announced as Independent Chairman

4.2. 18 July 2007

4.2.1. Mr. Eoin Rush, Independent Child Care Consultant, who at the time of the establishment of the Review Inquiry Team was Lead Strategic Manager – Children’s Services and Safeguarding, Kingston upon Thames, agrees to participate as member of Review Inquiry Team

4.2.2. Unsolicited email from a former colleague of Dr A’s in Waterford Institute of Technology relating to Dr. A and his teaching practices in W.I.T. which raised child protection concerns for her

4.3. 19 July 2007

4.3.1. Unsolicited email received from an academic staff member, Athlone I.T. raising issues in respect of Dr. A and the study visit to Amsterdam

4.4. 25 July 2007

4.4.1. Amended methodology furnished to HSE. Terms of Reference finalised.

4.4.2. Correspondence from Dr. A’s Solicitors requesting terms of reference on behalf of Dr. A

4.5. 26 July 2007

4.5.1. Preliminary meeting with Mr. AIT 1, Athlone I.T.

4.6. 27 July 2007

4.6.1. Preliminary meeting with Mr. MHB 1, formerly Midland Health Board, and IMPACT Trade Union.
4.7. 30 July 2007

4.7.1. Invitation extended to Dr. A's Solicitors for preliminary meeting and terms of reference and methodology furnished

4.8. 1 August 2007

4.8.1. Email forwarded to Review inquiry Team by PCCC HQ of notification from LHO Manager, Galway, that Dr. A visited an orphanage in Romania in 2003

4.9. 2 August 2007

4.9.1. Receipt of written statement from Mr. MHB 1

4.10. 4 August 2007

4.10.1. Meeting with Mr. Eoin Rush, London, and provision to him of all documents to date

4.11. 7 – 10 August 2007

4.11.1. Contact details for proposed interviewees finalised and telephone contact made with interviewees

4.12. 13 August 2007

4.12.1. Formal invitations to interviewees to meet on 28/29 August or 6/7 September (10 individuals issued with invitations)

4.13. 15 August 2007

4.13.1. Preliminary meeting with Dr. A's Solicitors on behalf of Dr. A

4.14. 16 August 2007

4.14.1. Correspondence received from the Department of Justice Equality and Law Reform confirming that the Department and the Office of the DPP had knowledge of the substance of the alleged offences committed by Dr. A from 27 July 2004 and that the Garda Síochána in August 2005 were requested to serve summons on Dr. A on behalf of the Dutch Directorate General
4.15. 20 August 2007

4.15.1. Contact details obtained for Detective Sergeant GS 1 who accompanied Dr. A on the study visit to Amsterdam in June 2004

4.16. 21 August 2007

4.16.1. Detailed series of questions are put in writing to Dr. A’s Solicitors

4.17. 23 August 2007

4.17.1. Contact made with Detective Sergeant GS 1 by telephone

4.18. 24 August 2007

4.18.1. Detective Sergeant GS 1 formally invited to attend for interview. A series of questions were put to Detective Sergeant GS1 to be the subject matter of the interview.

4.19. 27 August 2007

4.19.1. Confirmation from Dr. A’s Solicitors that Dr. A will formally respond in writing to questions put prior to meeting with Review Inquiry Team in the week beginning 17 September.

4.20. 28-29 August 2007

4.20.1. Interviews conducted with the following
- Mr. MHB 1 and IMPACT representative
- Ms. MHB 3, Director of Communications, HSE Midlands
- Mr. D 1, Chairperson of the Regional Drugs Task Force
- Ms. MHB 4, former ACEO, Midland Health Board

4.21. 30 August 2007

4.21.1. Unsolicited telephone call from (named academic), formerly of Waterford Institute of Technology giving details of her concerns re child protection issues and Dr. A’s teaching practices in W.I.T. and her concern about the process used by W.I.T. in investigating those issues.

4.22. 31 August 2007

4.22.1. Telephone contact from Mr. GS 5, Garda Press Office querying the terms of reference of the Inquiry and advising of
his understanding that Mr. GS 2 of Athlone and Mr. GS 1 would be co-operating with the Review Inquiry.

4.23. 3 September 2007

4.23.1. Formal invitation to W.I.T. to attend for interview

4.24. 7 September 2007

4.24.1. Interviews conducted with the following:
  - Ms. D4, Director, National Drugs Strategy Team
  - Mr. D2, Assistant Principal, Department of Justice, Equality and Law Reform
  - Professor AIT 1, Director of Athlone Institute of Technology

4.25. 10 September 2007

4.25.1. Request to LHO Manager with lead responsibility for Child and Family Services in HSE South, Mr. SEHB 1, to provide records of contacts between HSE/SEHB with W.I.T. on any matters relating to Dr. A and child protection matters.

4.25.2. Invitation extended to Superintendent D3, Chair NDST to attend for interview

4.26. 11 September 2007

4.26.1. Meeting with HSE to provide update on progress of Review Inquiry

4.27. 12 September 2007

4.27.1. Documentation received from Athlone I.T. relating to the research application furnished by Dr. A on behalf of the Centre for Child and Youth Care Learning, Athlone I.T. to the HSE in November 2004.
4.28. 14 September 2007

4.28.1. W.I.T. furnished book of documents relating to Dr. A’s alleged use of inappropriate material while employed at Waterford Institute of Technology.

4.29. 17 September 2007


4.30. 19 September 2007

4.30.1. Meetings with

- Dr. A and his solicitor,
- Dr. HSE 2,
- Ms. HSE 1,
- Superintendent D3, NDTF,
- Senior officers from Waterford Institute of Technology

4.31. 21 September 2007


4.31.2. Request from Dr. A’s Solicitors for documentation relating to their client Dr. A.

4.32. 26 September 2007

4.32.1. Informal meeting with former member of academic staff, Waterford Institute of Technology

4.32.2. Dr. A’s Solicitors furnished with documentation as requested.

4.32.3. Consent was requested from W.I.T. to furnish book of documents to Dr. A.
4.33. **28 September 2007**


4.33.2. Interviews conducted separately with Superintendent GS 2 and with Inspector GS 2.

4.34. **5 October 2007**

4.34.1. Typed draft shorthand notes of interviews of 19 September 2007 furnished to interviewees.

4.34.2. Waterford Institute of Technology contacted for clarification on whether an officer of W.I.T. served on the interview board to appoint Dr. A to Athlone I.T.

4.34.3. Athlone I.T. formally written to in order to confirm membership of interview board for the appointment of Dr. A.

4.34.4. Ministry for Justice in The Netherlands contacted to confirm dates when details of allegations against Dr. A were furnished to the Irish Authorities.

4.35. **8 October 2007**

4.35.1. Formal letter to Department of Justice, Equality and Law Reform requesting clarification on six matters of fact.

4.35.2. A response from Athlone I.T. confirming that interviewers on a selection board did not include any individual from Waterford I.T.

4.36. **10 October 2007**

4.36.1. Written clarification on two issues received from Dr. A.

4.36.2. W.I.T. confirmed that a W.I.T. staff member was not part of the interview board for the appointment of Dr. A to Athlone I.T.
4.37. **14 October 2007**

4.37.1. Correspondence from former member of academic staff, W. I.T. on the appropriateness of educational slides used by Dr. A.

4.38. **15 October 2007**


4.38.2. A print out of Dr. A’s mobile telephone calls made in June 2004 and September and October 2005 furnished by Dr. A’s Solicitors.

4.39. **18 October 2007**

4.39.1. Meeting of the Review Inquiry Team

4.40. **25 October 2007**

4.40.1. Request for meeting with LHO Manager, HSE West (Galway) regarding measures taken on receipt of information re Dr. A’s conviction.

4.41. **26 October 2007**

4.41.1. Telephone conversation with Dutch police officer NL 1, who liaised with Irish Gardai in June 2004 at the time of the arrest of Dr. A. Formal registered correspondence also issued that day to NL 1.

4.42. **30 October 2007**

4.42.1. Documentation furnished to IMPACT Trade Union (acting on behalf of Mr. MHB 1) in respect of information which had come to light in the course of other interviews and arising from mobile telephone records of calls between Dr. A’s mobile telephone and Mr. MHB1’s mobile telephone.

4.42.2. Written update provided to Assistant National Director, HSE, on the progress of the Review Inquiry.
4.42.3. Letter issued to Dr. A’s Solicitors requesting a meeting with Mrs. A following on from suggestions that she witnessed telephone conversations between Dr. A and Mr. MHB 1 of the HSE.

4.42.4. Written response from the Department of Justice Equality and Law Reform to a series of questions put in writing on 8 October 2007.

4.43. 6 November 2007

4.43.1. File issued by LHO Manager HSE South re file correspondence on any child protection matters connected with Dr. A. (received on 12 November 2007)

4.44. 8 November 2007

4.44.1. NL 1 of the Dutch police confirmed that he had received authorisation to cooperate with the Inquiry.

4.45. 9 November 2007

4.45.1. Interviews with LHO Manager, HSE West (Galway), Mr. MHB 1(and IMPACT), Dr. A’s Solicitors and Mrs. A.

4.46. 12 November 2007

4.46.1. Request for information from NL 1, Dutch police

4.46.2. Extract from HSE South file on child protection matters concerning Dr. A, furnished to Dr. A’s Solicitors acting on behalf of Dr. A.

4.47. 13 November 2007

4.47.1. Formal response by Mr. NL 1 to Review Inquiry

4.48. 14 November 2007

4.48.1. Telephone query to Athlone I.T. regarding any details on arrangements between HSE and Dr. A on conducting a project entitled “Youth Resilience” in 2005.
4.49. **15 November 2007**

4.49.1. Clarification obtained from the Department of Justice Equality and Law Reform on matters arising from its written response to the Review Inquiry Team dated 30 October.

4.50. **5 December 2007**

4.50.1. Written response received from Dr A to extract provided relating to child protection matters, Waterford 1998.

4.51. **11/12 December 2007**

4.51.1. Nine separate versions of draft report issued to relevant parties with a request to return comments by 28 December 2007

4.52. **28 December 2007**

4.52.1. Meeting of Review/Inquiry Team to consider responses from parties.

4.53. **January 2008**

4.53.1. Additional responses to the draft report received on 16, 17, and 22 January.

4.54. **25 January 2008**

4.54.1. Final meeting of Review Inquiry Team
5. Chronology of Matters of Fact Established by the Review Inquiry Team

5.1. 1997

5.1.1. Concerns raised by the South Eastern Health Board in respect of a meeting between Dr. A and a young person who had recently been in the care of the Health Board as part of Dr. A’s research into a book on prostitution in Waterford.

5.2. 1998/1999

5.2.1. Internal inquiry undertaken by Waterford Institute of Technology arising from a complaint from an academic member of staff relating to the use of teaching materials by Dr. A as part of a course module on child sexual abuse.

5.2.2. 21 December 1998 - Correspondence issued by the South Eastern Health Board to Dr. A raising concerns about the use of medical slides relating to child sexual abuse for teaching purposes.

5.3. 2001

5.3.1. 10 Regional Drugs Task Forces established as per the National Drugs Strategy 2001 with funding provided by the Department of Health and Children and the Department of Community Rural and Gaeltacht Affairs.

5.4. 2003

5.4.1. May 2003 – First meeting of the Midland Regional Drugs Task Force.

5.4.2. 10 November 2003 – Dr. A applied for placement in children’s residential home Aras Geal, Western Health Board.

5.4.3. 8 December 2003 – Garda clearance furnished to Western Health Board in respect of Dr. A.

5.5. 2004

5.5.1. Mr. MHB 1 met with Dr. A and Ms. MHB 5, a Health Promotion project worker with the MHB who was also a student of Dr. A’s. Mr. MHB 1 agreed in principle to fund research into
heroin use in the Athlone area. There was no tendering process in respect of this project. The documentation surrounding the project was processed by the Finance Office, Athlone Institute of Technology. The project was stated to be funded by the RDTF with separate funding from the Midland Health Board for the publication of the report and an associated conference to be held in Ireland.

5.5.2. 18 February 2004 - Dr. A commenced his placement in Aras Geal.

5.5.3. 19 February 2004 - Discussion took place at the Regional Drugs Task Force (RDTF) on undertaking the research project relating to heroin use in Athlone. On the suggestion of the RDTF the study was extended to include Portlaoise. Dr. A was identified to the RDTF as the individual leading the project under the auspices of the Centre for Child and Youth Care Learning, Athlone Institute of Technology.

5.5.4. In or around April 2004 Mr. MHB 1, Health Promotion Manager Midland Health Board and Acting Regional Co-ordinator RDTF, indicated to the RDTF that funding would be available for the research study into heroin abuse utilising funds which had been unexpended due to the non appointment of a Regional Co-ordinator post for the RDTF.

5.5.5. 20th May 2004 – Dr. A and Ms. MHB 5 presented the methodology for carrying out the research “commissioned by the RDTF”, (as per the minutes of the meeting).

5.5.6. 11 June 2004 - Dr. A indicated that his placement in Aras Geal would be ending, five months into the twelve month placement, because of his commitments to the Drug Study.

5.5.7. 24 June 2004 - An incident took place in Amsterdam involving Dr. A which led to his arrest for suspected indecent/sexual assault on young girls who were part of an American school touring party.

5.5.8. 24 June 2004 - A written statement was issued by Detective Sergeant GS 4, Garda Liaison Office, Irish Embassy, The Hague to the Deputy Chief Superintendent, Liaison and Protection, An Garda Síochána, outlining the circumstances of the allegations against Dr. A describing the incident as an “alleged rape“ and that the allegation had been made by three American females who were part of a tour of seventy American
students and that the average age of the American students was 17 years.

5.5.9. 25 June 2004 - Mr. MHB 1 was advised by telephone by Detective Sergeant GS 1 of the incident, it is disputed whether Detective Sergeant GS 1 indicated the ages of the young girls who were the subject of the alleged assault. MHB 1 states that Detective Sergeant GS 1 advised that the age profile of the students making the allegations was between 15 and 18 years.

5.5.10. 26 June 2004 - Dr. A claims that he telephoned Detective Sergeant GS 1 advising of arrest and current situation. Detective Sergeant GS 1 does not recall receiving a telephone call but does recall receiving a text from Dr. A apologising for his behaviour. Telephone records provided by Dr. A indicate that Detective Sergeant GS 1’s mobile telephone number was contacted on three occasions on the 26th with a suggested duration of calls being in two instances of 10.46 and 5.22 minutes respectively.

5.5.11. 26 June 2004 - On his release from custody Dr. A telephoned Mr. MHB 1 and advised him by telephone of the detail of the incident. Telephone records provided by Dr. A indicate that a call was made to Mr. MHB 1's mobile number at 13:41 on that date with a duration of 9.44 minutes.

5.5.12. 26 June 2004 - Mr. MHB 1 informed Mr. D1, Chair of the Regional Drugs Task Force, by telephone, that Dr. A had been arrested. Mr. D1’s note of that conversation indicated that Mr. MHB 1 had advised him that Dr. A had been arrested “under certain suspicions”. Mr. D1 indicates that he was not aware that this matter was related to any activities being undertaken by Dr. A in connection with the RDTF.

5.5.13. Week beginning 28 June 2004 - Mr. MHB 1 claims that he advised the Acting Assistant CEO of the Midland Health Board, Ms. MHB 4, whose responsibilities included Addiction Services and Child Care Services, of the circumstances relating to Dr. A’s arrest in Amsterdam. Ms. MHB 4 denied that such a conversation took place at that time and indicated that it was not until the latter half of 2004 that Mr. MHB 1 made a comment to her about Dr. A behaving badly late at night in Amsterdam and that there were women involved. Ms. MHB 4 further stated that Mr. MHB 1 never indicated the ages of the women involved.

5.5.14. Ms. MHB 3, Communications Manager, Midland Health Board confirmed that she was approached by Mr. MHB 1 and advised that Dr. A, in the course of a paid trip to Amsterdam,
funded by the Midland Health Board, was involved in an incident “with ladies in a hotel bedroom”. Ms. MHB 3 could not recall if reference had been made as to the ages of the women concerned and no action was taken by her or requested to have been taken by her, on foot of that information.

5.5.15. Alleged telephone contacts made by Mr. MHB 1 to Ms. D4, Director National Drugs Strategy Team. Subsequent telephone contact between Mr. MHB 1 and Superintendent D3 of the NDST.

5.5.16. Telephone conversation between Mr. MHB 1 and the Garda Liaison Officer, Irish Embassy, The Netherlands, Detective Sergeant GS 4.

5.5.17. Mr. MHB 1 and Dr. MHB 2, Director of Public Health, Midland Health Board and Mr. MHB 1’s line manager, met on or around Monday 28th June. Mr. MHB 1 advised him of the incident, which amounted to a suspected case of sexual abuse by Dr. A against young girls who Mr. MHB 1 indicated were under age. Mr. MHB 1 also indicated that there was a possibility of prosecution against Dr. A. Dr. MHB 2 could not specifically recall suggestions that this be reported to appropriate child protection functions within the Midland Health Board but did state that he had been informed by Mr. MHB 1 that Ms. MHB 4, who was senior manager responsible for Child Care, had been advised of the incident by MHB 1.

5.5.18. 30 June or 1 July 2004 – Dr. A met with Mr. MHB 1 in the HSE Offices, Tullamore to discuss the Amsterdam incident and to review the heroin research and the completion of the project.

5.5.19. 1 July 2004 – Mr. MHB 1 and Detective Sergeant GS 1 met at lunchtime in a hotel in Moate, Co Westmeath, to discuss the Amsterdam incident. Detective Sergeant GS 1 denied that the ages of the young persons at the centre of the allegations were disclosed to him or discussed with Mr. MHB 1. There is no formal record of that meeting.

5.5.20. July 2004 – Dr. MHB 2 confirmed that an additional discussion with Mr. MHB 1 on the issue had taken place and that Mr. MHB 1 had advised him that he had spoken to Ms. MHB 4. That contact with Ms. MHB 4, reported by Mr. MHB 1 to Dr. MHB 2, is denied by Ms. MHB 4.

5.5.21. 27 July 2004 – The Directorate General for International Affairs of the Dutch Ministry for Justice wrote to the Central
Authority for Mutual Assistance in Criminal Matters, the Department of Justice, Equality and Law Reform. The letter enquired as to whether it would be possible to transfer criminal proceedings against Dr. A to the Irish jurisdiction. The letter stated that the allegation was that Dr. A sexually harassed American girls, two of them being 18 years old, and one of them being 16 years old. According to the Department of Justice Equality and Law Reform this letter was furnished to Garda Authorities and to the Offices of the Attorney General and the Director of Public Prosecutions. It was not furnished to the Midland Health Board, the Department of Health and Children, or to any agency responsible for third level education. Dr. A’s profession was not set out in the letter.

5.5.22. 3 August 2004 – A copy of the letter from the Dutch Ministry for Justice as outlined in 5.5.21 above was forwarded by the Central Authority based in the Department of Justice Equality and Law Reform to the Mutual Assistance Section of the Garda Síochána.

5.5.23. 4 August 2004 – Detective Sergeant GS 1 furnished a written report to Superintendent GS 2, Athlone, indicating that allegations of rape and sexual assault had been made against Dr. A by a number of female students and “their tour party totalled 70 with the average age of the students being 17 years.” No specific age of the alleged victims is indicated. The report concludes by stating that Detective Sergeant GS 1 had met and spoken briefly to Mr. MHB 1.

5.5.24. 1 September 2004 – Memorandum from Dr. A copied to Mr. MHB 1 stating that the Midland Health Board had asked that Ms. MHB 6 and Ms. MHB 5 travel to Calgary Canada for the National Conference for Child and Youth Care Workers in October 2004.

5.5.25. 8 September 2004 – A copy of the letter from the Dutch authorities regarding the substance of the alleged offences committed by Dr. A was forwarded by the Central Authority for Mutual Legal Assistance in Criminal Matters, based in the Department of Justice Equality and Law Reform to the Office of the Director of Public Prosecutions.

5.5.26. 25 September 2004 - Dr. A asserts that at a conference in Athlone he informed Mr. MHB 1 of the situation regarding the Amsterdam incident. Mr. MHB 1 recalls Dr. A stating at this meeting that Dr A’s lawyer did not think that the case would progress.
5.5.27. 4 October 2004 – Dr. A’s claims a planning meeting with Mr. MHB 1 took place regarding the forthcoming study trip to Canada. Discussion took place on whether to advise Ms. MHB 5 of the detail of the allegations relating to Amsterdam. Mr. MHB 1 added one additional female member of staff from the Midland Health Board to accompany Dr. A and Ms. MHB 5 on the study trip which took place later that month.

5.5.28. 22 October 2004 – The Dutch Authorities were informed by the Department of Justice Equality and Law Reform that the Office of the DPP had concluded that any criminal proceedings arising from the matters relating to the allegations against Dr. A would be more appropriately disposed of by the competent authorities in The Netherlands.

5.5.29. 5 November 2004 – MHB 1 alleges that he was advised by Dr. A that the case in Holland would not be proceeding. Dr. A denies that he advised Mr. MHB 1 of this and states that he advised Mr. MHB 1 that the case would probably not carry jurisdiction in Ireland but that the case might well go ahead at a later date in Holland. Mr. MHB 1 states that he notified Ms. MHB 4 of this. MS. MHB 4 acknowledges that at around this time (latter end of 2004) a conversation took place with Mr. MHB 1 and MS. MHB 4 states that this was the first time she was notified of an incident in Amsterdam involving Dr. A in June 2004. MS. MHB 4 denies that any reference was made to a court case in Holland.

5.6. 2005

5.6.1. 21 January 2005 – Launch of the publication Darkness on the Edge of Town at Athlone Institute of Technology by the Minister of State, National Drugs Strategy. No discussions or meetings took place between any personnel aware of the June 2004 incident on the potential implications of a disclosure of the incident prior to the launch. Dr. A asserts that he and Mr. MHB 1 spoke at the launch of the then current situation regarding the case in The Netherlands.

5.6.2. 8 February 2005 – Dr. A reports that his lawyer advised him that the Dutch prosecutor had confirmed that the case was going to court in Amsterdam as the Irish Authorities had referred the case back to The Netherlands.
5.6.3. March 2005 – Mr. MHB 1 entered into an arrangement with Dr. A through Dr. A’s private consultancy to fund a “Youth Resilience” research project to the amount of €40,000. This arrangement was arrived at without engaging in a tendering process. Mr. MHB 1 asserts that it was within the scope of his authority to finalise this arrangement.

5.6.4. Also in 2005 Mr. MHB 1 arranged to partially fund two other projects undertaken by Dr. A “Walking between Two Lands” and “Developing Effective Interventions with Families”.

5.6.5. 15 August 2005 – Dutch Directorate General forwarded a request to the Department of Justice Equality and Law Reform to have a summons served on Dr. A for a Court session on 13 September 2005. This letter is stated by the Department of Justice Equality and Law Reform to have been received by the Central Authority for Mutual Legal Assistance in Criminal Matters on 2 September 2005.

5.6.6. 2 September 2005 – The Central Authority requested the Mutual Assistance Section of An Garda Síochána to make arrangements to serve the summons on Dr. A.

5.6.7. 9 September 2005 – Dr. A attended Athenry Garda Station on foot of a warrant. Dr. A claims that he contacted Mr. MHB 1 by mobile telephone that day and advised him about the summons to attend court in Amsterdam. Dr. A tabled a mobile telephone record which indicated that a call was made to Mr. MHB 1’s mobile number at 11:49 on 9th September 2005 with a recorded duration of 6 minutes 47 seconds. This telephone call is stated to have been witnessed by Mrs. A. Mr. MHB 1 denies that Dr. A notified him of the summons or that there was a pending trial in Holland.

5.6.8. 12 September 2005 – Dr. A travelled to Amsterdam to attend the court case.

5.6.9. 26 September 2005 – Dr. A was convicted of attempted physical indecent assaults by the Amsterdam court.

5.6.10. 6 October 2005 – Dr. A claims that he made Mr. MHB 1 aware of the conviction in the course of a telephone call to Mr. MHB 1’s mobile telephone number. Dr. A tabled his mobile telephone record which indicated that a call had been made to Mr. MHB 1’s mobile telephone on that date at 12:11 and that duration of the call was 39 seconds.
5.6.11. 26 October 2005 – Mr. MHB 1 met with Dr. A in the HSE Offices, Tullamore before a scheduled “Youth Resilience” project meeting where Dr. A asserts that he informed Mr. MHB 1 of the convictions and penalties.

5.7. 2007

5.7.1. 28 June 2007 – The Sunday World contacted Mrs. A stating their intention to publish a story on 8 July of Dr. A’s conviction.

5.7.2. 3 July 2007 – Dr. A, informed Prof. AIT 1, Director, Athlone Institute of Technology of the incident which occurred in Amsterdam in June 2004 and his subsequent conviction in September 2007. This was the first occasion on which Dr. A informed the Institute of these matters.

5.7.3. 4 July 2007 - Athlone Institute of Technology communicated to Dr. A that he either tender his resignation from the institute or the Director would convene a special meeting of Governing Body to seek the authority to suspend him. In the event of this happening, an investigation into the matter would then be established by the Minister for Education and Science.

5.7.4. 5 July 2007 - Discussions between Dr. A’s and AIT’s legal representatives proceeded during the day.

5.7.5. 6 July 2007 - A copy of Dr. A’s letter of resignation was received.

5.7.6. 9 July 2007 - The Institute engaged forensic IT specialists to examine Dr. A’s college computer.

5.7.7. On Friday 13 July 2007 media outlets published and broadcast details of the conviction of Dr. A in respect of the June 2004 incidents in Amsterdam. Over the succeeding days, issues relating to Dr. A’s use of certain teaching materials in Waterford Institute of Technology showing examples of injuries consistent with child sexual abuse were also raised via the media.

5.7.8. On Friday 13 July 2007 the National Director for Primary Care Continuing Care (PCCC) HSE issued queries to all HSE LHO Managers and Assistant National Directors to determine whether Dr. A had been employed in the HSE in any capacity.
5.7.9. 13 July 2007 The Director contacted Supt GS 2, Athlone, following information received by the institute’s communications consultants that the Gardaí had informed the Director AIT about Dr. A’s conviction. Supt GS 2 – who had not been in Athlone at the time of the incident – confirmed that the Gardaí had not informed AIT about the incident, either formally or informally. Supt GS 2 did confirm, however, that Sgt GS 1, who had accompanied Dr. A on the trip to Amsterdam, had met with Mr. MHB 1 of the HSE at the time and informed him of the situation.

5.7.10. 18 July 2007 - Formal report received by AIT from Rits Security confirming that Dr. A’s PC was “clean.”
6. Interviews with HSE Staff Members

6.1. Summary of Interview, Mr. MHB 1, 26 August 2007, Santry, Dublin, accompanied by IMPACT representative

6.1.1. IMPACT representative stated that Mr. MHB 1 would cooperate fully in relation to questions. He stated that at the time of the alleged incident Dr. MHB 2 and Ms. MHB 4 were contacted. Conal Devine confirmed that he had received Mr. MHB 1’s written statement dated 31/7/2007 on 2 August 2007. Mr. MHB 1 confirmed that the statement set out his recollection of his interactions with Dr. A, the RDTF, and Health Board/HSE personnel relating to the matters under inquiry.

6.1.2. Mr. MHB 1 stated that the only contact that he had from any HSE personnel since the Dr. A conviction became public knowledge in July 2007 was from Mr. HSE 2 who was acting Assistant National Director PCCC at the time, seeking information from him with a view to preparing a HSE response to the disclosure of the conviction.

6.1.3. Mr. MHB 1 stated that his substantive post at the time of the incident in June 2004 was Senior Health Education Officer for Substance Misuse Grade VII. He was asked to act as Regional Promotional Manager in September 2003. From that point Mr. MHB 1 was acting Regional Promotional Manager until July 2006. Mr. MHB 1 was dealing with the Audit of the service and said that there were significant issues going on in the service at that time and that his role was only a small component of that work.

6.1.4. Mr. MHB 1 was asked what his understanding was of the Health Board’s responsibility for the RDTF and summarised this as follows:

- Each Health Board had a Regional Drugs Co-ordinator, no such position existed in the Midland Health Board. Key functions of regional Drugs Co-ordinator’s position were added to his substantive post and he attended Regional Meetings, Budget Meetings etc.
- In his substantive post his key responsibility was for Education & Prevention.
- The role of Interim regional Drugs Taskforce Co-ordinator was also added to Mr. MHB 1’s substantive post. All these roles carried across when he was asked to act as Regional Health Promotion Manager.
- The role of Interim Drugs Taskforce Co-ordinator both compromised and caused difficulties in respect of Mr. MHB 1's Health Promotion post, primarily because many of the views of the Taskforce were different to and critical of the Health Board position.
At one point it was agreed that Mr. MHB 1 would only speak on behalf of the Regional Taskforce and not the Health Board, to avoid confusion, but this did not really address the issue. He felt some pressure from Senior Management on the conflicting roles and positions of the RDTF and the Health Board's position.

This issue of governance was raised with the Health Board and the Department of Health and Children, in the end there was a Ministerial decision that the Minister would approach the Health Board on the appointment of Co-ordinator and Acting Co-ordinator. This was an add-on to Mr. MHB 1’s role and he stated that it lessened his role within the Region in respect of his substantive post.

6.1.5. At this point Mr. MHB 1 tabled a document “Measures needed to support the work of the Regional Drugs Task Forces October 2004” by way of a background document. Mr. MHB 1 stated that he would go to meetings every six weeks. A new appointee took over the Chair nationally and decided that the Co-ordinator would not attend all meetings. The chairpersons of the RDTFs attended instead. This caused a lot of ill feeling. When it came to funding there was a very clear line. Mr. MHB 1 was not sure if this was understood within the Health Board.

6.1.6. Mr. MHB 1 was asked if a Co-ordinator was appointed and answered as follows “Yes, in 2006 the Minister created a number of wholetime equivalent posts. However, the filling of these posts dragged out. It became more difficult for me when I became Regional Health Promotion Manager because of what happened in the Health Board at that time. I was not allowed to replace senior staff which left me with only one senior officer part time. It was difficult to manage given the lack of staff. I was told to ‘get on with it’ and manage. I was the senior. I was not in a position to say no. Eventually Taskforce Co-ordinators were appointed.

6.1.7. With regard to Dr. A and his research study in Athlone and Portlaoise and his subsequent trip to Holland, Mr. MHB 1 said that he was involved in deciding on the composition of that study group. There had been a meeting reviewing how the work was going and who should go to Holland. Mr. MHB 1 had been aware of Sgt. GS 1 being involved in the drugs field in the Midland area and that it would be appropriate for him to go. They planned on meeting police groups there.

6.1.8. Mr. MHB 1 said that Dr. A had been involved with the Centre for Family & Childhood Learning, Athlone Institute of Technology and that his name was coming back constantly through the system.
Detective Sergeant GS 1 had a good understanding of where the heroin users were coming from.

6.1.9. Mr. MHB 1 stated that he would not have discussed the composition of the study group with the Chairman, Mr. D1, who he described as a very honourable man who left a lot to the discretion of Mr. MHB 1. The Chairman’s primary role was to attend the meetings and to chair them. Mr. MHB 1 described Mr. D1 as very supportive and very experienced as a former County Manager.

6.1.10. Mr. MHB 1 said that the outcome of the study trip to Amsterdam was generation of the published study *Darkness on the Edge of Town*.

6.1.11. Mr. MHB 1 was asked who he contacted on his first learning from Sgt. GS1 on 25 June 2004 that Dr. A had been involved in an incident involving female students of a young age profile (*note: in Mr. MHB 1’s written statement dated 31 July 2007 he states that Detective Sergeant GS 1 indicated by telephone on Friday 25th June 2004 that the age profile of the young persons concerned was 15 to 18 years*). Mr. MHB 1 answered that he spoke to three key people – he was not clear in what order he spoke to them. They were Ms. MHB 3, Ms. MHB 4 Acting ACEO, and Dr MHB 2, his direct line manager. Mr. MHB 1 said that he outlined the circumstances as given to him by Sgt. GS 1. He denied that any of the three persons suggested to him that he take any further record of what Sgt. GS 1 had told him. Mr. MHB 1 stated that he did not speak to the Child Care Manager. He also recalled that Dr. MHB 2 made a comment in relation to risk assessment regarding Dr. A but did not ask Mr. MHB 1 to follow through on it.

6.1.12. Mr. MHB 1 stated that he then outlined the position to Mr. D1, possibly on the Friday evening, 25th June 2004.

6.1.13. Conal Devine remarked on the obligations in respect of matters of concern relating to abuse of young persons as outlined in a number of documents including Children First and the notification procedures on receipt of any information that would put a child at risk, as well as notification procedures with regard to the Child Care Managers and procedures with Gardai. Conal Devine remarked that none of this seemed to have been discussed at all. Mr. MHB 1 answered as follows “*No it was not. Can I just make the point that this had happened outside our jurisdiction. I have had involvement previously in relation to three cases of alleged child abuse and one of inappropriate behaviour. It was when I was in (another Health Board area) and I reported them to my senior. Following this I was advised of inappropriate behaviour in a Youth Club and again we*”
followed Children First procedures. When I was clear about the context I was working in I followed those procedures."

6.1.14. IMPACT interjected to state that there was also a criminal process proceeding at the time in relation to the alleged in June 2004. Conal Devine advised that in relation to any such incident there is a criminal pathway and a parallel domestic inquiry pathway, the latter of which is the responsibility of the relative Health Authority and takes into account duty of care obligations, notification procedures, standards, and other matters relevant to this jurisdiction. There was a criminal matter being explored outside of the State. Conal Devine indicated that it would be noted for the record that no communication had taken place in accordance with the Children First Guidelines.

6.1.15. Mr. MHB 1 stated that he was unaware if conversations on the June 2004 incident had taken place within the HSE or the RDTF/NDTF in his absence and outside his own role.

6.1.16. Mr. MHB 1 confirmed that he spoke with Dr. A over the weekend of 25/26 June 2004, as described in his written statement dated 31 July 2007.

6.1.17. Mr. MHB 1 stated that he notified the Health Board Communications Officer, Ms. MHB 3, when he met with her on Monday 28 June 2004. He explained to her that Dr. A was still in Holland and Dr. A needed some time to “get his head around what happened” and needed time with his family on his return. Mr. MHB 1 said that he had asked Dr. A to contact him on his return in the course of the telephone conversation with Dr. A over the weekend of 25/26 June 2004.

6.1.18. Mr. MHB 1 stated that he informed Ms. D4, as Director of the National Drugs Strategy Team at a meeting of the RDTF in Tullamore. She was the most senior person there and the funding for the RDTF was coming from that source (NDST). When she said that Mr. D2 who is a member of the NDTF (as the nominee of the Department of Justice, Equality and Law Reform) and RDTF Midlands, should know, he was unsure what to tell him. Mr. MHB 1 recalled a conversation with Mr. D2 some time later but believed it was prior to attending a Taskforce meeting.

6.1.19. With regard to his discussion with Supt D3 from the National Drugs Task Force, Mr. MHB 1 recalled that Supt D3 was unclear about what would happen in Holland and he was not sure what would be the outcome.
6.1.20. Mr. MHB 1 said that Detective Sergeant GS1 was very concerned about his own situation. Mr. MHB 1 said that his understanding was that when the Dutch police came to the hotel, Detective Sergeant GS 1 was awakened. Mr. MHB 1 did not know how a second Garda became involved, he understood that the second Garda had been working in The Hague and may have become involved because of Sgt. GS1's presence. He confirmed that he spoke to this Garda by telephone and had a very brief conversation with him.

6.1.21. Mr. MHB 1 said that he met with MS. MHB 4 on Monday, 28th June when she came to the Health Promotion Office for a pre arranged meeting. Mr. MHB 1 stated that arising from that meeting he was to meet with Dr. A and put restrictions around work he was doing and report back to MS. MHB 4 on any developments. Restrictions around work were subsequently discussed with Dr. A but Mr. MHB 1 was not sure if this would be acceptable to Dr. A. Mr. MHB 1 discussed suspending the research. The restrictions meant that interviews would be done with a third party and Dr. A would be asked to take a “back seat” and write up the work over the summer.

6.1.22. Mr. MHB 1 was asked if he discussed with MS. MHB 4 about informing Athlone Institute of Technology and he answered that he was not sure when this came up. There was the issue of the man's character. Mr. MHB 1 said that he had only heard from one side and there was no way of verifying this. A decision was made not to contact the College, Dr. A's employer.

6.1.23. Mr. MHB 1 stated that in his telephone conversations with Dr. A, Dr. A had never acknowledged that he had taken off his clothing, just that he was very unhappy and regretted it very deeply and acknowledged that he had been under the influence of alcohol.

6.1.24. Conal Devine asked Mr. MHB 1 if, when he met with Detective Sergeant GS 1 on his return to Ireland, there was any discussion about notifying the appropriate authorities. Mr. MHB 1 answered that he assumed that Detective Sergeant GS 1 would notify the authorities. Mr. MHB 1 said that he had no knowledge of who Detective Sergeant GS 1 reported to and he did not ask that question. Sgt. GS 1 had worked in Athlone and had a good working relationship with them there. Detective Sergeant GS 1 informed Mr. MHB 1 that he had told the Garda Authorities about the incident.

6.1.25. Mr. MHB 1 said that to his knowledge the Gardai were unclear on what would happen next with regard to the next steps of the Dutch police. Mr. MHB 1 was asked if the Gardai had indicated how they would manage it if the incident had happened in this
jurisdiction and he answered that there was just an “off the cuff” remark made.

6.1.26. Mr. MHB 1 said that he met with Dr. A on 6th July 2004. He stated that he had informed MS. MHB 4 and she had told Mr. MHB 1 to go ahead with the meeting. He did not minute the meeting. Mr. MHB 1 stated that he advised Dr. A to inform his employer about the incident and said that Dr. A was not happy with this suggestion.

6.1.27. It was agreed that Dr A would undertake joint research and not interview any others alone. Mr. MHB 1 said that he agreed to meet Dr. A again in relation to heroin research in September, not about the ongoing issue re Holland.

6.1.28. Mr. MHB 1 stated that Dr. A had spoken to (named academic), a visiting Professor from Canada to the Athlone Institute of Technology about getting advice in order to complete the research.

6.1.29. Mr. MHB 1 stated that he did not have minutes of the third meeting with Dr. A in November 2004, only minutes in relation to the heroin study. Mr. MHB 1 stated that Dr. A came in before the formal meeting in relation to heroin. Mr. MHB 1 stated that at this heroin meeting, he met Ms. MHB 4 and told her that the case in Holland was not going ahead.

6.1.30. Mr. MHB 1 said that the Minister of State, National Drugs Strategy, launched the study publication a few months later. Mr. MHB 1 was asked if there was any sense of discomfort in view of what had happened a few months earlier and he answered that it was in his head and he was very concerned. At that stage Mr. MHB 1 said that there were no proceedings against Dr A. He had spent the weekend before going back and forth to the Director of Communications (Ms. MHB 3) just trying to explain what was going on in Athlone.

6.1.31. Mr. MHB 1 said that the Task Force were never informed of what happened in Holland. Mr. MHB 1 said that there were some concerns in relation to the confidentiality of issues tabled with the Task Force as previously matters discussed at the task Force had appeared in the media a week or so later. When the “Darkness at the Edge of Town” report was published it was widely circulated and was used in relation to the Regional Action Plan.

6.1.32. Mr. MHB 1 stated that there were three international trips which were taken in the context of the study - Holland, Canada, and Glasgow. He believed that the Canadian trip was in November 2004.
He believed that the trip took place after Dr. A told him that the Dutch police were not going to prosecute.

6.1.33. Mr. MHB 1 stated that the study trip to Canada had already been provided for in the budget for the study. Mr. MHB 1 felt that he should send another member of staff with him in addition to Ms. MHB 5. He stated that he had asked Ms. MHB 5 had she any concerns with working with Dr. A and she said she was happy to go with Dr. A. Mr. MHB 1 said that he had spoken to Ms. MHB 5 about the incident in Holland and said that it was a concern to them if she had any concerns about working with Dr. A.

6.1.34. Mr. MHB 1 was asked if he had any concerns about Dr. A and he answered that he had concerns but they were only allegations. He could not recall discussing the Canadian study trip with Ms. MHB 4.

6.1.35. Mr. MHB 1 stated that Dr. A had gone to Glasgow on his own.

6.1.36. Mr. MHB 1 said that he asked Dr. A in November 2006 if there had been any repercussions about what had happened in Holland and Dr. A had told him no. Mr. MHB 1 said that he was leaving the Midland Health Board at that time and he asked Dr. A to link with the new Manager. Mr. MHB 1 said that Dr. A asked him if, in Mr. MHB 1's current brief, there was work that he could link with. Dr. A was thinking of changing his role, maybe going into private practice.

6.1.37. Mr. MHB 1 confirmed that he advised Ms. HSE 1, Assistant Director Population Health, of the issue as part of a briefing during his handover period. Mr. MHB 1 was going through staffing issues with Ms. HSE 1 and mentioned that an incident had happened re Dr. A “that was now over with”.

6.1.38. Mr. MHB 1 stated that aside from Dr. A, the staff he dealt with mostly at AIT were Mr. AIT 2, Professor AIT 1, and AIT 3, Student Manager. Mr. MHB 1 said that the only comments on Dr. A that he heard were that they were delighted to see him working with Dr. A. Mr. MHB 1 said that if there were any issues they never said anything.

6.1.39. Mr. MHB 1 was asked if in his discussions with Mr. D2 in the Department of Justice, did Mr. D2 indicate anything to Mr. MHB 1 about the charges brought against Dr. A? Mr. MHB 1 answered that he didn't know if Mr. D2 ever pursued any enquiries within the Department.
6.2. Draft of second interview with Mr. MHB 1, accompanied by IMPACT representative, November 9th 2007, Radisson Hotel, Dublin Airport

6.2.1. CD explained that he had been offered an opportunity to meet again to address the significant variations in recollection between his own account and the account of Ms. MHB 4. Mr. MHB 1 had been provided with Ms. MHB 4’s interview summary. Mr. MHB 1 was also advised that Dr. A had tabled mobile telephone records which suggested mobile telephone conversations with Mr. MHB 1 in September and October 2005 and that Dr. A was claiming in the course of those conversations Mr. MHB 1 had been advised of both the summons and conviction of Dr. A. CD further advised that he had met with Ms A that morning and that she was adamant that her recollection was that Mr. MHB 1 was aware that the trial was upcoming and he was advised by telephone in early October 2005, that there had been a conviction and that there had been other follow up conversations between Mr. MHB 1 and Dr. A.

6.2.2. Mr. MHB 1 stated that he had examined the documents provided to him during the week. With regard to Ms. MHB 4’s interview and comments, Mr. MHB 1 stated that he stood by his original account that he had advised Ms. MHB 4 in the summer of 2004 of the Amsterdam incident. He described Ms. MHB 4’s account as disingenuous and reiterated that after initially speaking with Dr. MHB 2, he spoke to Ms. MHB 4 and then spoke to Dr. MHB 2 again when he mentioned that he had spoken to Ms. MHB 4.

6.2.3. CD asked for further clarification on the reporting relationships between Mr. MHB 1 and Ms. MHB 4 and Dr. MHB 2. Mr. MHB 1 stated that Ms. MHB 4 was responsible as ACEO for the Regional Drugs Task Force. Dr. MHB 2 was Mr. MHB 1’s line manager in respect of his role as Acting Health Promotion Manager. However Dr. MHB 2 also had a role in policy issues relating to Public Health and addiction issues such as the establishment and provision of methadone services in Athlone. The operational responsibility for the HSE input into the Regional Drugs Task Force lay with Ms. MHB 4.

6.2.4. Mr. MHB 1 described the line reporting relationship on drugs issues with Ms. MHB 4 as follows; where requests came from the local authorities in the Midlands for information on drugs services, this would go directly to Ms. MHB 4’s office and he would be requested by Ms. MHB 4 to deal with it and draft a response. This response was then furnished to Ms. MHB 4 or at her request.
furnished directly to the local authority by Mr. MHB 1 with a copy to Dr. MHB 2.

6.2.5. In briefing Ms. MHB 4 on the Amsterdam incident as claimed by him, Mr. MHB 1 alleged that his understanding was that Ms. MHB 4 would take the information provided by him and then make the appropriate contact with the appropriate child care manager.

6.2.6. With regard to Dr. A, Mr. MHB 1 stated that he would monitor the rest of Dr. A’s work. The information was that it was just an allegation at that stage and the HSE would monitor Dr. A’s work and there was concern at some point that if they stopped Dr. A’s work it might become a litigation issue for breach of contract. Ms. MHB 4 did not give him a clear indication of where she was going with this matter when he left the room. Mr. MHB 1 stated that he had turned to Ms. MHB 4 as a senior manager for guidance on this issue.

6.2.7. CD stated that to his mind it was puzzling that in the run up to the Ministerial launch of the study, there did not appear to be any reflection between colleagues about the consequences of this significant issue surfacing. Mr. MHB 1 had no answer to that but stated that it had raised questions with him. He was not based in the central office at that time and he and Ms. MHB 4 did not cross paths on a day to day basis for that type of interaction or dialogue to take place. The issue was not mentioned in the context of funding.

6.2.8. Mr. MHB 1 stated that when he spoke to Ms. MHB 4 after the methadone meeting, he was unsure whether the issue had been “put to bed”.

6.2.9. CD advised that Dr A was indicating that he had had some discussions with Mr. MHB 1 by telephone in 2005 about being summoned and then about the conviction and fine. Dr. A was also saying that it didn’t appear that the Irish authorities would proceed against him but that he would never have said to Mr. MHB 1 that the Dutch authorities were not proceeding. Mr. MHB 1 stated that the only authorities that he knew were involved were the Dutch authorities. Mr. MHB 1 was unaware whether Dr. A assumed Mr. MHB 1 had been consulted or not. Mr. MHB 1 believed there was the possibility of a mis-communication here. Mr. MHB 1 presumed it all related to the Dutch authorities and was unaware of Irish involvement at Embassy level.
6.2.10. CD drew Mr. MHB 1's attention to specific telephone conversations in September and October 2005 as listed on the mobile telephone records tabled by Dr. A. Mr. MHB 1 confirmed that the phone number on the printout was the mobile number for the phone he held when he was in the Midlands - 086 380 1164. Mr. MHB 1 stated that he could not recall the conversation with Dr. A that allegedly took place on the day a summons was served on Dr. A at Athlone Garda station. Mr. MHB 1 remarked that he found it quite strange that he would be one of the first people Dr. A would ring. Mr. MHB 1 had no recollection whatsoever of Dr. A ringing him to tell him of this. CD said that the A's had said that there was a very small circle of friends that they would have discussed this with and that they were appreciative and supportive of Mr. MHB 1. Mr. MHB 1 responded that he had tried not to be judgemental from the very start and had suggested avenues of support to the As but believes that there is a big leap from being supportive to being a personal friend. Mr. MHB 1 said that he had been invited for dinner by Dr. A but he had never availed of those opportunities. Mr. MHB 1 said that he didn't socialise with people he worked with. Mr. MHB 1 said that although it was true to say that Dr. A would come in to his office and they would have conversations, that did not mean that there was a significant relationship there. Mr. MHB 1 did not recollect meeting Dr. A's wife. Mr. MHB 1 confirmed that Mrs. A would answer Dr. A's mobile phone and that she had once spoken to Mr. MHB 1 to cancel a meeting.

6.2.11. Mr. MHB 1 stated that Dr. A knew that Mr. MHB 1 had informed the Asst CEO and Mr. D1. It was Mr. MHB 1's opinion that Dr. A should have assumed that if Mr. MHB 1 knew of the incident, he would say something and that there was no reason why Mr. MHB 1 would sit on this type of information. If Dr A had told him this, Dr. A would have known Mr. MHB 1 would act on it. Mr. MHB 1 thought that Dr. A would surely be wondering how Health Board authorities would be reacting.

6.2.12. Mr. MHB 1 was asked whether he could recall a phone call which occurred on 6/10/06, after the A's received the English translation of Court judgement. The As have stated that the phone was on speaker and that Dr. A was advising Mr. MHB 1 in the hearing of his wife what the detail of the conviction was and that Mr. MHB 1 said "that's not as bad as it could have been". Mrs A had alleged that she overheard the conversation on the speaker while in the car. Mr. MHB 1 responded by stating that he remembered that morning very clearly as he was meeting an individual for the first time with major responsibility for health promotion. He was with that individual at an 11 am meeting that
morning, and he would have been in transit from Mullingar when the phone call was allegedly made. Mr. MHB 1 stated that he had absolutely no recollection of that conversation. Mr. MHB 1 said that he knew of the allegation but that he had no idea how it would pan out from a Dutch perspective and that the Gardai were unable to advise him. He therefore did not know what type of sentence Dr. A could expect in either the Dutch or Irish system. Mr. MHB 1 remembered that morning very clearly as it was his first meeting with an individual with a major responsibility for health promotion.

6.2.13. Mr. MHB 1 was asked if he could clarify who his line manager was on 9 September 2005 and he answered that due to changes of posts occurring, he was unable to recall who his line manager was at the time. Ms.Ms. MHB 4 had left by that stage and Mr. MHB 1 believed that Ms. HSE 1 may have had responsibility during that transition period but ultimately Dr. MHB 2 was the “port of call” as Service Manager.

6.2.14. Mr. MHB 1 was asked what work would have been agreed with Dr. A after that period which would have been funded by HSE. Mr. MHB 1 stated that there was a 16 month piece of work called the “Youth Resilience Project”. His role was to work with members of staff to work on a project about how promotions can be more effective, clear etc. This was in March 2005 but that project did not conclude. When the project broke down, Mr. MHB 1 intervened and it was revised. His staff had difficulties engaging with the target audiences. Dr. A came in looking to do research into Traveller health with co-researchers in Canada. Mr. MHB 1 agreed to fund some of the cost of the publication if it would be available to Travellers in Ireland. That would be the case for any researcher. Mr. MHB 1 explained that there had been lots of difficulties in the Midlands with Travellers. It was felt that because of tensions between some of the Travellers, questions could cause difficulties. There was no tendering process for this study. Dr. A submitted an application and Mr. MHB 1 funded it. When asked if this was rather unorthodox, Mr. MHB 1 replied that they were short of staff and he had significant funds to spend at his discretion. Dr. A received €40,000 through his consultancy called SOCSCI. Mr. MHB 1 said that no authorisation on the expenditure was needed for that contract at the time and that it fell within his level of authorisation as Acting Head.
6.2.15. Mr. MHB 1 was asked whether, on reflection, any of these matters could have been dealt with more appropriately. Mr. MHB 1 answered that as a critical issue he should have documented everything and sent things to everyone in writing. CD then said that the issue of a study visit to Canada caused him concern on the basis that there was a certain amount of knowledge available to Mr. MHB 1 and yet he had facilitated Dr. A to go on another study trip with 2 female members of staff and that this would not suggest a risk management approach in facilitating this trip. Mr. MHB 1 replied that the context here was that he understood the authorities were not proceeding. He spoke to Ms. MHB 5, who was to accompany Dr. A, and asked if she had concerns. The reason the second female member was going was in relation to health and safety. Ms. MHB 5 was aware that there was a serious sexualised incident that had occurred in Holland. Mr. MHB 1 stated that he was not advised not to tell Ms. MHB 5. He did give Ms. MHB 6 information and he knew that the two female members of staff knew each other well. Mr. MHB 1 reflected that he would probably make a different decision now.
6.3. **Summary of Interview, Ms. MHB 3, 26\textsuperscript{th} August 2007, Santry, Dublin**

6.3.1. Ms. MHB 3 stated that she has been with the Health Service for 8 years, first with the Midland Health Board and then with the HSE. Ms. MHB 3 explained that as Communications Manager, people would come to her if they were aware of something in their area which might become a media query, people with a Health Service background - something that may become a media issue. They would come to her and say something has happened. They would give her a brief outline of the issue. That would be all that she would have. She would not discuss it with anyone else. If the issue was raised with her by somebody in the media she would go back to the person that told her about it first and would prepare a statement with that person. She reported to the CEO. Of the Midland Health Board at the time.

6.3.2. Ms. MHB 3 stated that when Mr. Mr. MHB 1 came to her one morning, she was in the office in Tullamore. She was not aware of the trip in question. He explained that persons had gone on a trip in Holland in regard to drug research. She was aware that there was an issue in Athlone about drugs. There was a perception particularly in the media that drugs were a problem in the town. Mr. MHB 1 said that Dr. A was on the trip.

6.3.3. Ms. MHB 3 stated that her recollection was that there was an incident with ladies in a hotel bedroom. She was aware that the Midland Health Board had paid for the trip. She was thinking if the media hear this she will have to justify the Health Board paying for this trip. She did not hear anymore about it. She would not discuss it and did not ask anyone about it. She never discussed it again. There were no queries about it until this matter was disclosed in the national media in July this year.

6.3.4. Ms. MHB 3 stated that she could not remember if Mr. MHB 1 had said anything to her about the ages of the women concerned. She did not make a note of it at the time.

6.3.5. Ms. MHB 3 said that sometimes people would come to her with issues on a “just in case” basis. She said that she would first go to Mr. MHB 1 if any matter emerged in the media related to what he told her. Ms. MHB 3 said that it would not be treated
any differently by her if Mr. MHB 1 had come to her and Dr. A had been an officer of the Midland Health Board.

6.3.6. Ms. MHB 3 said that she was first became aware that the media were in possession of information relating to Dr. A’s visit to Holland when she heard it in the media in July 2007.

6.3.7. Ms. MHB 3 confirmed that she attended the launch of the publication of the study but that she was not involved in the launch. She understood that Athlone Institute of Technology was launching the study.

6.3.8. Ms. MHB 3 said that she didn’t think about whether the incident would affect the launch and said that things like this would be said to her formerly as a journalist and not be mentioned again. She was wondering if it was true.

6.3.9. Ms. MHB 3 said that she was on holidays when she heard about the issue in July 2007. She did not meet with either Mr. MHB 1. Ms. MHB 3 said that she was the manager for the Regional Press Office and thought that Mr. MHB 1 might have spoken to someone in the National Press Office and may have spoken to Dr. A in her office as well.

6.3.10. Ms. MHB 3 said she supposed she was surprised when the details of the allegations were made known to her, given what she was told in June 2004.

6.3.11. Ms. MHB 3 was asked if in June 2004 she had been aware of the ages of the women in the bedroom, would that have made a difference to how she dealt with the issue. Ms. MHB 3 answered “Probably not to me as there would be more senior people to me. I would have seen that I was told just as a communication. I would have taken it that I was told just in case of Media involvement“.
6.4. **Summary of interview with Ms. MHB 4, The Crown Plaza Hotel, Santry, Dublin 9, 29th August 2007, accompanied by Observer.**

6.4.1. Ms. MHB 4 stated that she was still on Annual Leave.

6.4.2. CD explained that he wished to establish a factual chronology of the series of events involving Dr. A in June 2004 and then the subsequent notification to the Midland Health Board and what steps, if any were taken at that point, moving on to any knowledge Ms. MHB 4 had involving a further trip taken by Dr. A in 2004 in connection with the RDTF.

6.4.3. Ms. MHB 4 stated that she welcomed the opportunity to give her recollection of events and was happy to cooperate. She confirmed that at the time she was acting Assistant CEO in the Midland Health Board and would have had responsibility for Disabilities, Mental Health and the Elderly. She also had some involvement with Environmental Health, Dental and some Child Health Services as well, some of this being shared with other colleagues.

6.4.4. Ms. Ms. MHB 4 stated that the RDTF came under her responsibility in a slight way under Mental Health, along with Alcohol and Drugs. It straddled a number of areas. The RDTF Chair at the time was Mr. D1. The Midland Health Board provided secretarial and support services and Mr. Mr. MHB 1 was RDTF Coordinator. She clarified that the Midland Health Board was a “post box” for funding of the RDTF. Mr. MHB 1 kept her up to date in respect of RDTF developments. Mr. MHB 1 also acted as Health Promotion Manager/Director.

6.4.5. CD asked whether Mr. MHB 1 reported to Ms. MHB 4 in relation to proceedings of the RDTF in his role of Acting Coordinator. She answered that Mr. MHB 1 kept her informed and that he reported to Dr. MHB 2.

6.4.6. Ms. MHB 4 said that she had no recollection of Mr. MHB 1 allegedly indicating to her in April/May 2004 that monies were available and not being spent on the Regional Coordinator and that these monies were available to continue research in a particular area. She did know that research into Mental Health – drugs and alcohol research was ongoing but nothing specifically in relation to Dr. A.
6.4.7. Ms. MHB 4 said that she could not remember when she first learned that Dr. A was involved, but believed it was the latter half of 2004 when Mr. MHB 1 at the end of a Methadone Services meeting made a comment that Dr. A and others were on a trip to Holland. She said that Mr. MHB 1 had made a comment about Dr. A behaving badly late at night and that there were women involved.

6.4.8. CD stated that Mr. MHB 1 had dated that contact as Monday 28 June 2004 and Ms. MHB 4 said that she had no access to dates.

6.4.9. CD stated that Mr. MHB 1 had recollected that he had spoken to Ms. MHB 4 on two occasions, once then and once again in November 2004. Ms. MHB 4 concurred that she told Mr. MHB 1 to follow up appropriately and to keep her apprised but that this had occurred in the latter part of 2004 or the end of the year and the matter was raised with her on only one occasion.

6.4.10. Ms. MHB 4 said that Mr. MHB 1 never indicated to her the ages of the women involved. She described Mr. MHB 1’s comment as very much a throw away comment at the end of a meeting.

6.4.11. Ms. MHB 4 stated that Dr. MHB 2 did not discuss this issue with her.

6.4.12. Ms. MHB 4 confirmed that after speaking to Dr. A, Mr. MHB 1 had spoken to her in the latter part of November 2004 informing her that no charges were brought against Dr. A involving the Dutch incident. She said that the first she heard of charges was when it broke in the media in July of this year. She had left the Health Board prior to the trial of Dr. A which she now knew happened in September 2005.

6.4.13. Ms. MHB 4 stated that she had no recollection of discussion or any reference being made by Mr. MHB 1 about an upcoming trip to Canada being undertaken by Dr. A or staff accompanying Dr. A on that trip. She believed he would have discussed this with another colleague.

6.4.14. Ms. MHB 4 denied that she was invited to the launch of the book *Darkness on the Edge of Town* and said that if she had been invited, she did not attend. She had only one recollection of visiting AIT which was on one occasion when Dr. MHB 2 was not available to do a talk in AIT to do with Drugs in May 2004. Ms. MHB 4 said that she met Dr. A that day when she was filling in for Dr. MHB 2.
6.4.15. CD asked Ms. MHB 4 if the ages of the women/young persons involved in the incident had been disclosed to her in 2004, would it have made a difference on how it would be managed. Ms. MHB 4 responded by saying that she could only give the facts as she knows them. She also stated that every officer has a responsibility and the Children First Guidelines would have to be implemented.

6.4.16. Ms. MHB 4 clarified that if there is a risk to young persons the Director of Child Care and Child Care Manager would be involved. There would be ongoing training and people would be aware of their responsibilities and would be aware of Best Practice procedures.

6.4.17. With regard to what Mr. MHB 1 said to her in relation to the June 2004 trip to Holland, Ms. MHB 4 said that her recollection was that Mr. MHB 1 commented that “others” were with Dr. A. She knew nothing about funding or anything else in relation to that trip. The name Sgt. GS 1 (RDTF) was not mentioned to her.

6.4.18. Ms. MHB 4 said that she had no knowledge or recollection of whether the Midland Health Board was contacted by the Department of Justice about Dr. A.

6.4.19. Ms. MHB 4 stated that when the issue broke in the media she was contacted by Mr. HSE 2 of the HSE but she did not furnish any documentation to him.

6.4.20. In answer to a question Ms. MHB 4 stated that her diary from that period would not be available and it would not have contained any information on her meetings with Mr. MHB 1.

6.4.21. Ms. MHB 4 said that it was only on one occasion that Mr. MHB 1 raised Dr. A’s name and the Dutch trip with her and that was at the end of the year 2004. She did not take any note of this.

6.4.22. Ms. MHB 4 stated that she met Dr MHB 2 at a function following the disclosure in July 2007 and discussed it very briefly with him then.

6.4.23. Ms. MHB 4 confirmed that she left the Health Board in July 2005, prior to Dr. A’s conviction in September 2005. She handed over to two General Managers. It was a challenging time and all were under a lot of pressure. The General Manager changed again to LHOs. Ms. MHB 4 stated that she had very regular meetings with her own management team at that time but at no time at these meetings was the issue relating to Dr. A’s trip discussed.
6.5. **Interview summary Ms. HSE 1, Assistant National Director, Population Health, 19 September 2007**

6.5.1. Ms. HSE 1 stated that she assumed her post in November 2005 and met with the various managers reporting to her in early 2006. She recalled having a detailed discussion with all of the managers including Mr. MHB 1. Ms. HSE 1 said that Mr. MHB 1 had mentioned the matter as a passing thing, or as historical business from the Midland Health Board that would not be transferring into her area (Drugs Task Force). Mr. MHB 1 had spoken of someone on contract from AIT, but she either did not know the name or Dr. A as a name didn’t have any significance to her. Ms. HSE 1 recalled that Mr. MHB 1 had mentioned alcohol, but had not mentioned that the matter had anything of a sexual nature. Mr. MHB 1 had said that the business was historical and he had been reporting through Ms. MHB 4 but said that the matter was over for some time at that stage.

6.5.2. Ms. HSE 1 stated that all of the Regional Health Managers reported into her and together they would have gone through service planning, budgets, staffing, top line issues in relation to the running of Department. When she met managers she would have asked if they had any concerns that they wanted to discuss.

6.5.3. Ms. HSE 1 said that when the story broke this summer, Mr. MHB 1 rang her. She recalled that Mr. MHB 1 saying “remember when I told you about Dr. A?” and she asked him to refresh her memory and he reiterated what he had told her. Ms. HSE 1 said that alcohol was mentioned but could not recall anything of a sexual matter. They spoke about communications and that Mr. MHB 1 was linking into people at the PCCC side.

6.5.4. Ms. HSE 1 confirmed that Mr. MHB 1 reports to her and said that her concern would be that he has the support he requires at this time.

6.5.5. Ms. HSE 1 said that if Mr. MHB 1 had mentioned that the issue was of a sexual nature with underage females that the issue would have been important to her as would the management of the issue.
6.5.6. Ms. HSE 1 was asked about her familiarity with the protocols for child protection issues. She answered that there was a responsibility to report and go through appropriate channels. She would link with and talk to appropriate Child Care Manager and go through those channels. Ms. HSE 1 said that she has never had an issue with reporting or managing child abuse issues and would only have professional contact with young persons through schools, e.g. working with teachers, principals, and chairmen rather than directly with pupils.
6.6. **Interview summary Dr. MHB 2, National Director, Population Health, Crowne Plaza Hotel, 19 September 2007**

6.6.1. Dr. MHB 2 was advised that Mr MHB 1 had made a statement in his interview to the Review Inquiry Team and had stated that he had raised the issue of Dr. A’s arrest in June 2004 in Amsterdam with Dr. MHB 2 at that time. Dr. MHB 2 was advised that the interview would focus on the contacts made by Mr. MHB 1 and any other party with Dr. MHB 2 in respect of Dr. A.

6.6.2. By way of background, Dr. MHB 2 was asked to outline the nature of the reporting relationship that Mr. MHB 2 had with him in 2004 and whether this covered both MHB 1’s Health Promotion role and his Acting Regional Coordinator RDTF role. Dr. MHB 2 confirmed that in his role at the time as Director of Public Health, that he was responsible for Health Promotion and that accordingly Mr. MHB 1 reported directly to him for that service. Dr. MHB 2 recalled also that Mr. MHB 1 had been for a year or two acting as Coordinator of the RDTF. His recollection was that at the time that the RDTF was being established it was felt that the Chair would be outside the Health Board as would the Coordinator. In the absence of authorisation to appoint permanent Regional Coordinators, he had asked Mr. MHB 1 to take on the responsibility pending the filling of the Coordinator post. He further recalled that Mr. MHB 1 would keep him informed about what was happening in the RDTF but he would not have described it as an accountability or formal reporting relationship in that respect. Addiction services came under control of community care services at that time but Dr. MHB 2 could not recall who the responsible officer for the service in the Midland Health Board was at the time. Dr. MHB 2 stated that he had a role in this area as Director of Public Health in that he had identified and raised the need for methadone clinics in the Region.

6.6.3. Dr. MHB 2 was asked whether Mr. MHB 1 kept him briefed on significant developments under in the RDTF in his role as Acting Regional Co-ordinator of the task force. Dr. MHB 2 advised that in his view the relationship between the Health Board and the RDTF was not sufficiently clear. Dr. MHB 2 took more of an interest than other managers in the activities of the RDTF and Mr. MHB 1 would have kept him briefed on, and
would have reported, the Amsterdam incident to him as his line
manager.

6.6.4. Dr. MHB 2 was asked when he became aware of the
study and he stated that he must have been vaguely aware of
the study prior to June 2004. He was not aware of Dr. A’s
background and had not met him previously. It was a Friday, Mr.
MHB 1 told him about the trip, about an incident in Amsterdam
(within days). Mr. MHB 1 seemed to be concerned about the
reputation of the Midland Health Board. He sat down with Mr.
MHB 1 on the Monday to discuss it. His recollection was that Mr.
MHB 1 told him that Dr. A and a Garda sergeant had gone to
Amsterdam and had socialised with a group of girls in the hotel,
both had retired and apparently Dr A then went back to the
room of the girls in an intoxicated state, made advances to them
and they called the police. The Garda sergeant was called and
came down to discuss the matter. He was given to understand
that there was a possibility of prosecution.

6.6.5. Dr. MHB 2 stated that his understanding was that the trip
to the Amsterdam conference was entirely funded by the RDTF.

6.6.6. Dr. MHB 2 was asked whether Mr. MHB 1 indicated at
any stage whether underage girls were involved in the incident.
Dr. MHB 2 answered that Mr. MHB 1 had indicated that some of
the girls were underage. It was a significant detail and caused
Dr. MHB 2 great concern, in part due to it happening in a
different jurisdiction, plus it was a suspected case of sexual
abuse. Dr. MHB 2 discussed this with Mr. MHB 1 and wondered
what should be done and speculated on the possible outcome.
Dr. MHB 2 recalled asking Mr. MHB 1 if Dr. A had children
himself, what the risk was, whether the matter had gone to the
authorities here. Dr. MHB 2 believed a risk assessment might be
appropriate. Because they were dealing with a matter outside of
Ireland, Dr. MHB 2 said that there was not the normal flow of
information that would one would have in order to assess risk.
Dr. MHB 2 could not specifically recall suggestions that this be
reported to the relevant child protection functions within the
Board. He remembered an A W in childcare and believes he
probably suggested to Mr. MHB 1 that he contact him. Dr. MHB
2 could not recall whether there was any response. He believed
he had a short conversation but that was as much as he could
recollect.
6.6.7. With regard to the issue of the HSE Midlands being exposed, Dr. MHB 2 said that Mr. MHB 1 mentioned this issue initially but it faded after a few days. There had been no media comment or other comment that he could remember. It was the child protection issue that was the issue that remained of concern to him.

6.6.8. Dr. MHB 2 stated that the issue would not have been discussed at top Management Team level, as they dealt mostly with policy.

6.6.9. Dr. MHB 2 said that he learned of further developments a few days later when Mr. MHB 1 told him that he had spoken to Ms. Ms. MHB 4 who was Acting CEO of Community Care at the time. Dr. MHB 2 could not recall if he suggested that Mr. MHB 1 tell the head of Child Care but recollected believing that if the matter had been reported to Ms. Ms. MHB 4 that things would take their course. He believed a risk assessment would be done.

6.6.10. Dr. MHB 2 said that Ms. Ms. MHB 4 did not speak to him on the matter at the time but that they had spoken briefly this summer.

6.6.11. Dr. MHB 2 was asked if he had been advised by Mr. MHB 1 of the progress of the study that Dr. A was undertaking. Dr. MHB 2’s recollection was that Mr. MHB 1 mentioned it at one stage and suggested Dr. A would not continue with it. Dr. MHB 2 thought that it was later than the summer of 2004 but said that he didn’t take a great interest in that. Dr. MHB 2 was thinking in terms of risk i.e. that there seemed to be no risk in the job that Dr. A held as he had no access to children in his position. Dr. MHB 2 stated that Mr. MHB 1 did not come back to him on any action taken in relation to Dr. A nor did he raise the issue again with Mr. MHB 1.

6.6.12. Dr. MHB 2 said that it was only through the recent publicity that he became aware that the study had been completed and a study report had been published by Dr. A.

6.6.13. Dr. MHB 2 said that this matter did not feature in any handover to the Acting Director of Public Health when Dr. MHB 2 left office. Dr. MHB 2 had left the Midland Health Board in December 2004 and from that time had a national role. He was not in the Midlands when the study was launched in 2005 and it next came to his attention in the summer of this year.
6.6.14. Dr. MHB 2 was asked whether in his role as Manager responsible for the Health Promotion Unit and other areas, if there were issues in the past where child protection matters had been brought to his attention. Dr. MHB 2 affirmed that this was the case, and cited health promotion activity in schools where concerns would be brought to their attention through teachers or about teachers. He was aware of fewer than 10 cases that he would have been aware of in the 10 years that he was there. Cases would have been notified to Gardai but in the A case, the Gardai were already aware. Dr. MHB 2 said that the Gardai would have had more first hand knowledge than they would in the Health Board.

6.6.15. With respect to notification procedures, Dr. MHB 2 understood that social work services was specifically mentioned via a formal notification form. CD said that there was no evidence of that in this case. Dr. MHB 2 said that he was aware of informal notification practices as former Director of Public Health.

6.6.16. Dr. MHB 2 was asked if any discussion had taken place with Mr. MHB 1 about contacting Athlone IT and notifying them about the incident. Dr. MHB 2 said that he could not recollect but believed that Mr. MHB 1 had wondered whether they should. Dr. MHB 2 could not recall a definitive decision being taken as there was no immediate risk to children arising out of Dr. A’s job. Dr. MHB 2 was unaware that Dr. A would have attended centres in Galway and said that that knowledge would have made a difference. The assumption had been that Dr. A didn’t have children himself or access to children.

6.6.17. Dr. MHB 2 was asked in general terms about Garda clearance and vetting procedures in place, particularly in relation to employees who return to the health care system from extended periods abroad. Dr. MHB 2 said that to his knowledge, he has never heard a discussion about further Garda clearance and was not aware of this but that he believed that this area should be explored and addressed. Dr. MHB 2 said that he had had experience in the past where social workers held strong convictions but were not able to act on that ‘soft’ information against the devious nature of child abuse.

6.6.18. Dr. MHB 2 was asked if the HSE approached the Gardai to ensure that successful prosecutions of sexual assault outside of this jurisdiction might form part of their Garda clearance. Dr. MHB 2 replied that he has seen confidential reports on Garda clearance but could not remember seeing anything relating to an offence committed in another jurisdiction.
6.7. **Interview Summary, Ms. HSE 3, LHO Manager, Galway, HSE West, 9 November 2007, Santry, Dublin**

6.7.1. CD explained to Ms. HSE 3 that she was being interviewed regarding actions she took as Local Health Manager when she became aware that there were potential child protection issues with regard to Dr. A arising from media reports in July 2007 of a conviction for sexual assault on young persons in Holland in June 2004. Ms. HSE 3 tabled a number of reports including a summary of the risk assessment steps taken by her office on learning from medial reports in 2007 of Dr. A’s conviction. Ms. HSE 3 stated that at no time did anyone formally advise her office that there was a problem with Dr. A. She did recall receiving a call from the Child Care Manager, Galway, who is currently A/General Manager in early July 2007 advising that Dr. A had some contact with a young persons’ residential unit in Galway in the past. She then met with both him and the A/Child Care Manager and obtained additional details of Dr. A’s contacts with the service.

6.7.2. Ms. HSE 3 indicated that on learning that Dr. A had a practice placement in a children’s residential unit, Aras Geal in 2003/2004 she immediately asked for review of the practice placement. She established that a request had been received from the Irish Association of Social Care Educators in 2003 to facilitate a “pilot” practical placement for Dr. A, a lecturer in Athlone Institute of Technology, so that he could familiarise himself with front line child care work.

6.7.3. Ms. HSE 3 stated that she had further established that the same procedures that applied to all students seeking a practical placement were adopted. Dr. A was asked to submit

- A Garda reference
- An employer reference
- 3 personal references
- Specific indemnity was obtained from HSE insurers for the placement

Ms. HSE 3 understood from the report provided to her in July 2007 that Dr. A had attended Aras Geal Children’s Residential Unit for one day a fortnight for approximately six months - a total of 10 days, although the original observation placement was for one year. She stated that during that time he was closely observed and supervised at all times and was never on the premises at night. The preliminary report indicated that Dr. A had advised staff
that he was ceasing his placement in June 2004 because of commitments associated with drugs research which he was undertaking. On receipt of that preliminary report, Ms. HSE 3 requested the areas Inspection and Monitoring Officer to undertake a safety review of young people living at Aras Geal in the period November 2003 to June 2004.

6.7.4. Ms. HSE 3 also arranged for the Area's Principal Social Worker to ask social workers to undertake a visit on Dr. A as she understood that he had one child. This was not possible as Dr. A was in Scotland at the time. Social workers were instructed to keep a watching brief and carry out an interview with Mrs. A when they returned.

6.7.5. Ms. HSE 3 stated that as she had responsibility for the Children's Residential Services for the former Western Health Board area since all the services were located in Galway, arrangements were made to contact the other service providers in Galway but they did not confirm any links with Dr. A. However, Dr. A did visit one other Unit in his role as Student Supervisor. A meeting was arranged with Mrs. A by social workers when the A family returned to Galway.

6.7.6. In response to a direct question, Ms. HSE 3 confirmed that at no time did her office receive formal notification that Dr. A had a conviction for sexual assault of young persons in Holland. She did acknowledge that contacts were made from the HSE in respect of seeking reports on the Aras Geal placement and any other information. She also confirmed that she was in contact with the Social Services Inspectorate in relation to the placement.

During Dr. A’s observation placement, the SSI conducted an inspection of Aras Geal and he received permission from the SSI to observe the inspection process.

In the course of her enquiries she became aware that Dr. A had made a number of visits to orphanages in Romania and she forwarded this information to the HSE. (Note - Dr. A stated that there was only one trip to an orphanage and that this was made in the constant presence of a female social care lecturer.)

6.7.7. In the course of the enquiries initiated at Galway LHO level, she reviewed the information personally three or four times with the Inspector/Monitoring Officer and her own Staff. They had, on the basis of the information available to them, nothing to be particularly alarmed about in respect of Dr. A’s
placement. She was satisfied that the appropriate actions had been taken in respect of the request for a placement. Ms. HSE 3 pointed out that the pilot placement had finished just before Dr. A went to Amsterdam in June 2004.

6.7.8. Ms. HSE 3 advised that the Inspection and Monitoring Officer had interviewed young people who had been resident in Aras Geal in the period in question and provided that report on 14 August 2007. That report concluded that there were no child safety issues arising for those young persons owing to the presence of Dr. A during the November ’03 – June ’04 period.

6.7.9. Ms. HSE 3 tabled the Social Work report dated 4 October 2007 arising from the social worker meeting with Mrs. A and Dr. A. That report indicated that the Team Leader was satisfied that Mrs A was fully aware of her responsibilities and that Dr. A was cognisant of his circumstances and the Team Leader did not see a further role for the Social Work Department, there being no child protection concerns. Mrs A was interviewed alone and then jointly interviewed with Dr. A as Dr. A had requested that his wife be present for his interview. In his report the Team Leader notes that Dr. A states that he told the HSE of his conviction.

6.7.10. Ms. HSE 3 advised that no academics had been placed in Aras Geal since Dr. A on the basis that it had not been a successful pilot because he didn’t stay the full year. In response to a direct question, Ms. HSE 3 confirmed that her office had received no notification from the Garda Authorities in respect of Dr. A’s conviction for sexual assault, notwithstanding that Dr. A was resident in County Galway within Ms. HSE 3’s LHO Area. Ms. HSE 3 contrasted this with the normally attentive and efficient input from the Garda Authorities in respect of both suspicions of child abuse and where individuals convicted of sexual offences were being released from custody and returning to the geographical area. Ms. HSE 3 stated that Gardai will invariably utilise the formal notification form where there are suspicions of child abuse. As per Children First, there are regular meetings between the Gardai and Social Workers.

6.7.11. Ms. HSE 3 was asked for her observations on the question of safeguards to be applied when a health service employee who would initially have obtained Garda clearance leaves the country for an extended period and returns to work with the health service. CD asked whether such individuals had to obtain a new Garda clearance which would also include reference to clearance from the jurisdiction from which the individual had returned from. Ms. HSE 3 stated that there had been informal discussions on this scenario when no second
Garda clearance is obtained. It was her view that the Garda Authorities should be moving toward a pan European database but she is less concerned about a staff member for whom they have a Garda clearance going off and coming back, than with the thousands of staff who have been appointed prior to there being a Garda clearance system in the first place. There is also the question of where the boundaries regarding clearance extends to, for example volunteers, first responders, etc., all having a duty of care to young people. Ms. HSE 3 also stated that there were concerns in respect of the practice of staff transferring from local authorities to the HSE and that such staff did not appear to be subject to reference checks or Garda clearance.

6.7.12. Ms. HSE 3 highlighted the model introduced by the Mental Health Commission recently. Under the Mental Health Act, Approved Centres need to be registered and Registered Proprietors have been asked to have annual Garda clearance in respect of those mental health facilities which cater for patients admitted involuntarily. Ms. HSE 3 contrasted this with the situation pertaining to residential care of the elderly and of young persons, many of whom would be the subject of Court Orders.
7. Interviews with Members of the Regional and National Drugs Task Forces

7.1. Summary of Interview, Mr. D1, Chair of the Regional Drugs Task Force, 28th August 2007, Dublin

7.1.1. Mr. D1 said that he had been aware from Mr. Mr. MHB 1 that a certain piece of research was going to be undertaken by Dr. A in Athlone with the help of students. Mr. D1 had taken over as Chair in September 2003. He said that people were dropping in and out of the committee all the time. The RDTF involved Longford/Westmeath and Laois/Offaly. They had no staff and no money and no premises. The Department of Health gave €50,000 to the Midland Health Board to facilitate the recruitment of a permanent coordinator in 2003. Mr. MHB 1 said this €50,000 would not be spent as no advances had been made in recruiting the permanent coordinator for the Region. Mr. MHB 1 had mentioned that €50,000 would be ideal to do research into heroin. He was the Manager, Health Promotion Section Health Board/HSE. The only involvement that Mr. D1 had was that in May 2004 at a meeting of their committee Mr. MHB 1 brought in Dr. A and Ms. MHB 1 who was involved in his Department. Dr. A indicated that he was interested in doing research and looked for a response/suggestions from the Committee and gave his email address that night. Mr. D1 said that this was his only involvement in the survey. That was in May 2004, probably 20th May.

7.1.2. Mr. D1 said that he was not consulted about funding or who was to get what out of it. Subsequently, he became aware in the last month or so of documents relating to the study that he was not consulted about.

7.1.3. Mr. D1 said that he did not see anything wrong with the study. They were Health Board employees (Mr. MHB 1 and Ms. MHB 5) and they were availing of somebody in the College to find out what was wrong in the two towns – Athlone and Portlaoise. The logistics were not brought to Mr. D1’s attention.

7.1.4. Mr. D1 stated that the only indication of a problem he got was a telephone call from Mr. MHB 1 about an incident about Dr. A involving drink while he was away in Amsterdam. It did not occur to him that it involved the study. Mr. MHB 1 said he had
no knowledge about what happened but there was a Guard from Athlone who would look after whatever was wrong. Mr. D1 said he took a note of the conversation but could not locate it at the time of interview. He took the call at night. Mr. D1 recalled saying to Mr. MHB 1 “(B) you don’t know what is involved and as you don’t know what is involved, everyone is innocent until proven guilty”. The next thing Mr. D1 heard was on the RTE News 6/8 weeks ago.

7.1.5. Mr. D1 said that Mr. MHB 1 never came back to him to update him. Mr. D1 said that when he thought back on that phone call three years ago the penny never dropped that Dr. A was in Amsterdam on that study.

7.1.6. Mr. D1 said that he had been invited to the launch of the study but had been on holidays at the time. He assumed that the Midland Health Board was running it as the RDTF had no staff of its own.

7.1.7. Mr. D1 said that his committee is a separate entity to the HSE and they have no involvement with them. The committee received money in late 2006 which meant that they had a focus.

7.1.8. Mr. D1 stated that the committee has a monthly meeting to discuss action plans funded by the NDST and there is a National Coordinator Liaison Group. Genesis Consultants drew up the Midland Action Plan. Mr. D1 stated that Mr. MHB 1 had a big part to play and had done a lot of the work and Genesis put the whole package together. This Action Plan was launched by the Minister in 2006.

7.1.9. CD asked whether the funding for all of these, the implementation of the Action Plan and the funding of the €50,000 were all channelled through the HSE. Mr. D1 answered “No. This is why there is such a huge delay in the employing of staff and the actions that take place. We have to find a host Agency who will act as the channel of funding and eventually take over the action. Management - Westmeath Community Development Ltd., and Foroige are host organisations. €160,000 last year, €160,000 this year. The money to cover overheads comes through the HSE. The funding for actual projects will come through the host organisations. The funds are provided by the Department of Community Rural and Gaeltacht Affairs to the HSE to cover the overheads.”

7.1.10. Mr. D1 stated that when Dr. A came to the meeting in May 2004 it was on the basis of how he was going to conduct
the Athlone study. Dr. A never indicated that it would be outside the Country. Mr. D1 only learned of the trips after the RTE news item. Mr. D1 said that he only knew about the Canadian trip about six weeks ago when it hit the airwaves and the HSE in Tullamore started looking for documents. Mr. D1 said he knew it seemed strange as Chairman, but he was not made aware of it.

7.1.11. Mr. D1 said that nothing moves now in relation to the RDTF that he doesn’t know about. When he started as Chairman in 2003 they had no premises, no staff, no finance, and all they were attempting to do was get representatives from the various statutory and voluntary bodies to sit on the Committee. In 2003 when he took over they had two meetings. In 2004 they had four Committee meetings.

7.1.12. Mr. D1 stated that he had no memory of whether Mr. MHB 1 made any suggestion in relation to discussing this matter at RDTF level.

7.1.13. CD suggested that it seemed to be a matter of agreement that this would not be raised with the RDTF at any subsequent meetings. Mr. D1 responded by saying that he had spent his lifetime in the Public Service. On the night he took the call it never occurred to him that Dr. A was in Amsterdam on foot of that study and certainly when Mr. MHB 1 mentioned about the Gard “he said he would look after whatever the problem was” – Mr. D1 would not have associated a Garda in the study.

7.1.14. Mr. D1 confirmed that Mr. MHB 1 had never mentioned anything about international trips relating to the study.

7.1.15. CD asked if Mr. D1’s reaction would be different if Mr. MHB 1 had disclosed the connection between the trip and the study - as the concept was only made known to Mr. D1 the previous May. Mr. D1 answered “I can only say to you that the fact that I was a Public Official for so many years to discover something like this would have annoyed me intensely. The first question I would ask is what has it got to do with the Midland Health Board.”

7.1.16. CD said that it is a little disturbing that a Chair would not have had such matters disclosed to him. Mr. D1 responded by saying “Can I say to you with respect. The €50,000 came to assist with the recruitment of a permanent coordinator. There
was €50,000 there to be spent and I would assume that the Midland Health Board have to clear the expenditure and not me as a Chair. The Committee was going to be the beneficiary of a study that would cost the Task Force nothing. I did not feel I was being left out of the loop."

7.1.17. With regard to being kept outside the loop over not being kept informed of Dr. A’s study in Holland, Mr. D1 said that Mr. MHB 1 never mentioned Dr. A’s name to him again or if he ever found out anything. It was the News at Six that informed him when it happened six weeks ago.

7.1.18. Mr. D1 said that he would search for his telephone note with Mr. MHB 1 of June 2004 and promised to forward it if found*.

* Mr. D1 forwarded on 9/10/07 a note which he located subsequent to the interview stating “Mr. Mr. MHB 1 called me on Friday 25/6 2004 at 18:40 and advised me that Dr. A was arrested on certain suspicions”.

Mr. D1 wished it placed on record his appreciation of the HSE’s support and cooperation in providing facilities for the Regional Coordinator and meeting rooms and other supports for the Midland Regional Drugs Task Force.
7.2. Summary of Interview, Mr. D2, Assistant Principal, Department Of Justice, Equality and Law Reform, 7TH September 2007, Crown Plaza Hotel, Santry, Dublin

7.2.1. Mr. D2 stated that he represents the Department of Justice, Equality and Law Reform on the National Drugs Strategy Team and that part of that role is that he works half of his working week with the NDST business and the remaining half at his own post at the Department. His role is acting as a liaison and support person to the Midlands Regional Drugs Task Force. Mr. D2 clarified that the whole Drugs Strategy is based on partnership and that he acts as a liaison person for the Midland Regional Drugs Task Force on behalf of the NDST. He is assigned as a liaison support to the Dublin North Inner City Local Drugs Task Force and to the Midland Regional Drugs Task Force.

7.2.2. Mr. D2 said that in general, the Government thinking is that, through Drugs Task Forces, one brings together the relevant different players and agencies to work together to address the problem of drug misuse in their regions. The Task Forces seek to establish the nature and extent of the drugs problem, identify gaps and look to develop better responses to the problem locally with the understanding that their role is not seen as being the panacea to everything concerning drugs in that area. Rather, their job is to look to build on and enhance the existing drugs services in place and lead to a better overall response to the drugs problem.

7.2.3. With regard to commissioning Studies and Research, Mr. D2 explained that the Task Forces have always had flexibility in terms of their proposed actions. Any funding which is provided for Task Force projects by the Department of Community, Rural and Gaeltacht Affairs is subject to formal processes. Funding for this particular study was not being provided by the Department but rather was being funded by funds set aside by the HSE for Task Force business.

7.2.4. Mr. D2 confirmed that Mr. Mr. MHB 1 had his own substantive post in the HSE - there were monies available through the Regional Health Board, €50,000 and this money was not being used to fund the vacant post of Coordinator and was therefore used to fund the study on drug usage in the Midlands.

7.2.5. With regard to the study, Mr. D2’s own sense of this particular study was that the Task Force was at that point
getting off its feet and was very keen that any work which would assist them in its work was welcome. There was an Education Conference held in November 2003 and also a training programme for youth workers dealing with the issue in substance misuse by young people. Mr. D2’s understanding is that while not directly funding these initiatives, the Task Force was very happy to give its blessing to such initiatives in the Midlands which would help focus on the drugs issue and would inform its future work. The first formal record that Mr. D2 had of the study coming to the Plenary Group of the RDTF is 19/02/2004. The minutes of that meeting state that the focus of the study was outlined. Mr. D2’s understanding of the study was that it was developed via the Task Force’s Research sub-group. Mr. D2 was not on this sub-group and would not receive its minutes nor attend the meetings.

7.2.6. Mr. D2 recalled the key meeting was 22nd May 2004. Dr. A and Ms. HSE 5 came to this Task Force meeting and presented the methodology.

7.2.7. With regard to 19th February 2004, Mr. D2 recalled that it would have been Mr. MHB 1 who outlined the focus of the research project to the Task Force. Mr. D2 tabled minutes of the meeting to CD, which proposed that the research be extended to include Portlaoise and that the age profile be extended and that there were additional costs that would have to be discussed with Dr. A.

7.2.8. With regard to the meeting of 20th May 2004, Mr. D2 said that he had handwritten notes of that meeting and that he recalled Dr. A and Ms. HSE 5 coming in. Mr. D2 could not recollect if there was any reference to a study visit to either Amsterdam or Canada.

7.2.9. Mr. D2 was asked if he would have been surprised if as part of that research project in respect of drug use in Athlone and Portlaoise that study trips would involve Amsterdam and Canada. Mr. D2 replied that he was not that “hands on” in terms of the specifics of that study. The Task Force was not funding the project. In the absence of much other available research data on the drugs issue in the area the Task Force was very welcoming that work was going on, and nothing of the bona fides of the study struck Mr. D2 as being inappropriate. It was hoped it would raise the profile of the drugs issue in the Region. This work was to feed into what was coming down the track.
later. If it was approved Task Force funded research now there would have to be by necessity a more formal process involving the Task Force itself and the NDST and it would be assigned a project code. This study did not fit into that category at the time.

7.2.10. CD asked, given that the meeting had taken place on 20th May 2004 and the trip to Amsterdam took place a month later, was Mr. D2 advised by anybody that the study involved foreign trips? Mr. D2 replied that he had no recollection of being told of foreign trips.

7.2.11. Mr. D2 stated that the only information that he received about the incident in Amsterdam in June 2004 was during a phone call that Mr. MHB 1 made to him. He could not recollect the overall context of that call but remembered that Mr. MHB 1 did mention that Dr. A had been arrested in relation to an incident abroad. Mr. D2 stated that he was clear that there was no reference to any assault on a young person or an assault of a sexual nature and his sense of it was that Dr. A had been arrested for public order type offences while being very drunk in his hotel. Mr. D2’s sense of it was that it had all been very embarrassing at the time for Dr. A but that it was over and done with. Mr. D2 stated that he did not have any knowledge that there were charges being pursued against Dr. A or have any knowledge of any outstanding court proceedings. It was Mr. D2’s understanding at the time that it was over and done with. The next group meeting was in September 2004.

7.2.12. Mr. D2 said that he never made any connection in terms of the incident and any issues concerned with the Task Force, including the study that had been discussed at the RDTF meeting at the end of May.

7.2.13. Mr. D2 stated that there did not appear to be any formal minutes available for the meeting of September 2004, possibly due to a lack of administrative support available to Mr. MHB 1 as Interim Co-ordinator during this period. Mr. D2’s records show that there were three plenary group meetings in the latter part of 2004. They were the 23rd September, 26th October and 16th December 2004. There seems to be no formal minutes available from these meetings. Mr. D2 said that he did have a Task Force progress report headed Update May-July 2004. Mr. D2 said that he was working off his own handwritten notes but there appears to have been no reference to the study at all at the September Task Force meeting. Mr. D2 tabled a documents entitled “Regional Drugs Task Force Midlands, update May to June 2004”. Point No. 3 of that update is headed “Heroin Research
Athlone/Portlaoise and it simply states “Pilot Study Complete, interviews underway, draft findings late September 2004. Final draft November 2004. Regional Conference November 2004.”

7.2.14. CD asked if it was fair to say that no reference to the study trip was made at any of the three meetings toward the end of 2004. Mr. D2 agreed but said that he could not be certain as he had only his handwritten notes to work off and they made no record of the study visit being discussed at those meetings. From the 26th October meeting, he had a small note that discussions took place on how best to manage media involvement with regard to the study’s findings.

7.2.15. With regard to the question of whether the disclosure of a recent incident involving Dr. A might have an impact on the report launch, Mr. D2 stated that the only one time he had any knowledge of or any discussion related to this incident was during that phone call with Mr. MHB 1. It was his clear sense that the incident in question was a public order type incident which was over and done with at that time and Mr. D2 was clear that there was no discussion of it either at the task force or at the NDST; it was raised at the Task Force this summer when it arose in the media in July this year. It never arose at previous meetings either formally or informally.

7.2.16. Mr. D2 confirmed that he attended the launch of the study in January 2005.

7.2.17. With regard to a summons being served on Dr. A in December 2005, Mr. D2 said that he could not really comment on whether he was surprised, as he was unaware of how procedures work in such cases as his own work in the Department is not connected in any way with issues of Mutual Assistance.

7.2.18. Mr. D2 confirmed that the first he had learned of the details of the incident involving Dr. A and the subsequent charge and conviction was when he read it in the media in July 2007. Mr. D2 said that he then made the link that this was the Dr. A who had completed the heroin study in the Midlands.

7.2.19. Mr. D2 stated that he did not discuss the matter with Mr. Mr. D1. Mr. D2 said that the Task Force had set up a small sub-group earlier this year (after the media coverage in July 2007) to agree a way of dealing with the many press queries which were being directed at the Task Force concerning this incident. This group consisted of Mr. D1, Mr. D5, Ms. D6 and himself and it
was agreed that it was best that all such queries be dealt with by the HSE media offices.

7.2.20. Mr. D2 stated that he did not discuss his own recollections with Mr. Mr. D1.

7.2.21. CD thanked Mr. D2 for his co-operation in contacting other sections in the Department of Justice, Equality and Law Reform to clarify a number of issues. Mr. D2 also wished it noted that in all his dealings with Mr. MHB 1 in Mr. D2’s role as liaison support to the Task Force, Mr. D2 found Mr. MHB 1 to be a very helpful and honourable person. Mr. D2 wished to emphasise the key role Mr. MHB 1 played in both driving forward and maintaining an impetus to the Task Force’s work during what was often a very difficult period in which to make progress due to a number of protracted problems with which the Task Force had to contend while it was being established.
7.3. **Summary of Interview, Ms. D4, Director of National Drugs Strategy Team, 7th September 2007, Crowne Plaza Hotel, Santry, Dublin**

7.3.1. Ms. D4 stated that she previously worked in the Department of Education and Science. The post of Director of the NDTS was an open competition and interview process and she came on board in July 2003 on secondment with a contract until the end of the NDS in 2008.

7.3.2. CD stated that he was hoping to get an understanding of the relationship between the NDST and the RDTFs, particularly the Midland RDTF. He stated that he was aware that Mr. MHB 1 of the Health Promotion Unit had been requested to temporarily take on the Regional Coordinator post in the Midland Area in addition to his own duties in the HSE. Ms. D4 stated that that was the case in the Midlands but it was also the case nationally. The National Drugs Strategy 2001 provided for the establishment of ten Regional Drugs Task Forces. Local Task Forces had been established in 1997 based initially in those areas of Dublin most affected by opiate misuse followed by Bray and Cork. The establishment process for the ten Regional Drugs Task Forces began during 2002 into 2003 with the first meeting of the Midland RDTF being held in May 2003.

7.3.3. Ms. D4 explained that both the Department of Health and Children and the Department of Community Rural and Gaeltacht Affairs had provided funding for the establishment and operation of the RDTFs. The funding provided initially from the Department of Health and Children in 2002 was in the amount of 50,000 Pounds per area to fund the appointment of Interim Coordinators and that there had been a delay in the appointment of permanent Coordinators because of employment ceilings in the Public Sector. Mr. D2, Department of Justice, Equality and Law Reform’s representative on the NDST was the link between the National Drugs Strategy Team and the Midland Drug Task Force. The Team met the Interim Regional Coordinators six times up to February 2005. They met 2/3 times a year. The priority for the Team was to develop Action Plans for each region.

7.3.4. With regard to the Study undertaken by Dr. A, a decision was endorsed at Regional level in the Midlands to look at the
prevalence of drug usage in Athlone and Portlaoise. The brief was formulated at local level and was not sent for approval or comment at National level. This work was initiated in advance of the RDTF action planning process. Ms. D4 said this was not unusual at the time as there was some flexibility at Regional level. With the development of action plans the Team with the National Advisory Committee on Drugs had provided seminars to support and build capacity of Task Forces with regard to defining and commissioning research. All proposals following approval at Task Force level are now determined at National Team level.

7.3.5. Ms. D4 stated that she recalled some discussion at Regional level in February 2004 in relation to the Study Visit but that she was not involved. She had no role in any amendments or adjustments to the Study proposal from National Level but stated that Mr. D2 was the link. She or the Team had no role in that matter.

7.3.6. Ms. D4 stated that she had no recollection of a conversation with Mr. MHB 1 in the summer of 2004 on the matter of the incident in Holland involving Dr. A in June 2004. Ms. D4 said that there was no indication given to her by Mr. MHB 1 or anybody else in the Task Force that Dr. A was involved in an incident in June 2004.

7.3.7. CD indicated to Ms. D4 that Mr. MHB 1 had said that he was notified of the incident on the 23rd June 2004 and by Tuesday 29th June he had contacted a number of people and included on the list was Ms. D4. CD stated that Mr. MHB 1 had said that he had spoken to Ms. D4 about what had taken place and that she had said she would speak to Supt. D3 and suggest that Mr. D2 should also be informed. Ms. D4 stated that she checked with Mr. D7, then chairperson of the Team, and Supt. D3, now the current interim chair and then a Team member, both of whom confirmed that there was no contact from her. Dr. MHB 2 and Mr. D2 were also contacted by her this summer and neither had any recall either. Dr. MHB 2 was the HSE representative on the Team at that time.

7.3.8. Ms. D4 stated that she first learned of the incident when she saw it in the papers in July 2007 and she recognised the name. She then rang the co-ordinator of Midland Region and asked her to put together anything she could find as Ms. D4 knew there would be some follow-up on this.

7.3.9. Ms. D4 confirmed that the Study itself was not sent back to the National Team for perusal before it was launched. She said that if a Research Project came up now it would be very
different. Ms. D4 said that there was nothing unusual in trying to identify the prevalence of drugs. She and other members of the Team attended the launch of the Study in January 2005.

7.3.10. Ms. D4 was asked if she recalled there being any reservations about the merit of the Study outcome at the time and she said that she could not recall any public reservations and the findings were not discussed by the Team. By the beginning of 2005 the Task Force action planning process was underway.

7.3.11. Ms. D4 mentioned that the Department of Community, Rural and Gaeltacht Affairs’ €50,000 Euro in 2004 was to support the initial establishment of the Task Forces. No money was drawn down by the Midland RDTF in 2005. Her understanding was that the study was funded using the DH&C/HSE funding.
7.4. Interview summary, Superintendent D3, Acting Chair of the National Drugs Strategy Team (NDST), 19 September 2007, Dublin

7.4.1. To put the interview in context, Superintendent D3 was informed that Mr. MHB 1 had had a recollection that after Dr. A said that he was in an incident in Amsterdam in June 2004, that he had contacted Superintendent D3 by telephone. An excerpt from Mr. MHB 1's statement on record was read to Superintendent D3.

7.4.2. Superintendent D3 was asked if he recalled the phone call and he answered that he did and that Mr. MHB 1's primary concern was in relation to Detective Sergeant GS1 arising from the incident. Although as Detective Sergeant GS1 had not acted in or had any involvement in the incident, Superintendent D3 did not see how he should have been affected.

7.4.3. Superintendent D3 stated that he was aware of the incident via the report which issued from the Garda Liaison Officer in Holland. The liaison officer in Holland reported the incident back through the authorities and the unit received a copy of that report.

7.4.4. Superintendent D3 was asked whether there had been an issue regarding advising other members of the team on the substance of the reports and he replied that he wouldn't have had any cause to raise the issue with the NDST.

7.4.5. Superintendent D3 said that he could not recall what he would have said to Mr. MHB 1. The Dutch authorities would have investigated the allegations. He couldn't have said much more, not knowing the substantive nature of what had happened. His recollection was the report from the Liaison Officer in Holland was 1.5 typewritten pages.

7.4.6. Superintendent D3 was asked whether, given the ages of the girls concerned, if the report would have gone to any child protection Gardai. Superintendent D3 answered that he did not know if the age of the girls was specified on the report.

7.4.7. Superintendent D3 could not recall how his conversation with Mr. MHB 1 ended but recalled that he perceived that the important thing for Mr. MHB 1 was the issue in relation to
Detective Sergeant GS1. Superintendent D3 said that Mr. MHB 1 did not raise the issue with him again. At that time Mr. MHB 1 was Acting Regional Coordinator and met with all the team coordinators every 2-3 months.

7.4.8. Superintendent D3 stated that it had never been indicated to him that there had been a conviction in this matter and he did not know until he read it in the media.

7.4.9. Superintendent D3 was asked whether, from a National perspective, would it have been unusual that a Regional Drugs Task Force would go ahead with a research study. Superintendent D3 answered that, to his recollection, this particular study would have been the only research proposal. Involvement would depend on where the funding was coming from. If funding wasn't drawn from the NDTF funding, he wouldn't see it as unusual.
8. Interviews with Institutes of Technology

8.1. Summary of Interview, Professor WIT 1, Director, and Mr. WIT 2, Registrar, Waterford Institute of Technology, 20th September 2007, Santry, Dublin

8.1.1. CD explained that the decision to invite Waterford Institute of Technology for interview was taken because it had been brought to his attention that the HSE, former Health Board, had been in contact with Dr. A while he was in Waterford. The focus would be in relation to paper work which was provided by WIT and in particular, would be in respect of the knowledge of WIT and correspondence between Mr. WIT 2 and Dr. A in 1998, as well as documentation exchanged between the South Eastern Health Board and Dr. A in late 1998/early 1999.

8.1.2. CD stated that the only reference that was made to WIT was that correspondence with the Health Services existed was in Dr. A’s letter to Mr. WIT 3, 24 November 1999, by which time WIT’s own investigations had been completed including instructions to Dr. A. In Dr. A’s letter he refers to the leaking of information. That is the only reference that WIT has to there being any correspondence with the HSE. WIT did not know what the correspondence was and they had no sight or knowledge of it.

8.1.3. CD explained that what Dr. A is suggesting in this letter is that this was a breach of confidence by a staff member in WIT. The question Dr. A asks is did they get permission to send this letter from the supervisors. CD said that his understanding is that it was a student that made this complaint but it would not have been known to WIT at the time.

8.1.4. Mr. WIT 2 explained that what was told to them was by a colleague of Dr. A and they were clearly concerned at reports that their students were upset by being shown inappropriate slides. There was also the question of the alleged use of hidden cameras to film students’ reactions and they launched a very detailed investigation into the matter. It was alleged that the slides were pornographic and this came from a very reliable source. It transpired that Dr. A received those slides via a very experienced Medical Practitioner, an Accident and Emergency Consultant in Waterford Regional Hospital. The Hospital Consultant was very familiar to WIT and was very reassuring at the time that the slides were legitimate and that they were provided for the purpose of training doctors. They were
legitimate slides, not pornographic, and they came from a legitimate source. It was clear following the investigation that it was unnecessary to use the slides for that course. Mr. WIT 2 said that he was receiving a number of telephone conversations from staff and external people in Social Care stating that it was necessary to use the slides. It was an Academic issue. The debate was intensely discussed. Ultimately he was the decision maker. It was clear to him at the time that if the slides were primarily designed for the training of doctors one could argue that the people providing the training should be medically qualified. Mr. WIT 2 established that on balance the course could be done without the use of the slides. Mr. WIT 2 said that in meeting with Dr. A and on the records of the meetings, students were informed that the slides were to be shown and that they might be upset and they were given the opportunity not to attend the class. The issue of the hidden camera and the Technology Technician being told to video students reactions was also investigated. It is understood that the technology technician was asked for advice on suitable recording equipment to be set up in the classroom but that there was no suggestion that this equipment should be hidden. The use of inappropriate slides and also the suggestion that Dr. A was setting up a process without the students’ knowledge was not true.

8.1.5. Mr. WIT 2 said that he could find nothing to substantiate the allegation that students viewing those slides were told not to discuss them with anybody outside of the college and to sign confidentiality agreements. Mr. WIT 2 said that he couldn’t say that that was not said but that in his discussion with Dr. A and others, he could find no evidence that this had happened.

8.1.6. Professor WIT 1 stated that it would not be unusual for students to be encouraged not to have discussions outside their own domain where there might be a danger of prurience. It would apply in the School of Nursing for example. Professor WIT 1 said that in his role as Director, he would be uncomfortable if he was not put on notice in relation to the type of correspondence issued by the SEHB in late 1998 and if this situation were to happen again, in principle he felt it would be common professional practice to have correspondence on important matters such as this on a Chief Executive to Chief Executive level. He would prefer to work through the Authorities. WIT have no evidence on file that that happened. CD said that he would have to ask why the option taken was to discuss this with Dr. A and not with WIT.
8.1.7. CD clarified that he had been advised that the issue was raised by a student but he has to establish that. If it was a case that something was put in writing by an individual that WIT has a duty of care to, accordingly it would be appropriate that a copy would be sent to WIT. Professor WIT 1 said that the correspondence was opened at the wrong level. CD stated that he understood that this correspondence was issued just as Mr. WIT 2 was finalising his report at the end of 1999.

8.1.8. Mr. WIT 2 was asked in respect of the 24th November 1999 letter from Dr. A to Mr. WIT 3, were any instructions given to Dr. A on his use of slides? Mr. WIT 2 stated that subsequent to finalising his report, there was quite an amount of correspondence which came after the event claiming that these slides must be used after it was decided that they would not be used. There were issues that were entirely a matter of academic opinion.

8.1.9. In relation to the receipt of unsolicited communications from former staff of WIT, the question put to WIT was at the level of Dr. A and his post, what would be best practice in WIT at the time in relation to references being sought? Mr. WIT 2 answered by stating that in the issuing of a reference one would normally go to staff member’s immediate supervisor. They had looked carefully at Dr. A’s file in relation to the latest incident. There is nothing in his file in relation to his performance. There would be no reason why he would not get a normal reference. There would be arguments at times, they erupt from time to time and they did in this case and everything then seemed fine. This would often have to do with controversy in the national scenario where he would not be qualified to give an opinion. There was nothing on his file. They looked at Dr. A’s progress, he was a young ambitious professional coming into Social Care in Waterford and he would say in fairness to Dr. A, he was the engineer for growth. Dr. A was a bit of a dynamo. When he came WIT were taking in thirty students. By the time he was finished WIT would be taking in between 80/100 and Dr. A deserves credit for that.

8.1.10. Mr. WIT 2 stated that Dr. A had brought the course up to level 8. Mr. WIT 2 stated “Whenever anybody is leading from the front you will get some reaction. He was promoted to lecturer 2 as part of regrading in 1998. He went for a vacant Head of Department post and was not successful. Just to say looking at his contribution and his career with them there was nothing; one could not predict what happened subsequently. The issue of a reference from Dr. WIT 4, there was nothing
unusual in this. References are given by individuals and not by the Institute. There was no reason why a perfectly normal reference would not be given." and said “He was at the centre of the establishment of the Social Care Field. The nature of the research in the areas he was researching sometimes gives rise to unhappy stories. We had no concerns about this. We had to support him. He led research projects in that area within the Institute itself. We were trying to become a research led Institute.”

8.1.11. CD enquired about the protocol of interview boards when one finds oneself as an external interviewer interviewing individuals from one's own college. Professor WIT 1 answered that he did not believe there was anything as formal as a protocol in the composition of an interview board and that the members are experienced professionals. If the shortlist was drawn and as the interview board was being composed, in his opinion one is then asked if one is comfortable to interview someone from one's own organisation. Sometimes the answer is yes and sometimes the answer is no. It is a matter for the board to take a vote or partake in the interview at all. It arises as well that somebody nominates a referee and then one finds that one is the referee for this person. In relation to appointments, there are clearly defined selection board procedures which determine the composition of selection boards. One then sets out to make it a strategy. Sometimes it is very difficult to secure an interview board and it may be impossible to get one's first choice for an interview board. Professor WIT 1 said that in this case it would be absolutely outrageous to suggest that it was to assist Dr. A in this post. If anything the fact that he did not get a post similar in Waterford would have put Dr. A at a disadvantage if an interviewer was on the board from WIT. Mr. WIT 2 agreed with this. He added that there was a suggestion that someone senior was on the board for Dr. A because that person had been involved in the process regarding the slides and hidden cameras and that they had checked and this person was not on the board.

8.1.12. Professor WIT 1 said that WIT had a duty of care towards all concerned and it would be totally unprofessional and it would have put the Institute in enormous peril to have denied Dr. A a good reference without grounds for doing so. He could then pursue the Institute in litigation.

8.1.13. Professor WIT 1 said that there was no connection between what Dr. A was doing in his teaching to suggest that Child Protection concerns were involved. It was viewed at the time as an academic matter. The Registrar ultimately asked
whether this course could be taught without slides and the answer was yes. Dr. A used slides but ceased to do so because confidence had been lost in the method. Once it was established that this module of the course could be done without the slides then this was what was advocated.

8.1.14. Mr. WIT 2 stated that there was a letter in 1999 from a Social Care professional who felt it was necessary to use the slides. Around this time the Head of School of Humanities Dr. WIT 4 asked the Head of Department Dr. WIT 5 to convene a meeting of the Board for the Social Care Course to discuss the slides without Dr. A being present. In spite of all that the instruction stuck. It was as controversial not to use them as it was to use them. Mr. WIT 2 said that Dr. A was trying to prepare young people for the future and he suspected nothing else.

8.1.15. CD thanked WIT for the documentation made available dating back some 8/9 years.
8.2. **Summary of Interview with, Professor AIT 1, 7th September 2007, Crown Plaza Hotel, Santry, Dublin, accompanied by Mr. AIT 2, College Secretary, Athlone Institute of Technology**

8.2.1. CD placed on the record his gratitude to Professor AIT 1 and to AIT for providing him with documentation relevant to AIT’s knowledge of the situation regarding Dr. A and the steps taken by AIT and to Professor AIT 1 personally for his cooperation. It was explained that the purpose of the meeting was to establish for the record the extent of Professor AIT 1’s knowledge of any matters relating to Dr. A and any issues related to Children and Young Persons, issues in respect of the Study undertaken by Dr. A in consultation with the RDTF and also any other matters to his knowledge which were raised by the HSE or with the HSE in his area in relation to the protection of young persons.

8.2.2. Professor AIT 1 acknowledged that it was 3rd July 2007 at 5:00 pm that AIT first had knowledge from a corporate point of view of an incident involving Dr. A in 2004. That was by Dr. A who was accompanied by Mr. AIT 3, Head of the School of Business.

8.2.3. Professor AIT 1 stated that Dr. A gave an overview of the issues in Amsterdam in 2004 and advised him that he had two convictions in 2005. Dr. A gave scant details in relation to the nature of the charges. Professor AIT 1 formed the view that the convictions against Dr. A were quite serious.

8.2.4. Professor AIT 1 said that Dr. A gave him a preliminary outline and Professor AIT 1 said it raised serious issues for Dr. A. It was suggested to Dr. A that he contact his legal team and furnish AIT with details of the charges. They gave AIT’s legal team an overview of the charges, they did not provide AIT with details of the charges; those came through another source. Professor AIT 1 said that what they were told by Dr. A’s legal team was sufficient to know that Dr. A’s employment in the college was untenable. Dr. A could go two routes – he could tender his resignation or Professor AIT 1 would call a meeting to suspend him. Dr. A indicated on Thursday 5th July that he had tendered his resignation and AIT received it on Friday 6th July, 2007.

8.2.5. Professor AIT 1 said that no contact was made by the HSE to AIT when matters became public in the media or since,
either formally or informally. He only received an email with the terms of reference for the Review Inquiry.

8.2.6. Professor AIT 1 stated that he had spoken with Supt. GS2 when it broke in the Press. Supt. GS2 said he had not contacted the Institute formally or informally. Superintendent GS2 did inform AIT that Detective Sergeant GS1, who was with Dr. A, had informed the HSE in relation to the charges. Since then they have made contact with Professor AIT 1 and he has given them information in respect of a separate investigation underway by the Gardai.

8.2.7. In answer to a direct question, Professor AIT 1 said that he had encountered a situation once before in his career where a staff member had been convicted of a criminal offence while he held a position in Northern Ireland. In that case the employee did not disclose the offence; it subsequently emerged from the police screening and the individual was dismissed for failing to disclose. In his seven years at AIT it was the first time that any of his staff had a criminal conviction.

8.2.8. Professor AIT 1 confirmed that given the Ministerial launch of the Drugs Study, at no point did the RDTF indicate that maybe there was a potential issue in respect of Dr. A and the Study.

8.2.9. Professor AIT 1 stated that the motivation behind the establishment of the Centre for Child and Youth Care Learning was that they wanted to establish more of a profile for research in the School and the post was advertised as an SL1. Dr. A applied and was successful for the position. He had applied from his post as Head of Humanities (an SC2 position). Professor AIT 1 said it would not be unusual for someone to apply for a more junior position. He said that Dr. A had an appetite for research and he felt the SL1 would be more advantageous to him in raising the profile in the School. There would be very little difference in salary between the SL1 post and the SL2 post. The date for the establishment of the Centre was November 2003.

8.2.10. Professor AIT 1 said that the study commissioned by the Midland Region and funded by the HSE was the first study undertaken and said that Dr. A had a number of publications including “Where have all the Young Men Gone” which was a Gender Study, and then the Heroin Study in April 2004.

8.2.11. With regard to the screening of study proposals, Professor AIT 1 stated that they understood that the proposals
would have gone through the HSE. It would be same with all submissions for funding.

8.2.12. When asked if the Institute would be aware that Dr. A was going abroad as part of the Study, he answered that everything is handled in their Accounts Office, they would be aware of it, everything must be outlined. Certain criteria would have to be included and some excluded from the funding. On that particular trip to Amsterdam Dr. A made no claim for expenses. Professor AIT 1 confirmed that all three visits, Glasgow, Amsterdam and Canada were in the proposals.

8.2.13. Professor AIT 1 said in relation to Ms. MHB 5’s presence on the team doing the research that she was quite a recent graduate but that was not unusual.

8.2.14. CD raised the matter of there being significant issues arising from Dr. A’s time in WIT, one of which was raised directly with the HSE in Waterford when Dr. A was a member of staff in relation to his teaching practices. Professor AIT 1 was asked if he was made aware at any time of any concerns about Dr. A’s service in Waterford. Professor AIT 1 answered that Dr. A had outstanding references from Waterford prior to taking up employment in 2001. References from the Head of Schools would normally come through Head of Schools. He had two outstanding references at that time.

8.2.15. Professor AIT 1 confirmed that he would have met Mr. MHB 1 on a number of occasions. The first time was at the launching of the book emerging from Dr. A's study. He had also met Mr. MHB 1 as part as their Healthy Campus Campaign in Mr. MHB 1’s Health Promotion role. Professor AIT 1 said that Mr. MHB 1 never raised any issues formally or informally involving Dr. A. Professor AIT 1 said that it was Mr. MHB 1 that was there the morning of the launch of the study. The Midland Health Board had done all the press releases for that event.

8.2.16. Professor AIT 1 said that there was some reaction to the drug study research from the communities in Athlone, that some of the data could not be stood over. There was some suggestion they did not want to acknowledge that there was a problem in relation to Heroin use. There was no comment in the AIT other than some concern about the spotlight being shone on Athlone in respect of the drugs issue. AIT said you cannot bury your head in the sand, if there is a problem it must be dealt with.
9. Interviews with Members of An Garda Síochána


9.1.1. Inspector GS1 confirmed that Mr. MHB 1 had approached him regarding going on a study visit. Inspector GS1 knew Mr. MHB 1 through the RDTF and the Longford/Westmeath Group. Both agencies were brought together to meet with schools, parent groups, etc.

9.1.2. Inspector GS1 stated that prior to the study visit, Dr. A and Ms. MHB 5 had interviewed him in relation to this study because of his involvement in dealing with drug abusers, and Dr. A had been present at other multi-agency meetings.

9.1.3. Inspector GS1 confirmed that his only involvement in the Dutch incident in June 2004 involving Dr. A was that he sought the assistance of the Dutch police on the night. He recalled that Dr. A was still in custody when Inspector GS1 left the country. A Dutch police officer, NL 1, was under the impression that Dr. A could be detained for a long period. Inspector GS1 said that he spoke to the Dutch police and was told that Dr. A was to appear before a magistrate on the following day. NL 1 had explained that in Dutch law, Dr. A could be kept for a long time in view of the charges, that they were a group of teenagers, average age of 17. Inspector GS1 did not get an opportunity to speak to Dr. A before he left and he did not get a lot of information from the Dutch police.

9.1.4. Inspector GS1 stated that he did not get any understanding that any of the girls might be under age from an Irish Law point of view.

9.1.5. Inspector GS1 was asked to outline when Detective Sergeant GS 4 (Irish Embassy in The Hague) became involved. Inspector GS1 stated that it was quite traumatic. He rang Detective Sergeant GS4 early that morning. He had met him previously regarding the comparative study. He asked Detective Sergeant GS4 to assist them because Detective Sergeant GS4 had organised things from the Irish end re liaising with groups in Holland. Detective Sergeant GS4 was the first person he rang. It was between 4:00 and 4:30 am. Detective Sergeant GS4 was up early and made calls again to his own parties. He then met Detective Sergeant GS4 at the Maarlingstraat Police Station in Amsterdam. Inspector GS1 said that he gave Detective Sergeant GS 4 a brief outline of what had
happened on the phone. Appointments had to be cancelled which had been organised for the study.

9.1.6. Inspector GS1 stated that he rang Mr. MHB 1 because he understood that there were Health Service people to be notified and Mr. MHB 1 had to be notified as well as Inspector GS1’s own parties. Inspector GS1 rang Mr. MHB 1 that morning from the car when he was driving from the Amsterdam police station to The Hague with Detective Sergeant GS4. Inspector GS1 said he would have told Mr. MHB 1 that Dr. A was arrested and detained. Inspector GS1 was with his own liaison staff. Inspector GS1 told Mr. MHB 1 of the reason for the arrest, the rest was conjecture.

9.1.7. CD asked Inspector GS1 whether from that point would Mr. MHB 1 have been aware that it involved a young person. Inspector GS1 answered that Mr. MHB 1 would have known that they were American students but he himself did not have proper ages, only the ages that the Dutch Police Officer, NL1, had given him.

9.1.8. Inspector GS1 said that he notified his Chief and Superintendent and Headquarters at that time. Inspector GS1 confirmed that liaison protection was Detective Sergeant GS 4’s area of responsibility.

9.1.9. Inspector GS1 stated that notifications from the Embassy were both in writing and by fax. He said that he was not given a lot of detail from the Dutch police. Inspector GS1 said that he returned to Ireland on the earliest available flight.

9.1.10. Inspector GS1 recollected that he met Mr. MHB 1 over lunch on 1st July and discussed what had occurred. Inspector GS1 said that the quality of his information was the same as when he left Holland. Inspector GS1 confirmed that he did not have any further meetings with Mr. MHB 1 but that they might have chatted on the phone about reimbursement of expenses.

9.1.11. Inspector GS1 said that he would have encountered Mr. MHB 1 two other times after the Holland incident, in their respective roles in Athlone and in the RDTF. Inspector GS1 said that he had a very small role in the RDTF and that was on a sub-committee. The only recollection he had of meeting Mr. MHB 1 again formally was in the Athlone Institute of Technology at the end of summer 2004. After that Inspector GS1 met Mr. MHB 1 at the formal launch of the book which was the outcome of the comparative study.

9.1.12. CD told Inspector GS1 that Mr. MHB 1 had recollected at the 1 July 2004 meeting that Inspector GS1 had outlined to Mr. MHB 1
the circumstances surrounding the Dutch incident as follows. CD’s understanding of Mr. MHB 1’s account was that Inspector GS1 and Dr. A had returned to the hotel, that Dr. A was intoxicated and Inspector GS1 thought that Dr. A had gone to his room. Then Inspector GS1 was awoken by a call from the police in reception. The police were professional and shared limited information. There was damage to the hotel room and that Mr. MHB 1 and Inspector GS1 had a discussion on what might happen. That Inspector GS1 was concerned that there might be some inappropriate speculation about himself because he was on the trip.

9.1.13. At that lunchtime meeting Mr. MHB 1 told Inspector GS1 that Dr. A was at home at that stage and his family were supporting him and Inspector GS1 inquired into Dr. A’s welfare. Inspector GS1 said that he was under the impression that Dr. A was getting support both from his family and professionally at that point.

9.1.14. Inspector GS1 was asked by CD whether hard or soft information had come to him at that point in respect of the Dutch incident indicating that a young person was involved. Inspector GS1 answered that it was limited information. He was not sure whether they were going to proceed, it was a different jurisdiction, and there was a lack of information in relation to the specifics of the charges. Dr. A had not been charged at the time but the Dutch authorities had powers to detain him. Inspector GS1 said that he had given formal notification to the person most appropriate in the Health Board. Then Dr. A was at home and Inspector GS1 did not know where the case was going. Inspector GS1 said that he never knew anything again in relation to the incident.

9.1.15. Inspector GS1 stated that it was when the issue broke in the summer of 2007 that it first came to his attention that one of the young girls was 15 years of age.

9.1.16. Inspector GS1 stated that, apart from the report that went from the Embassy which he followed up with his own Superintendent when he returned to Ireland, at no point did anyone in a State Authority, whether in the Gardai, the Department of Health and Children, the HSE, the DPP or the Department of Law Reform contact him before the issue came to light.

9.1.17. Inspector GS1 stated that he had no recollection of Mr. MHB 1 sharing the information with him that the age of one of the girls was 15. Inspector GS1 said that if he had known he would have brought it to his own Superintendent’s attention. Under the Children First Policy, because they had no hard information it would be important to liaise with Garda Liaison Officer GS4 and get some
information from the Dutch Authorities which seemed to be difficult enough.

9.1.18. Inspector GS1 confirmed that he had made a formal statement and was not called to attend the trial in Holland in 2005.

9.1.19. Inspector GS1 said that he was “gobsmacked” when he learned of Dr. A’s conviction through the media and that it was a shock to have learned that one of the girls was underage. Inspector GS1 agreed that in his own job he would have had to report such matters to the HSE.

9.1.20. Inspector GS1 said that Dr. A might have sent him a text message apologising for his behaviour, but nothing else.

9.1.21. Inspector GS1 stated that he saw Dr. A at the January 2005 book launch but did not speak. Dr. A was at the top table with the media, multi-agency representatives, Ms. MHB 5 and Mr. MHB 1.

9.2. Interview Summary, Superintendent GS2, 28TH September 2007, Crown Plaza Hotel, Santry, Dublin

9.2.1. Superintendent GS2 confirmed that he is a Superintendent since 2005 for the Athlone District.

9.2.2. Superintendent GS2 was asked when it first came to his attention that there was an incident involving Dr. A. Superintendent GS2 responded by stating that prior to his promotion in July/August 2005 to Superintendent in Athlone, he was Inspector attached to the Regional Commissioner Office in Mullingar. It would have been brought to his attention in that role and although he did not know the exact date, he assumed it would be July/August 2004. Superintendent GS2 said that an initial report would have been sent through the Garda channels to Mullingar and then sent to the Regional Commissioner GS5. Superintendent GS2 was his administrator. To the best of his recollection the Chief Superintendent would have written back to Mullingar seeking a further report from Detective Sergeant GS1 on his return to work. It would have been shortly after the event in Amsterdam.

9.2.3. Superintendent GS2 was asked if there was any emphasis on the profile of the individuals making the complaint, particularly in relation to age and he responded “no”.

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Superintendent GS2 said that the report from the Liaison Office in The Hague made only a reference to the victims as being in a party of female American students.

9.2.4. CD stated that he would be aware from other inquiries he has conducted in the Health Service in child protection matters of the Garda system of notifying the Health Services of complaints of child abuse and would be aware that the Garda approach in this area is exemplary, particularly where there may not be the immediate possibility of processing a prosecution. Superintendent GS2 concurred with this and stated that the protocols and guidelines are set down. Even from the most innocuous situations they are passed to the Health Service Executive.

9.2.5. Superintendent GS2 was asked if in this situation would it be fair to say that if the age of the victim was made known it would automatically trigger the process and he answered “that would be true to say, in this jurisdiction”.

9.2.6. Superintendent GS2 said that he was not aware when the Garda Authorities became aware that one of the victims was a below age young person. Superintendent GS2 said he would be aware that the average age was 17 years of age but he has not received any notification from the Dutch Authorities to date regarding the age of the complainants involving Dr. A. It would have been this Summer when Superintendent GS2 became aware of the age issue and the fact that a conviction had been secured against Dr. A.

9.2.7. CD stated that he has a translation of the judgement and an accompanying note which clearly state that one of the young people was 15 years of age. CD said that he understood that in Holland the prosecution system is somewhat different and he was unclear as to what detail would have been forwarded by the Dutch authorities. It is the case however that in the reports from the Garda relating to the incidents, firstly Garda GS4’s report in The Hague and subsequently the two reports Sgt. GS1 delivered when he returned, the same formula of words would be used, “the Touring Party had an average age of 17”. Superintendent GS2 said that the reference to average age could have referred to the Touring Party or to the three that complained.

9.2.8. With regard to whether on the information available at that stage in 2004, a notification should have been made to the appropriate Health Service Authorities, Superintendent GS2 was asked if in his own examination of all the matters surrounding this, he had come across a formal notification to the HSE at any
time and whether there is a formal notification form to be used in such circumstances. Superintendent GS2 answered by stating firstly that in the summer of 2004 he was not attached to Athlone. Secondly, whatever may have happened was outside of the jurisdiction and thirdly, the age issue was not obvious from the official documentation. Superintendent GS2 was aware that at the time from Sgt. GS1’s report of 2004 that he had communication from and to Mr. MHB 1 of the HSE. That would be the only information that Superintendent GS2 would have had; he has found nothing else.

9.2.9. Superintendent GS2 stated that he had no knowledge of whether Gardai in Athlone were advised when a summons was issued to Dr. A in early September 2005 to attend for trial in Holland, and he had found nothing to support that. He stated that in the normal run of events it would only be made known to the person involved by the local Garda station, in this case the Athenry Station.

9.2.10. CD stated that it had been confirmed to him by the Department of Justice and Law Reform that a file had been issued to that Department in 2004 and an opportunity had been given to the Irish Authorities to prosecute Dr. A. Superintendent GS2 stated that he was unaware if any detail of that file had been made available to the Gardai in Athlone. He could find no record of such files in Athlone.

9.2.11. Superintendent GS2 was asked if, on the basis of the information known at the time, it would have been appropriate to interview Dr. A on his return from Holland in relation to Sgt GS4’s report alleging that there was a case against Dr. A and where prosecution was being considered. Superintendent GS2 answered that in the normal course of events, if cases relate to other jurisdiction the protocol would be that the Gardai would respond to a request coming from that jurisdiction. He could find no evidence of any request in that period in relation to interviewing Dr. A. Dr. A’s permanent address at the time was Galway. That would be the Galway West Division of the Gardai and Superintendent GS2 speculated that it might have been that a request was made through that Division.

9.2.12. With regard to actions taken between the Gardai and the HSE on receipt of “soft information” in respect of matters relating to the physical and sexual abuse of young persons, Superintendent GS2, in response to a question, agreed that he would view it as appropriate that information is provided to employers to put them on notice of a potential risk arising from such soft information. Superintendent GS2 stated that he saw
this as the responsibility of the Statutory Body, i.e. the HSE, rather than the Gardai. Superintendent GS2 said the function of the Gardai is investigative with a view to prosecution. The notification to other third parties is always done by the HSE because Child Protection issues are the responsibility of the HSE. Superintendent GS2 agreed that there might be situations that arise where the HSE might have some knowledge of the soft information but that information may not be notified to the Gardai.

9.2.13. CD asked Superintendent GS2 if it would be fair to say that if the reports from Holland had indicated that the age of the youngest girl was 15 years of age, a different response would have been triggered? Superintendent GS2 responded that it was a difficult question to answer. CD elaborated by saying that in his experience, when young persons are at risk and something is being perpetrated against a young person, the Gardai would promptly put in motion the appropriate procedures and CD’s assumption is that a formal notification would be made to the HSE and of course it is then a matter for the HSE to carry out a risk assessment and it is then a case for the Gardai to investigate. This assumption is based on what would happen if it was clear that a young person was at risk and other young persons were potentially at risk. Superintendent GS2 stated that age would certainly be a strong factor in making a decision in that realm. Considering the statutes that exist, Superintendent GS2 thought that would make it a much more black and white issue.
9.2.14. With regard to the issue of Garda clearance for nationals and non nationals going abroad and coming back into the system, Superintendent GS2 stated that background information is handled centrally through the Garda Vetting Unit in Thurles. Superintendent GS2's own experience in this area would be in relation to visas and related matters. The Pulse system would be used for character references etc which is done centrally.

9.2.15. Superintendent GS2 stated that he was unaware if the Gardai were notified by any Authority when Dr. A was convicted in 2005. CD suggested that it had to be a concern from the a mutual assistance point of view, that he as Senior Garda with responsibility for a particular area, would be advised of a child protection matter in respect of someone located in his area. Superintendent GS2 concurred and said that it could have a great deal of connotations for others if one was not made aware of the issue.

9.2.16. Superintendent GS2 stated that in his time in the Region both in Mullingar and in Athlone, he had encountered only one case of a conviction from outside of the jurisdiction. It was in relation to a sex offence where they were obliged to pass on that information. Superintendent GS2 was not aware of other situations where people were convicted elsewhere and information was passed on in any formal basis. Superintendent GS2 stated that if anybody is convicted outside of the State, it certainly would be of benefit to all to be made aware of that.
10. Interviews with Dr. and Mrs. A

10.1. Summary of Interview, Dr. A, 19th September 2007, Dublin, accompanied by Crowley Millar Solicitors

10.1.1. CD clarified that this inquiry is not into Dr. A's actions but into the HSE's reaction, action or inaction relating to the issues that have arisen.

10.1.2. CD explained that the first issue to be looked at related to WIT and the reason that WIT came into the picture and into his Terms of Reference was that he became aware while constructing the file that there was an item of correspondence from Mr. SEHB 2, who was at the time coordinator of the Child Care Services in the South Eastern Health Board. It raised the question if there was any contact from the SEHB or the HSE with WIT in relation to the slides used in 1996. With regard to the letter that Mr. SEHB 2 wrote to Dr. A in 1998, Dr. A was asked how he perceived that letter which was raising questions regarding his teaching practices and how he characterised that correspondence. Dr. A responded by saying that he did not have that particular letter and stated “Before I answer that I want to say I deeply regret the incident in Amsterdam. Before that I had many years of good service; I am sorry for the hassle it has caused my wife and family. Just to go back to the correspondence, the context is very important. I took it as from one colleague to another. You referred to them as Slides, I would prefer to refer to them as an educational package which was developed by a reputable source - Gower Medical Educational. The Slides were purchased by the college out of a discretionary fund in the college. It was not as if I just downloaded them.

In May 1998 I met informally with the Registrar, Mr. MHB 2, where he raised the issue of the Slides. I had ceased using the slides and subsequently informally agreed not to use them in the future.

I telephoned Mr. SEHB 2 and he was happy with the matter. His response was that he was more than happy with the matter and clarified it. It is now nine years ago. I understood that the matter was clarified in Mr. SEHB 2's letter to me in February 1999. In the supporting documentation which I have given you
I have copies of emails etc. I kept the School of Humanities in the information loop.”

10.1.3. Dr. A said that the Registrar has never given him any final report on the conclusion of his inquiry. The first communication was in 1998 and there was no other formal communication. Dr. A said that a report was furnished at the time (26 February 1999) to the college which he did not get a copy of and Dr. A understood that Dr. AIT 4 (Head of Department) did not get a copy either. Dr. A stated that in June 1999 all lecturers supported the use of the package. He did not get any formal communication from WIT on the “gentleman’s chat” with the Registrar, Mr. MHB 2. Dr. A said that he was sorry now that he did not demand a written communication as if he had this he could have gone to the TUI. Mr. MHB 2 has said that Dr. A had done nothing wrong but would he mind not using the material and Dr. A agreed. Dr. A said that it was highly unusual that he did not receive a copy of the report.

10.1.4. Dr. A referred to support for the use of the slides being given by the Director of Services, St. Patrick’s Centre Kilkenny. Dr. A said that he met all of the ethical guidelines and the Director of Services fully endorsed the use of the educational package. Dr. A claimed that this was at odds with Mr. SEHB 2’s (Regional Child Protection SEHB) letter. CD responded that in Mr. SEHB 2’s letter there were two concerns; one of those was the issue in relation to the establishing of a confidentiality clause for students.

10.1.5. With regard to the confidentiality clause, Dr. A stated that that came from a Course Board Meeting in 1994. Some students had problems and at the same time he was involved in a voluntary help line where students who had difficulties could get advice re depression and suicide and one morning he heard three students discussing an issue that had come in through the phone line. It was decided that students would not discuss any matters arising from the lectures including any issues raised by individual students with any other students outside of the Faculty. Only the evening students were asked to sign anything. All students were given the opportunity not to be present or to leave the room at any time if they so wished and all students were offered the services of two female lecturers if they wished to speak with them. That was in keeping with National Guidelines.

10.1.6. In response to a direct question, Dr. A agreed that there would be some differences between proponents of the medical and social care models of approach at the time. Dr. A stated that
he was starting to specialise in Social Care in North America and he brought this to Ireland in his work. Dr. A stated that he agreed for harmonious reasons with WIT, not on educational Practice grounds, to discontinue using the slides. He had the agreement of the hierarchy of the Board, of professional advisors to the SEHB and many others. He (formally) stopped using the Slides after the first meeting with MHB 2 in 1998. Dr. A stated that he had not been using the material for eighteen months before that.

10.1.7. CD referred to Dr. A’s letter to Mr. SEHB 2 wherein he took issue with Mr. SEHB 2 writing to him rather than informally contacting him. Dr. A also took on board matters of insensitivity and pointed out that he had not used the slide material in two years. The additional point was made that he was looking for support from Child Care professionals. Dr. A interjected that he had invited the Health Board to become more involved in the Social Care course.

10.1.8. CD stated that it was Mr. SEHB 2's view that given that the students themselves would never be required to take any physical examination of the children he did not see it was appropriate to show physical effects of child sexual abuse at all. Mr. SEHB 2 also took the view that any such medical educational material should be supervised by a Medical Practitioner. Dr. A answered that that was Mr. SEHB 2's opinion and crucially, the package was bought by School Management and given to Dr. A by a colleague. Dr. A said that he felt aggrieved at the manner of the approach made by Mr. SEHB 2. Dr. A wished it noted that a Psychiatric Nursing Director who was advising the HSE on child protection issues at the time had agreed with Dr. A's use of the educational slides and had confirmed this in writing.

10.1.9. With regard to the alleged filming of students, CD said that to his knowledge no complaint had been made to the Health Board. Dr. A stated that the individual who suggested this was a friend of a colleague. Dr. A said that he had no memory whatsoever of asking anybody to film anything. It was the norm in the School of Humanities that cameras were used as a teaching aid. Dr. A said that he was utterly shocked to see this coming up in the Media. CD said that the record he had been shown indicates that there was no record of any such request. Dr. A said that the complaint had come from a Dr. WIT 5 and made at the same time as he and her daughter was applying for the same post and it seemed extraordinarily coincidental that the complaint was made at that time. Dr. A said that there is a question as to what the Institute should have done with a verbal complaint instead of a written complaint. He would like to put
this on the record. Dr. A suggested all these were connected; He explained that Dr. WIT 5 considers herself certainly the Irish expert, if not a Global expert, on the social history of prostitution. Dr. A wrote an article for the Irish Times and also a book on prostitution in Waterford City which led to difficult exchanges with Dr WIT 5.

10.1.10. CD said that the Review Inquiry had also been furnished with a letter issued to Minister Martin from a number of academic staff in WIT dated 15 January 2000. There was also an unsolicited email sent on 15th January 2000. CD received that email on 18th July 2007. CD said that it was clear that Dr. A had a significant number of issues with WIT and that it was a matter for him to address theses with WIT. CD said that he was looking at those issues in terms of context but that he would not make findings in respect of those matters which were internal to WIT.

10.1.11. Dr. A asked if there were any matters of Child Protection raised in that letter to the Department of Education and CD answered that the matters raised related to alleged favouritism shown to Dr. A and alleged pressure of working with him on particular courses and that there was no reference in respect of the education package including slides.

10.1.12. With regard to the second issue relating to the circumstances surrounding the RDTF, CD said that he had received from AIT all the documentation surrounding that proposal, the research application, the expansion of the study to include Portlaoise and that he had also spoken to Mr. MHB 1 and Mr. D1 in relation to the process under which Dr. A was awarded the research project. That is a matter of record and there was no need to go into that any further.

10.1.13. Dr. A was asked if he understood the contract to be with an autonomous or multidisciplinary agency and if it was clear to him what the distinction was between the two? Dr. A answered that he was dealing with Mr. MHB 1. Mr. MHB 1 was with the HSE and the RDTF and it was clear to him what role Mr. MHB 1 had when dealing with him.

10.1.14. Dr. A stated that he had been supervising Ms. MHB 5 and thought that some of the academic work being undertaken might progress into something else. Mr. MHB 1 was very supportive. Dr. A always wrote to him on his HSE email, not the RDTF email and would email him from an AIT email account.
Dr. A said that when Mr. MHB 1 wrote back it was signed A/Regional Health Promotion Manager.

10.1.15. CD described what he understood about the background to the visit to Amsterdam and that initially it was Mrs. A who would accompany Dr. A on this trip as co-researcher but that ultimately Mr. MHB 1 decided that Detective Sergeant GS1 would travel as Mr. MHB 1 had heard positive feedback about Sgt. GS1 and his work with substance abuse in the Athlone area. Dr. A said that he and Ms. MHB 5 had interviewed Detective Sergeant GS1 previously in Athlone but that he did not know him. ( Note - Dr. A subsequently clarified that it was the Head of the Department of Humanities in Athlone IT who refused to allow Mrs. A to travel to Amsterdam and that it was Mr. MHB 1 who suggested Detective Sergeant GS1 as an alternative).

10.1.16. Dr. A was asked if when speaking to Mr. MHB 1 after his release from custody, he made Mr. MHB 1 aware that at least one of the young women in question could be characterised as being a child? Dr. A responded as follows “It was made quite clear to Mr. MHB 1 after my release from Custody. I called Mr. MHB 1 and GS1 and apologised to both. I explained in detail to both what had happened. We agreed that when I came back I would have an immediate meeting with Mr. MHB 1. My understanding at the time, and my understanding afterwards, was that there was some kind of liaison between Amsterdam and Dublin. In my diary I note that fact. June 30th 2004 meeting took place in Clonminch at 11.00 a.m. Mr. MHB 1 stated he was observing all the relevant protocols. He had spoken with senior Gardai in Amsterdam and that it was now less serious than previously thought. Mr. MHB 1 was very good to me professionally and very helpful to me during all this. He was very supportive. We agreed that when Mr. MHB 1 had spoken with GS1 we would meet again that day in his office and that the project would continue but that I would not do any interviews in July and recommence in August and the project would go forward.”

10.1.17. CD clarified that what Mr. MHB 1 had said in interview was that he was made aware by Inspector GS1 that the age profile was 15/18 years of age. It was not clear if he was aware of that information from Dr. A. Dr. A stated that he had told Mr. MHB 1 this when he spoke to him from Amsterdam.

10.1.18. Dr. A was asked if when Mr. MHB 1 told him that he was observing Midland Health Board Protocols in this area, was it his understanding that the involvement of the Child Care Manager had been triggered? Dr. A answered that what Mr. MHB 1 said to
him at that meeting was that he (Mr. MHB 1) would have to tell a superior. Dr. A stated that he did not know what would happen after that as it had happened in Holland. Dr. A immediately got a lawyer in Dublin and Amsterdam. Then Ms. MHB 5 was called in to the meeting and was told that Dr. A had been arrested in Amsterdam but was not told specifics. Mr. MHB 1 advised that he would deal with the issue with Ms. MHB 5 as he was her line manager. Ms. MHB 5 was told that Dr. A had been arrested in Amsterdam and that it would cause problems with the Study and that he would not be restarting interviews and that he was not to claim expenses for the trip.

10.1.19. Dr. A said that Mr. MHB 1 had told him to report in as sick and to visit The Hague as planned. Detective Sergeant GS1’s expenses would be claimed but not Dr. A’s. Dr. A said that with regard to notifying Ms. MHB 5, the impression had been given to her that it was a drunken incident.

10.1.20. With regard to the meeting on 30th June with Mr. MHB 1, Dr. A said that Mr. MHB 1 would have to have been clear about the ages of the young ladies in Amsterdam as it had been stated by both him and GS1.

10.1.21. Dr. A confirmed that he had received a phone call from Detective Sergeant GS1 on June 30th and that GS1 had an issue with expenses and he had raised the issue with his supervisor and another colleague. Dr. A knew that Mr. MHB 1 was going to be meeting with Detective Sergeant GS1 that afternoon but that he was not that familiar with the protocols.

10.1.22. With regard to the meeting that likely took place on 4th October 2004, and a discussion between Mr. MHB 1 and Dr. A relating to the upcoming Canadian visit, Dr. A said that he was not given any directions on anything and that the two enjoyed a very good professional relationship. A second person was added to the Canadian trip following the Amsterdam visit.

10.1.23. CD said that with regard to the above meeting, Mr. MHB 1 was of the belief that he had that discussion with Dr. A after he claimed Dr. A had said to him the case was not going ahead in Holland and clearly the arrangements for the Canadian trip predated this. Dr. A answered “This is a matter of difference between the two of us. I did not see that this was going to happen. There was a case in 2004/ 2005 where the Dutch were trying to get the case to Ireland. Mr. MHB 1 and the Gardai could easily find out what was happening. He was the person I had spoken to from the outset.”
10.1.24. Dr. A stated that he had received a letter on 24 September 2004 from (named solicitor), his Irish solicitor, that the case could not go ahead in Ireland and that the Irish Courts had no jurisdiction over the case against him. There was ongoing discussion between both lawyers in Dublin and Amsterdam.

10.1.25. With regard to the study launch, Dr. A was asked if at any stage was there any discussion with himself and Mr. MHB 1 or any other person of the potential difficulties that could arise for everyone concerned if there were any hints of the incident in Amsterdam. Dr. A said that he was very worried about that. He had met with Mr. MHB 1 in November 2004 and Ms. MHB 5 also attended. It was agreed Mr. MHB 1 would speak on behalf of the Task Force. The Minister of State with Special Responsibility for Drugs Strategy would then speak. At that stage Dr. A did not know what was going to happen as the Dutch lawyer did not know what would happen. Dr. A had got Garda clearance prior to going to Amsterdam showing there was nothing against him. Dr. A said that he never had any unsupervised access to children. Dr. A agreed that he was concerned going into the launch that this was still a live issue. Dr. A advised that the Garádú knew about it, Mr. MHB 1’s superiors in the Health Board knew about it, and the Department of Equality of Justice Equality and Law Reform knew about it. Dr. A remembered Mr. MHB 1 telling him that he had told somebody in the National Drugs Task Force as well.

10.1.26. With regard to risk management, Dr. A said that he thought he had done the responsible thing in notifying a Senior Manager in the HSE. Mr. MHB 1 knew and had told his supervisor and the Guards knew. Dr. A said that he had been advised not to tell his employer, AIT and that had catastrophic consequences for him.

10.1.27. Dr. A stated that his Dutch lawyer up to two weeks ago, was not given a reason why the Irish Authorities were not pursuing a prosecution against him other than the fact that it was outside the jurisdiction. Nor was there any explanation given as to the delay in arriving at that decision.

10.1.28. With regard to being summoned to Athenry Garda Station, Dr. A said that he was told by the Gardai that he did not have to attend but he wanted to do what he thought was right. His wife and brother travelled to Amsterdam with him. Dr. A said that with regard to protocols, the MHB was informed of it, Athenry Garda Station was informed of it and the Dept. of Justice, Equality and Law Reform was informed of it.
10.1.29. Dr. A claimed that the Superintendent had spoken to Senior Gardaí in Amsterdam and they had said it was less serious than originally thought. *(Note - Dr. A subsequently clarified that it was Mr. MHB 1 who had spoken to senior people in Amsterdam about this).*

10.1.30. Dr. A stated that both he and his wife had spoken to Mr. MHB 1 pre and post conviction in 2005. Dr. A said that he made Mr. MHB 1 aware of everything following the conviction. CD stated that the account varies from Mr. MHB 1’s account which indicates that he had no knowledge of Dr. A’s conviction until the summer of this year. Dr. A responded “*It is clearly a matter of dispute*” and said that Mr. MHB 1 was aware of the upcoming trial.

10.1.31. CD stated that Mr. MHB 1’s position was that in the course of the meeting they had in early November 2004, his understanding from his conversation with Dr. A was that there would be no charges.

10.1.32. Dr. A said that he had confirmation of his discussion with Mr. MHB 1 after calling to Athenry Station. He stated “*After calling to Athenry Station I spoke to (Mr. MHB 1) and my wife also spoke to him. He was certainly clear that the case was imminent. The purpose of my wife and I phoning him was that the summons came “out of the blue”. The fact that we called him immediately was to discuss that the case was imminent.*” Dr. A said that he had copies of phone records and that his wife had also spoken to Mr. MHB 1 and also spoke to him post conviction to thank him for his kindness.

10.1.33. Dr. A said that he enjoyed a very good relationship with Mr. MHB 1. He said that as the Department of Justice, Equality and Law Reform knew about it, it would not make sense to tell Mr. MHB 1 that this had gone away.

10.1.34. With regard to his placement in Aras Geal Young Persons Residential Centre in Galway in 2004, Dr. A said that the work he did there was in a shadow position and that he was supervised. Dr. A said that he was not a qualified child care worker and has never worked with children in a professional capacity. Dr. A said that he was a Social Care and Youth Care Academic Researcher.

10.1.35. CD said that he had a note from St Michael’s House where Dr. A had been involved in open training courses which he had stepped aside from. Dr. A was asked what other HSE
attachments he had in the period 2004 onwards. Dr. A answered that the only contract he had was with the MHB. St. Michael's House was not connected to this. It was just an open education programme, and he was there as a researcher and advisor.

10.1.36. Dr. A said that the visit he had made to Romania with a colleague was to get practice placements for their students and that students were sent there on foot of the visit.

10.1.37. Dr. A said that a further study trip to Canada was partly funded by the HSE and acknowledged in the book. CD read for the record that on the trip to Canada, Dr. A gathered data and information on mental health topics, visited various centres, First Nations people and Travellers. Dr. A said that he acknowledged Mr. MHB 1 personally in his book and that he sent Mr. MHB 1 selected materials that he had picked up for him at Mr. MHB 1’s request.

10.1.38. Dr. A stated that the Youth Resiliency project was 90% complete when he was advised by the HSE that the HSE would not be continuing with that project.

10.1.39. Dr. A ended his interview by stating “Just to say on a professional level I am devastated. I am sorry it has a ripple effect on so many parties. I am a good educator and deeply regret the way everything has turned out.”
10.2. Interview Summary, Ms. A, accompanied by Crowley Millar Solicitors, 9 November 2007. The interview took place in the offices of Dr. A’s Solicitors.

10.2.1. CD advised that Ms. A was being interviewed arising from suggestions by Dr. A that she had witnessed telephone conversations between him and Mr. MHB 1 of the HSE surrounding both the serving of a summons on Dr. A in September 2005 and the subsequent conviction of Dr. A that month in Amsterdam. CD also advised that it had also been suggested that Ms. A had spoken directly with Mr. MHB 1 on issues surrounding the conviction and she was advised that mobile telephone records had been furnished by Dr. A which suggested telephone contact with Mr. MHB 1’s mobile telephone number in September and October 2005. Ms. A was asked if she could clarify the circumstances when her husband, Dr. A, advised Mr. MHB 1 (Health Service Executive) about the issue of a trial going ahead. Her recollection was that Dr. A would have contacted Mr. MHB 1 and kept Mr. MHB 1 “in the loop”. Mr. MHB 1 was seen as a life line and she said that Mr. MHB 1 was very understanding and good to them in light of the arrest and conviction. Ms. A said that she wasn’t acquainted with Mr. MHB 1 before but would have known about him and would have answered the phone when he rang without having met him personally. After the whole Holland incident in June 2004 her husband would have spoken more regularly with Mr. MHB 1 which she stated was evidenced from the details of the mobile phone records presented to CD. Ms. A also asked CD if Mr. MHB 1’s phone records had been supplied to the investigation as she and Dr. A had taken calls from Mr. MHB 1 on many occasions.

10.2.2. Ms. A stated that she and her husband were in private consultancy practice together and that her background would have been in child care and that she had some previous experience working with the HSE in the 1990’s.

10.2.3. Ms. A said that when Dr. A got notification of the summons it had come out of the blue. She recalled that this was in September 2005 (and Ms. A subsequently confirmed following the interview that they had received notification of the summons on 9 September 2005). She remembered answering the phone in early September 2005; it was a member of the Garda located at Athenry Garda Station who requested to speak to Dr. A “about a sensitive matter”. Dr. A asked Ms. A to accompany him to Athenry Garda Station where they went over the paperwork relating to the summons. Ms. A said that the Garda asked if Dr. A was intending to go over to the
case in Amsterdam and alleged that the Garda they met in the Station said if it were him, he wouldn't bother going over because of the nature of it. Ms. A stated that there had been some surprise on Dr. A’s part that the case was proceeding as it had been hoped that the Dutch authorities would not proceed after the Department of Justice here in Ireland refused jurisdiction. She and her husband had decided to go to Amsterdam for the trial.

10.2.4. Ms. A said that she understood that the case had been sent previously to Irish authorities and from July 04 to February 05 the Irish authorities had not made their decision as to whether the case would proceed in Ireland. They received confirmation from their legal advisors in February 2005 that the case was not going ahead in Ireland but probably in Amsterdam. During that period Dr. A would have been in regular contact with his Dutch lawyer.

10.2.5. With regard to their alleged mobile phone conversation with Mr. MHB 1 after the summons was served in September 2005, Ms. A said that they saw Mr. MHB 1 as a ‘friend’ and ‘confidant’. Ms. A recalled that she and Dr. A were in their car and she made the call to Mr. MHB 1 and told him that her husband would talk further to him and she passed over the phone. Ms. A said that the phone calls would be on loud speaker so both of them would know what was going on. They wanted to know if Mr. MHB 1 had heard anything else from the Gardai or the HSE. Mr. MHB 1 told them no – nothing new had come to him. Mr. MHB 1 would have known from that conversation that they were going to Amsterdam for the trial. Ms. A said that she did not detect any surprise on Mr. MHB 1’s part on hearing about the summons. That conversation concluded with Mr. MHB 1 saying that he did not know anything more about it from a HSE perspective and that they would “catch up again”. Ms. A said that sometimes they spoke about the case with Mr. MHB 1 and other times not and said that Mr. MHB 1 was a ‘friend’ and very ‘good to them the whole time’.

10.2.6. Ms. A confirmed that she attended the trial. The Judgment was delivered in Dutch in their presence and their lawyer translated but didn’t go into specifics with the A’s.

10.2.7. They understood that Dr. A received a fine and suspended sentence and they were told by the lawyer that they should go home and continue their lives as normal and there was nothing further for them to do. Ms. A was not sure when they understood what the conviction was actually for. They knew that there was a 3 month suspended sentence and knew generically what it was about. In response to a direct question, Ms. A confirmed that she understood that it was a conviction for attempted indecent assault. In response to another direct question, she also stated that she...
could not be sure if there was any contact with Mr. MHB 1 while they were in Holland in September 2005. [Subsequent to her interview Ms. A clarified that after the hearing, they knew that two of the more serious charges were not being proceeded with by the Court and were struck out. This was translated by their Dutch lawyer and discussed with the As, therefore, any judgement was going to be less serious than it might have been - hence the comment to the A’s to go home and try to get on with their lives. The actual full judgement came later and was reported to the A’s from their Dutch lawyer and then via letter in Dutch in the post.]

10.2.8. On returning to Ireland, Ms. A recalled a conversation with Mr. MHB 1 when they rang him and told him about the outcome of the trial. Ms. A could not recall the exact circumstances around that call but did recall that Dr. A spoke to Mr. MHB 1 about his conviction. There were numerous telephone calls about this. She recalled that Mr. MHB 1 stated that the sentence was much less than he thought it would be. She overheard this conversation on the phone loudspeaker. She couldn’t recall who made the call but speculated that Mr. MHB 1 could have called from Dublin, Tullamore or from his work or personal mobiles and suggested there may be telephone records which might confirm this. She remembered speaking to Mr. MHB 1 after the conviction and specifically thanking him for his support. On that occasion she recalled answering the phone when Mr. MHB 1 had rung. She and Dr. A were grateful to Mr. MHB 1 for his support and being good to them. She added that they wished to maintain a good working relationship with Mr. MHB 1 as there would have been the possibility of engaging in additional private practice through Mr. MHB 1 with the HSE and they didn’t want to hide anything from Mr. MHB 1 or get Mr. MHB 1 in trouble.

10.2.9. CD asked whether any issue had been raised by Mr. MHB 1 in respect of extending any further work in the child care area to Dr. A and Ms A answered by stating that Mr. MHB 1 had said that it was much lesser conviction than what he thought and he told Dr. A that he had conveyed the details of the incident at the time to someone above him in the HSE as well. CD asked whether Ms. A formed the impression that they were now personae non grata because of conviction. She answered that it was the opposite case. She described Mr. MHB 1 as very measured and cool and that he never indicated, to her knowledge, that there would be a problem and that once the conviction came, they would see what Dr. A could do with HSE vis a vis future work. To her knowledge there was never a time when Mr. MHB 1 told Dr. A that there was no future work for him in the HSE.

10.2.10. CD asked whether she recalled any discussion with Mr. MHB 1 or any HSE officer about adjusting the type of approach or work in
relation to the Athlone/Portlaoise drugs study following the incident in Holland in June 2004. Ms. A stated that she thought that Mr. MHB 1 had requested Dr. A to pull back on the interviews until August 2004.

10.2.11. CD asked after September/October 2005 were there any discussions between the Dr. A and Mr. MHB 1 that she directly witnessed regarding the conviction. Ms. A answered that she remembered a meeting in Tullamore prior to another meeting taking place and she recalled that Dr. A wanted to speak to Mr. MHB 1 first himself. She speculated that perhaps this meeting took place in October 2005 and subsequent to her interview confirmed that date as being 26th October. She was not present.

10.2.12. Ms. A formed the impression that there was no noticeable reduction of business opportunities between their consultancy and the HSE. She recalled being advised by Dr. A that Mr. MHB 1 had advised him that notwithstanding Mr. MHB 1 moving from his position in Tullamore to Dublin, that there were monies available and that they could work together on different projects. Specifically, this was to be in the area of population health and mental health/addictions and Dr. A was asked to present a workshop to HSE staff in Tallaght which did not happen due to a reorganisation of funding.

10.2.13. Ms. A was not aware of who Mr. MHB 1 had advised in the HSE about any matter relating to Dr. A and the June 2004 incident and the subsequent September 2005 conviction.

10.2.14. Ms. A was asked if there were any further discussions after October and she reiterated that Mr. MHB 1 was au fait with the summons having been served and Mr. MHB 1 had heard of the detail of the conviction from the very start. She added that Dr. A had kept Mr. MHB 1 informed the whole way through as Mr. MHB 1 was considered to be in the close circle of people who knew the details.

10.2.15. Ms. A was requested to give an account of interactions from the Social Work Department HSE West Galway following the public disclosure of Dr. A’s conviction. Ms. A stated that, following receipt of a letter from the HSE, arrangements were made to meet with a social worker and both she and Dr. A met with the social worker and a social work team leader in the Community Care offices in Galway. She claimed that the social worker stated that it was a matter of protocol to call them in arising from the media coverage of the conviction and the matter being brought to their attention. She added that the social workers stated that no file would be opened and there would be no need to call on them again.
10.2.16. Ms. A was asked about the extent of the circle of knowledge regarding the conviction and she answered that that as far as she knew, Mr. MHB 1 had taken the knowledge “up the line” within the HSE. Ms. A stated that she had no contact with anyone else from the HSE in relation to this matter.
11. Summary of Written Responses to Review Inquiry

11.1. The Health Service Executive

11.1.1. Each Local Health Office Manager was contacted on 13 July 2007, on the instruction of the National Director PCCC to check whether the HSE had employed Dr. A in any capacity.

11.1.2. The Local Health Office Manager, Galway, furnished a detailed chronology of actions taken in that area on learning through media reports of Dr A’s conviction in July 2007. The Child Care Manager, Galway, notified the LHO Manager that Dr A had undertaken a pilot practice placement in Aras Geal Young Persons Residential Home some years previously. This matter was inquired into locally and it was established that Dr A applied for a practice placement in October 2003. The LHO Manager’s Local Inquiries established that that Dr A had been interviewed for the placement in November 2003 and Garda Clearance was received in December 2003 along with three character references. The placement was due to last one year but was terminated by Dr A immediately prior to his visit to Holland in June 2004.

11.1.3. The LHO Manager Galway instituted a Safety Review of the Young Persons resident in Aras Geal during Dr A`s placement. This Safety Review, conducted by the Inspection and Monitoring Officer, was carried out in July 2007. The resultant report was issued 14 August 2007 and was furnished to the Review Inquiry. That Report concluded that ........

“....there are no child safety issues arising for these two young people from the presence of Dr A in Aras Geal in the Nov `03 to June `04 period”

11.1.4. The LHO Manager, Galway, forwarded to the Review Inquiry a print out from an internet site (www.CYC-net.org) which outlined details of a visit paid by Dr A to Romanian orphanages, which was stated to be for the purpose of placing Social Care students in those orphanages as “field practica”

11.1.5. The LHO Manager, Galway, tabled documentation relating to her request on 17 July 2007 to the Principal Social
Worker to meet with Dr and Mrs A. On Dr A’s return to Galway he was communicated with by the Social Work Department, requesting a meeting. This meeting took place on 3 October 2007. The resulting Social Work report dated 4 October was furnished to the Review/Inquiry. That Report indicates that Dr A was advised that it was part of standard protocol to meet with the person, if it is known that they have a registered conviction for offences against minors and that they have current contact with children. He was also advised that Mrs A would also be met to ensure that she was aware of her protective responsibilities. The Social Work Team Leader concluded the Report by stating that he did not envisage a future role in the matter by the Social Work Department and that the case would now be closed.

11.1.6. The Children and Family Services Specialist, HSE South, forwarded copies of correspondence which issued between him in his former role as Regional Co-ordinator of Child Care Services in the former South Eastern Health Board, and Dr A. The correspondence dated from 21 December 1998 and related to concerns about the reported showing of medical slides of injuries consistent with child sexual abuse as part of the Social Care Course being delivered at the time by Dr A in Waterford Institute of Technology. Dr A responded on 22 December 1998 that the slide material had not been used for two years and sought to put in context the showing of the slides. Dr A tabled a letter from the Regional Co-ordinator dated 8 February 1999 indicating that Dr A’s response had “…….more than clarified the matter”.

11.1.7. The LHO Manager with lead responsibility for Child Protection matters in the HSE South was written to on 10 September 2007 as follows

"Private & Confidential
LHO Manager, PCCC Offices
Health Service Executive
St. Luke’s Hospital
Western Road
Clonmel
Co. Tipperary

Re: Review Inquiry on matters pertaining to Child Protection issues touching on or concerning Dr. A

Dear Mr. HSE 1,

I refer to the above mentioned Review Inquiry which has been established by the Health Service Executive, the terms of
reference and methodology of which I attach for your information.

It would be of great assistance to the Review Inquiry if you as the Officer with lead responsibility for Child and Family Services in HSE South were in a position to outline and provide any records in the possession of the HSE/South Eastern Health Board relevant to the terms of reference. What would be of specific interest would be any matters relating to Dr. As alleged teaching practices in his position as Course Leader in the Social and Child Care Department of Waterford Institute of Technology which raised any child protection concerns for the HSE/ South Eastern Health Board. The Review Inquiry would also be anxious to establish whether Waterford Institute of Technology or any staff member of the college or student or member of the public made any contact with, or were contacted by, the then South Eastern Health Board on any such matters and the outcome of any such contact.

11.1.8. The LHO Manager South Tipperary forwarded relevant documentation on 6 November 2007 which included a report from the Child Care Manager, Waterford, dated 19 October 2007, indicating the extent of the file review relating to matters touching on child protection issues and Dr A. The files examined in compiling that report were:

- Doras 1998 (Befriending people in prostitution), Child Care Manager and Section 65 funding files
- Fostering Care File relating to a young person (CC)
- Social Work file relating to a young person (CC)
- Community Child Care Leader File (CC)

The file review raised three areas as being “pertinent for consideration”

(a) Doras Report
(b) Meeting between Dr A and a young person previously in care of the Health Board on 29 January 1998 as part of a research project on “Prostitution in Waterford”.
(c) Concern regarding material used during college lectures in WIT

The Child Care Managers File Review, which included discussions with HSE personnel, concluded that no child protection issues concerning Dr A were notified to Waterford Community Services but that there had been concerns expressed about his professional boundaries.
11.2. Dr. A

11.2.1. Following a preliminary meeting with Dr A’s legal representative it was agreed that written questions would be put by the Inquiry Team prior to a formal interview taking place. The questions were put in a letter dated August 2007 as follows: the extract has been amended having regard to confidentiality of persons quoted.

Dear (Dr A’s Solicitor)

I refer to our meeting of 15 August 2007. Arising from my undertaken given to you at that meeting, I wish to outline in broad terms the issues that your client, Dr. A may be in a position to assist in establishing the facts and the background relating to matters encompassed within the terms of reference of the Review Inquiry.

The first issue relates to any knowledge in the possession of Dr. A relating to contacts in 1999/2000 between him or Waterford Institute of Technology with the South Eastern Health Board/ HSE South East, relating to certain teaching practices by Dr. A in his position as Course Leader in the Social and Child Care Department of Waterford Institute of Technology.

The second issue relates to the circumstances surrounding the commissioning by the Regional Drugs Task Force, Midland Health Board Area, of Dr. A to undertake research into heroin use in Athlone and subsequently in the Portlaoise area. Dr. A’s understanding/perception at the time of the relationship between the Midland Health Board/HSE Midlands and the Regional Drugs Task Force, Midlands Area would be welcomed.

The third issue surrounds the circumstances giving rise to the study visit by both Dr. A and Detective Sergeant GS1 to The Netherlands in June 2004 with particular emphasis on the authorisation for the study visit and the composition of the study team. Dr. A may wish to place on record, the events giving rise to his questioning by Dutch police in the course of that study visit. Dr. A might also be in a position to indicate whether there was any contact between him and representatives of the Regional Drugs Task Force or the Health Service Executive in the course of the study visit and in particular after the Dutch police had questioned Dr. A. Dr. A may also be in a position to indicate whether and to what extent the other member of the study team was aware of the Dutch police inquiries being undertaken. Dr. A may also be in a position to indicate whether, apart from Sergeant GS1, any other member of An Garda...
Siochana was either assisting the Dutch police with their inquiries at that time or assisting Dr. A or Sergeant GS1.

The fourth issue relates to Dr. A’s meetings with Mr. MHB 1 HSE and Regional Drugs Task Force on the following dates

- the week beginning 5th July
- a meeting in September 2004
- a meeting in November 2004 (at which it is suggested by Mr. Mr. MHB 1 that he was advised by Dr. A that the case against him in Holland would not be proceeding).

Dr. A may also be in a position to indicate whether he communicated /disclosed any details of the circumstances relating to his questioning by Dutch police to any other Officer of the HSE.

The fifth issue relates to a study visit funded by the Regional Drugs Task Force to Canada in 2005 and whether there was any discussion with him by the HSE or Regional Drugs Task Force on the conduct expected of him on that study visit and whether, to his knowledge, there was any discussion with the two other participants on that study trip, Ms. MHB 5 and Ms. MHB 6, of the behaviours in Holland in June 2004 which at that point were alleged against Dr. A.

The sixth issue is whether Dr. A can indicate at what point he was informed that the Dutch authorities were charging him with attempted indecent assault and whether he disclosed this detail to any member of the Regional Drugs Task Force or any Officer of the Health Service Executive. The same question applies to the trial and conviction of Dr. A in September 2005. As a subsidiary issue and in order to establish a precise chronology of significant events surround this matter, Dr. A may also be in a position to indicate, to his knowledge, whether the Dutch authorities communicated with any public authorities in this jurisdiction either leading up to or following Dr. A’s trial and conviction. Dr. A may also be in a position to indicate whether he had any formal contact with the Garda Siochana on any matters pertinent to his trial and conviction in Holland prior to the public disclosure of such details in July 2007.

The seventh issue relates to any structured or informal arrangements between Dr. A and the Health Service Executive, voluntary health provider or Nominated Health Agency in respect of the provision of any services by Dr. A to those agencies. Dr. A may be in a position to detail those arrangements and indicate the current status of those arrangements and his understanding of the administrative processes for disclosing any matters to those service providers which could compromise the services provided by those agencies.

There may of course by other issues which Dr. A wishes to table and he would be invited to do so subject to such matters being consistent
with the terms of reference and/or salient matters which will assist in establishing a chronology of significant events.

11.2.2. Dr A responded to the questions put as follows

**Response to Questions from Mr. Devine**

**Dr. A**

14.9.2007

**First Issue**

In the mid 1990s, an educational instructional package was purchased from a reputable Medical Publishing company called Gower Publishing (London and New York) on behalf of the School of Humanities from a discretionary budget held by School Management. I was allocated the package from the Head of School of Humanities, in a developmental context, as my primary lecturing areas at that time were applied social studies/applied sociology/applied anthropology/therapeutic interactional analysis – although it could have been used by any appropriate staff member and had been used previously by a Lecturer.

The precise title of the package is *Slide Atlas of Pediatric Physical Diagnosis 2 edition 6: Child Abuse and Neglect*, Holly W. Davis and Mary M. Carrasco edited by Basil Zitelli and Holly Davis.1

The media has referred to the package simply as ‘slides’ but the package must be seen as that – a package which includes textual context and thematic explanation and was published at a time of emerging interdisciplinary literature in the area. For the record, there were originally some sixty slides in all detailing a range of injuries to various parts of the body: a small percentage of these related to injuries to sexual parts of the body (51 slides dealt with child neglect and only 9 with child sexual abuse). Some seventeen pages deal with abuse and some seven with specific sexual abuse. This is not the portrait painted either in the media or by the Lecturer who complained about their use.

The package was also made available in the context of Applied Social Studies/Anthropology lectures for Art in Society students, either on their own or in the desired (and Institute encouraged) practice of joint learning groups. Their use was intended, again, as an aid to immersing students in the real

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1 Basil J. Zitelli, MD, Professor of Pediatrics, University of Pittsburgh School of Medicine, Diagnostic Referral Center, Children's Hospital of Pittsburgh, Pittsburgh, PA; and Holly W. Davis, MD, Associate Professor of Pediatrics, University of Pittsburgh School of Medicine, Child Advocacy Center, Children's Hospital of Pittsburgh, Pittsburgh, PA.
world of suffering (Waterford Institute of Technology had lately re-modelled its Art course to reflect live social issues, for instance). Students were expected to engage with a range of issues and strive to respond to them in their work in a sensitive, mature and responsible manner. I might add that this Art and Society module eventually lead to the wider developments in the Healing Arts at WIT.

At any time, I only used a discrete selection of the slides materials with any class. At no stage, with any class, were all the slides shown. This decision was made for the welfare of students and for practical reasons of time.

Furthermore, all students were invited to discuss any issues that might have upset them with allocated lecturing staff afterwards. In fact, in an academic course board meeting held on 21st November 1994, four years before a complaint was made, it was agreed that Dr. WIT 6 and I would “inform students prior to lecturing on delicate issues”. This became standard practice (see attached notes).

At no stage, did any student bring to my attention that she/he had been ‘very upset’ or that they felt she/he would ‘require formal therapy’ as suggested in an RTE radio broadcast by Dr WIT 5 in July 2007.

In fact, no formal negative communications were received by me from students and, to the contrary, two ex-students wrote in support of the educational package (see attached letters). On 1st January 1999, for example, a former part-time female student wrote in a supportive letter, “…I did not find these slides to be in any way traumatic for me other than the fact that it was upsetting to know that children had suffered terribly both mentally and physically. I also note that I cannot recall having any major conversation with any of the others attending the course or hearing afterwards any problems about this particular lecturer”.

One of the ex full-time students wrote in March 1999, “As a graduate of the NDSC at WIT I did participate in this exercise which, may I add, was totally voluntary to the students and which was discussed and explained thoroughly by Mr. A before the actual slides were shown.” Further she states, “As a graduate of the NDSC and now working in full time in the social care field I believe that these slides were beneficial to my studies and hence my working life”.

I would like Dr. WIT 5 to furnish some proof to the Inquiry around students requiring therapy and this to be made available for corroboration.

I think the context and timing of the complaint around my use of the educational package coming in from Dr. WIT 5 is interesting as both her daughter and I had applied for a senior post at the Institute (see letter from me at the time of the 1998/1999 investigation to the Institute Director and letter from Mr. NO’S,). By her own admission, Dr. WIT 5 is not familiar with the package I used, nor saw any of its content at the time of her complaint or since. In fact, she is a Social Historian with no background of publications in
this particular area of discourse. I would further note that I lodged a formal complaint against Dr. WIT 5’s behaviour towards me as noted in a letter from the Personnel Officer, Mr. WIT 7 on 2nd December 1999. [Note – W.I.T. wished it clarified that Dr. A decided in early 2000 not to proceed with this complaint against Dr. WIT 5]

Again, for the sake of clarity, on 21st December 1998, I received a letter from Mr. SEHB 2, Regional Co-ordinator of Child Care Services from the South-Eastern Health Board expressing concern at my use of the Slide Atlas educational package (see attached letter). I had a phone conversation with Mr. SEHB 2 and wrote back to him offering the inclusion of the South-Eastern Health Board as instructors/facilitators to which he replied positively and welcomed this (see attached letter of 8th February 1999). It is important to note that, in any case, I was no longer using the materials as noted by Mr. SEHB 2 in a second letter dated 30th December 1998.

Following a meeting on 27th May 1998, on the 8th June 1998 the Registrar, Mr. MHB 2 formally wrote to me and stated that he had an oral complaint from a fellow Lecturer. By that stage I was no longer using the slides for some months anyway. He further stated that he would investigate the matter (see attached letter).

That letter closed with the comment, “Since it is normal academic practice here to allow lecturers full scope to determine the most appropriate methods to implement the courses assigned to them, I want to assure you that I am making no judgement on the allegations made”.

The Head of School of Humanities, Dr. WIT 4 informally interviewed me and was assured that the material was appropriate. As Head of School, he directed my then line manager, the Head of Department of Humanities, Dr. WIT 8, to convene a meeting of the Social Care course board to discuss, in depth, the use of the Slide Atlas (see attached letter to Head of Department of Humanities dated 10th February 1999). Indeed, File records suggest that a meeting the previous year (1998) had earlier supported use of the package.

I was asked not to attend the scheduled course board meeting which was established to facilitate full and frank discussion by critical peers of all related issues and to issue a recommendation with regard to the educational package. I agreed to this request (although I could have insisted on a more difficult route of dialogue given my membership of the TUI).

Some eleven lecturers on the course board are recorded as being in attendance where the matter was discussed. The meeting noted that the complaint was made, apparently, months after the use of the Slide Atlas in class seminars. Again, this is important in terms of context.

The Course Board Minutes of 11th February 1999 note, “Each member present was asked to speak to each of the three items on the agenda. They were asked to be open and frank in their remarks so that the discussion would be as wide-ranging as possible. After each item had been discussed in this
way the Chairman offered a short summary to reflect the discussion in which there was a high degree of consensus. It is the Chairman’s understanding that the meeting agreed with these summaries and no one present objected”. In terms of my course management as course director, the meeting gave endorsement and stated that I had “the full confidence of the board”.

Not one lecturer present at the academic course board meeting spoke against using the educational package indeed, the minute reference reads: “The meeting gave general endorsement to the use of the slides on the courses. They were seen as necessary to the training of the students for the work they would do in employment. Adequate preparation was required as well as time for debriefing”.

Thus, the meeting clearly supported the practice of using the educational package as being consistent with a thorough student preparation for full careers across the human services. In addition to the lecturer support at the academic course board meeting, I also received letters of support for the relevance of my approach and from professionals in the field from the region and, indeed, nationally (see attached).

In fact, in a letter of 21st January 1999, Dr. WIT 9 notes, “I wish to place on record my conviction that Dr. A’s use of visual material in the context of social care teaching has been entirely correct and fully justified from a pedagogic point of view. The matter was discussed extensively within the course board last year, which fully supported Dr. A on this matter.”

In July 2007, several newspaper articles referred to an alleged request by me made to a Technical Support staff at Waterford Institute of Technology to film the faces of my students whilst they viewed the educational package and then feed this into me in my office. Notwithstanding the fact that the staff member is a personal friend of Dr. WIT 5, I would like the following noted. I shared an office at the time with a colleague and secondly I have no memory of making such a request. For the record, it is common practice to avail of video links, one way mirrors and the like in human services training (see attached email from, Course Director of Applied Social Studies, Waterford Institute of Technology. 17th July 2007).

At all times, I used the Slide Atlas in good faith and for the right reasons with my students. The specific aim of such packages is to provide a single comprehensive resource for multidisciplinary professionals responding to child maltreatment. I note, for example, that the running header for another like-manual reads “Handle any case of child maltreatment no matter what your discipline” (Gower Medical Catalogue). I have been informed as recently as July 2007 by a North American colleague that she uses similar materials in her courses with child and youth care students.
I believed then, as I do now, that students deserve a futurist approach – one that is theoretically sound, grounded in the real world and looks to external sources for direction. Indeed, this was the view of the academic course board and academic management at Waterford Institute of Technology.

There is no child protection issue around the use of this educational package. It was developed by qualified personnel, was purchased on behalf of the School of Humanities from its discretionary budget and was used with adult learners.

I believe to this day that attempts to discredit my use of such materials (as distinct from legitimately querying their use as was the case with the SEHB) were done so for personal and not professional reasons.

References: Suitability of Character and Professional Approach

There was some discussion in the media in relation to references sought and supplied from Waterford Institute of Technology. I can confirm that my then Head of School, Dr. AIT 4, was sent a standard reference request form from Athlone Institute of Technology on 28th June 2001 which he filled in on July 20th 2001. I note his comments under the section ‘strengths’, “In-depth knowledge of his area…perseverance and tenacity in accomplishing tasks…excellent communicator; excellent colleague”. Under the section Personal Competence, I received twelve ‘far above average’ ticks out of a possible thirteen. No mention is made of any child protection concerns at all in my time in Waterford between 1992-2001 (see attached reference from Dr. AIT 4).

I also received a further two references; one from (named academic) of Montreal, Canada who, amongst other roles, is co-editor of the international Child and Youth Care Network and one from the then Director of Oberstown Boys Centre, Lusk, Co. Dublin which remain on file at the Athlone Institute of Technology.

Second Issue

As an academic supervisor, I was allocated thesis supervision of a mature B.A. Applied Social Studies student, Ms MHB 5, who wanted to undertake research into heroin misuse. I did so, and along the path of supervision, it was felt by the two of us that a worthwhile regional study might be explored; one worthy of publication. I raised this with Mr. MHB 1 and he informed me that funding was potentially available for such an exercise. The Centre for Child and Youth Care Learning made several draft applications to the Health Service Executive and was ultimately successful. I was to be lead author and Ms. MHB 5 was second author.

I understand that the relationship between the Midland Health Board/HSE and the Regional Drugs Task Force was a co-operative venture. Mr. MHB 1 was
Interim Chair of the RDTF and held dual roles between that entity and the HSE. I am unaware of any personal relationships between, and within, both organisations. Thus, when I dealt with Mr. MHB 1 at this time, I did so mindful of his two roles.

Third Issue

Originally, I was scheduled to travel to Amsterdam to engage with the research with my wife (see draft application from CCYCL 1). The Head of Department of Humanities at Athlone Institute of Technology, Mr. AIT 4, objected to the involvement of my wife on the study as he felt the Institute might be open to accusations of nepotism. He insisted that if I wanted to proceed with the study, someone else would have to travel with me. Forced into this situation, as Mr. MHB 1 already agreed to the involvement of my wife who is a consultant in her own right, I revisited the application and revised the research team composition (see change in research team in draft application from CCYCL 2).

I phoned Mr. MHB 1 and informed him of the directive from my Head of Department. Mr. MHB 1 then suggested that Detective Sergeant GS1 travel instead of my wife (see confirmation memo from me to Mr. Mr. MHB 1 of this fact). Thus, the composition of this part of the study team was not made by me. Authorisation of this study visit came from both the Athlone Institute of Technology Executive Management and the Midlands Health Board Health Promotion Department (see attached documentation) as was agreed protocol.2

The events giving rise to my questioning by Dutch police are that I was arrested on the night of June 24th having returned to our hotel in an inebriated state where I sought out a party on the same floor on which I was booked into. Unfortunately, I walked into two rooms (looking for a bathroom in the second as I had left my own room key downstairs at Reception) whereupon a formal complaint was made about my alleged behaviour to the night receptionist from a group of American students. I was arrested and questioned and then released from custody on 26th June.

Contact was immediately made with both Detective GS6 from the Gardai and Mr. MHB 1 from the HSE on my release from custody as follows:

June 26th 2004
11.01am – voice message left on GS1’s Mobile Phone.

June 26th 2004

2 I did not charge expenses for this visit as instructed and agreed with Mr. MHB 1 in our meeting of 30.6.2004 (see copied diary notes).
11.26am – Mobile phone call made to GS1 (10.46 minutes duration) explaining my arrest and situation at that time.

June 26th 2004
13.41pm - Mobile phone call made to Mr. MHB 1, Midlands HSE, (9.44 minutes duration) explaining my situation at that time.

June 26th 2004
13.59pm – Voice message left on GS1’s Mobile Phone.

June 26th 2004
14.36pm – Mobile phone call (5.22 minutes duration) made to GS1 discussing potential ramifications and local response/procedures.

Following these discussions, a formal meeting was scheduled with the Midlands Health Board/HSE at its Regional Offices in Tullamore.

June 29th 2004
18.56 – Voice message left on Mr. MHB 1’s mobile phone confirming meeting for the following day.

June 30th 2004
My wife drove me to Tullamore and a Meeting was held in the Midland Health Board/HSE Offices Tullamore with Mr. MHB 1 and me in his office to discuss, in detail again, the Amsterdam incident. We did this and then reviewed the status of the heroin research project. My co-author, Ms. MHB 5 (HSE Health Promotion Officer) was invited in to the meeting by Mr. MHB 1 and informed of my arrest, but not the specific charges (at Mr. MHB 1’s direction as her line-manager). A course of action in terms of moving the project forward was agreed (see attached copied diary notes). This was that I would continue on the project but not undertake interviews until August. I would, instead, concentrate on analysis. I would also not claim expenses for the trip from the HSE but would pay for it out of my own monies which I did.

June 30th 2004
I received a call to my mobile phone from Detective Sergeant GS1 re the incident and had a discussion around expenses he had incurred (see attached copied diary notes). Detective Sergeant GS1 told me that he had informed his superior of the arrest and that at least one more junior member of the Gardai at the Station had been informed. Detective Sergeant GS1 mentioned that he intended on bringing up this matter with the Garda Representative Association as he was unhappy with the chain of information.

I understood from Detective Sergeant GS1, at the time, that another senior Garda (either based in Dublin or Amsterdam) was also informed of my arrest.
in a liaison capacity and was collaborating with Dutch authorities. This makes sense in that Mr. MHB 1 also referred to a senior Garda’s involvement in our phone discussion of 29th June 2004 in relation to my arrest and charges (see attached copied diary notes) and I did so in an email sent to my Dutch Lawyer in July 2004.

I was told that Detective Sergeant GS1 and Mr. MHB 1 were meeting at 2.00pm that same day (see attached diary notes).

The Fourth Issue

My diary shows that I had a planning meeting with Mr. MHB 1 on Monday 4th October in Tullamore HSE Offices re the forthcoming trip to Calgary, Canada. At this, we discussed a number of procedural issues in relation to the trip. I was advised to ensure the well-being of the two HSE Health Promotion staff (which I did), to assist them in preparation for our joint workshop, to lead delivery of the workshop and to introduce them to colleagues in the international child and youth care sector.

My diary shows that I had a meeting with Mr. MHB 1 on November 5th in relation to the on-going heroin research. At this time I had been made aware from (named law firm), in a letter dated 24th September 2004, that the case would probably not carry jurisdiction in Ireland. I informed Mr. MHB 1 of this but also that the case might well still go ahead in Holland at a later date as we were awaiting the outcome of my Lawyer writing to the Prosecutor seeking a dismissal of the case. In fact, my email correspondence from Holland shows that I was not made aware of the certainty of the decision to take the case in Amsterdam until 6th February 2005. 3

I did not make any other HSE Officer aware of my arrest as I had already informed a senior HSE Officer. Indeed, Mr. MHB 1 informed me at our meeting of 30th June 2004 that he had to inform more senior management in the HSE and the Chair of the Drugs Task Force. Thus, I understood that the Head of Department of Health Promotion in the HSE/Interim Chair of the Regional Drugs Task Force, his more senior management and the Drugs Task Force were all made aware of my situation and that there was not a difficulty in continuing to work with me.

The Fifth Issue

On the original application made from the Centre for Child & Youth Care Learning, Ms. MHB 5 was scheduled to travel out to Canada to present a workshop on our interim research. Following our discussions around my arrest in June 2004, Mr. MHB 1 suggested that both Ms. MHB 5 and Ms. MHB 6 might travel out as a representative HSE team (see attached memo of

3 See attached notes titled ‘Chronology’ where I phoned Mr. MHB 1 the day I was called to Athenry Garda Station in September 2005.
1.9.2004). Given the experience in Amsterdam, Mr. MHB 1 asked me to conduct myself in a 'proper' manner or words to that affect. I reassured him that I would and did so.

Neither Ms. MHB 5 nor Ms. MHB 6 was informed by me of the specifics of my arrest in Amsterdam in keeping with advice from their line manager, Mr MHB1.

The Sixth Point

I was informed of charges the day after my arrest when I was allocated a Free Legal Aid Lawyer who came to the Police Station and met with me and, then later, in discussions with both my Irish legal team from (named law firm) and my Dutch legal team from (named law firm) in Amsterdam.

As I have stated above, I made Mr. MHB 1 aware of this.

Again, following my trial in Amsterdam in September 2005, I made Mr. MHB 1 aware of my conviction during the course of a phone call in early October 2005. In fact, my wife also confirmed the conviction with Mr. MHB 1 first and then I took the call.

The conviction was again discussed with Mr. MHB 1 in a meeting at the HSE Offices Tullamore on 26th October 2005. Furthermore, my situation at Athlone Institute of Technology and private consulting work was discussed with Mr. MHB 1 on 31st February 2006.

I was informed by my Irish and Dutch Lawyers that the Dutch authorities had sent my case file to the Department of Justice, Equality and Law Reform but that the Department had sent the file back to Amsterdam declining to take the case as it occurred outside this jurisdiction. I did not receive any formal correspondence on this from the Department of Justice, Equality and Law Reform or from the Dutch Prosecution service. Correspondence went from the latter directly to my Dutch Lawyer's Offices who then conversed with me on the matter.

My email records show that it was not until 6th February 2005, that the Dutch Prosecutor indicated the Irish authorities declared that they had no jurisdiction to deal with the case and that the Prosecutor had decided she was going to pursue the case in The Netherlands.

The Dutch authorities must also have communicated with the Gardai again in late summer of 2005 as a Summons was received at the Athenry Garda Station in County Galway in early September. We were told that the Summons had been in Dublin “for some time” prior to being forwarded to Athenry. I was called at home to review this by the Garda on duty. My wife accompanied me to the Station.
I am unaware if the Dutch authorities conversed with Irish authorities following my conviction in September 2005. I have asked my Dutch Lawyer to look into this but the Prosecutor in my case has moved to another area so it is proving difficult.

I did not have any formal contact with the Gardai after my conviction in September 2005. I was advised by my Dutch Lawyer both pre and post trial that no European Register was in place and that I did not need to inform any further authorities as the conviction took place in another jurisdiction and I had paid the relevant penalty (see attached letter of September 11th 2007). This was again communicated to me in a shared phone call as recently as July 2007.

**The Seventh Issue**

I continued to work with the Midlands HSE in the period 2004-2007 both in my capacity as Senior Lecturer in the Institute and in my private practice. A full financial audit trail is available for this in the Athlone Institute of Technology and the Dublin Mid Leinster HSE region.

In this time, the HSE partly funded scholarly visits to Canada where I gathered data on a range of mental health and population health topics and visited centres and agencies and contributed to the research of a book on First Nations People and Travellers (Elsipogtog MigMag & Midlands Travellers) and a creative writing volume (Oisin’s Journey Home).

In July 2007, one project completion on youth resiliency remained outstanding (due to an inability of the entire team to meet and review template) and I communicated this to both Mr. MHB 1 and Ms.HSE 4 at the HSE. I was advised by Ms. HSE 4 that the HSE would not be continuing with that particular project.

With regards to the last question, I was unaware that I had to make any other declaration about my conviction as I had already informed a senior officer in the HSE both pre and post trial of developments (refer to earlier information).
11.2.3. Dr A furnished his chronological account of the circumstances surrounding the incidents in Amsterdam in June 2004 which led to his subsequent conviction

**Amsterdam Incident Chronology**

**Dr. A.**

**June 24th 2004**
Incident takes place in Amsterdam. I am released out of custody on June 26th.

**June 26th 2004**

11.01am – Voice message left on Det. Sgt. GS1’s Mobile Phone asking him to contact me.

11.26am – Mobile phone call made to Det. Sgt. GS1 (10.46 minutes duration) explaining arrest, detention details and current situation.

13.41pm - Mobile phone call made to Mr. MHB 1, Head of Department of Health Promotion Midlands HSE, (9.44 minutes duration) explaining arrest, detention details and current situation.

**June 28th 2004**

Meeting with (named law firm) in their Dublin offices. I was accompanied to this meeting by my brother Shane, my sister Julie and my father, Joe. We were specifically advised at this meeting not to inform my employer as the incident had taken place outside the Irish jurisdiction (this can be cross-referenced with the email and fax information outlined below).
June 29th 2004
18.56 – Voice message left on Mr. MHB 1’s mobile phone confirming meeting for June 30th.

June 30th 2004
My wife drove both of us up to a meeting held in the HSE Offices, Tullamore with Mr. MHB 1 and myself to discuss the Amsterdam incident in detail (she waited in the car park). We also reviewed the heroin research and informed my co-author, Ms. MHB 5 (HSE Health Promotion Officer) of my arrest (but not the specific charges as advised by Mr. MHB 1). A course of action to complete the project was agreed (see attached diary notes).

June 30th 2004
Mobile phone call from Det. Sgt. GS1 re the incident and discussion around his incurred expenses and how these might be recouped (see attached diary notes). I am informed by Detective Sergeant GS1 that Mr. MHB 1 and he have a meeting on the same afternoon of June 30th to discuss the situation. Thus, I was made aware that official interaction between the Gardai and the HSE took place at this time.

July 2004
A Dutch Specialist International Criminal Law Firm is engaged.

July 1st 2004
10.59am – Left voice message on Mr. MHB 1’s mobile phone re engagement of Dutch Law firm.

July 1st 2004
16.44pm – Left voice message on Det. Sgt. GS1’s mobile phone re engagement of Dutch Law firm.

July 5th 2004
Fax sent from my Father’s fax machine to (allocated Advocate). The second paragraph of my letter states, and I quote, “My Lawyer in Dublin has advised me that I should not discuss the case at all with my work…” (bold my emphasis) Point 8 of my letter states, and I quote, “The funder of the project I was over in Amsterdam with talked with the Irish Police Officer based in Amsterdam on the Friday night I was released and was told that the situation was not as serious as they originally thought. Is this also your feeling (named allocated Advocate)?”

This letter is important for two reasons; firstly, it shows that the professional advice I received from (named law firm) was not to inform my employers of the incident. I followed this advice. Secondly, it shows that I had spoken with Mr. MHB 1, and the HSE was formally aware of the incident and had instigated its own information seeking exercise.

July 8th 2004
I received a letter dated 20th June 2004 from Politie Amsterdam – Amstelland – to appear at Headquarters for further interrogation. The letter took some time to arrive as it had inaccurate address details.

July 15th 2004
I received a package from (named law firm) containing documents in Dutch marked with ‘important documents for translation.

July 16th 2004
16.16pm – Mobile phone call to my Dutch Lawyer, in Amsterdam (15.45 minutes duration) discussing the case.

July 16th 2004
I received an email from my Dutch Lawyer, stating that that the “Dutch Prosecutor is planning to hand the case file over to the Irish authorities. This was unusual in that it involved the Dutch Minister for Justice approving the Dutch Prosecutor’s request to the Irish authorities”.

July 19th 2004
I received a letter from my treating Psychiatrist/Psychotherapist stating ‘am no danger to society or myself’ which was forwarded to my Dutch Lawyer.

July 19th 2004
I sent an email to my Dutch Lawyer stating I had spoken with (named solicitor) that morning.

July 19th 2004
I received an email from my Dutch Lawyer, discussing the potential advantages and disadvantages of opposing a handover of my case file from the Dutch to Irish jurisdiction. He confirms that I should speak again with my Irish lawyer on this matter.

July 20th 2004
I sent an email to my Dutch Lawyer, stating that I had spoken with (named solicitor) on the 19th July and that his view was the Irish authorities would be very reluctant to take the case in this jurisdiction and that (named lawyer) should go ahead and oppose the transfer of the case.

July 22nd 2004
I received an email from my Dutch Lawyer informing me that there is no obligation on me appearing in court in person.

July 23rd 2004
I received copy of a letter sent by my Dutch Lawyer to the Dutch Prosecutor asking that the case be dropped and outlining reasons why this should be considered.
August 10th 2004
I received a letter from my Dutch Lawyer, stating that the Dutch Prosecutor had decided not to settle my case out of court. It further states, “The Prosecutor does not refer to her intention to transfer the procedure to Ireland”.

August 10th 2004
I sent an email to my Dutch Lawyer seeking clarification re the situation internationally with regard to travel and declaration. On the same day he responded, “There is no problem with going anywhere. So you can travel safely to Canada. Your name should not be in any international computer network or database…If convicted in The Netherlands, you will get a criminal record here. There is no such thing as a European criminal record yet…” (bold my emphasis). This email is very significant as it shows as early as August 2004, the professional advice was that there was no register.

August 15th 2004
I sent an email to my Dutch Lawyer confirming that I had received official notification from Holland that the hearing is to take place on September 13th.

30th August 2004
I sent an email to My Dutch Lawyer letting him know of dates I would be out of the country. The last line of my email states. “I have made no mention at work of Amsterdam nor do I intend to as advised” (bold my emphasis). Again, I had been advised not to mention anything about the incident.

25th September 2004
I organise a national conference (Irish Association of Social Care Educators) in Athlone where Mr. MHB 1 co-presents in my session. In the foyer, I bring him up to date with the case over a cup of coffee informing him that the Dutch were awaiting to hear back from the Irish authorities.

27th September 2004
I sent an email to confirming that I had received a letter from (named solicitor) who was of the opinion that my case could not be transferred to Ireland. My Dutch Lawyer responded to me on the same day stating that the Dutch Ministry of Justice had still not advised the Dutch Prosecutor.

November 11th 2004
I received an email from my Dutch Lawyer stating that he still had not heard back from the Dutch Prosecutor as to the intended course of action.

This is important as it contradicts Mr. MHB 1’s suggestion that I informed him in November 2004 that the case had been dropped. It would make no sense for me to do this as the HSE was aware from June 2004 of the incident and had immediate access to information. At this stage, no-one seemed to know what the outcome of the Prosecutor’s request might be.
2005

January 21st 2005
Mr. MHB 1 attends the national launch of our publication, Darkness on the Edge of Town at the Athlone Institute of Technology. In my office and before the launch took place, I bring him up to date on the case informing him that the Irish authorities still had not decided what to do with my case file.

February 8th 2005
I received an email from My Dutch Lawyer stating that on February 6th he had been phoned by the Dutch Prosecutor and informed that the Irish authorities decided they had no jurisdiction with my case and that the Dutch Prosecutor was now going to take the case to court in Amsterdam. Thus, it took the period July 2004 – February 2005 for the Department of Justice, Equality and Law Reform to make its decision. At no time did I receive any communication from that Department.

April 22nd 2005
I travel out to Amsterdam to meet with my Dutch Lawyer in person and be re-interviewed by the Police.

August 15th 2005
Phone call made from home landline to my Dutch Lawyer (1.51 minutes duration).

August 16th 2005
Phone call made from home landline to my Dutch Lawyer (13.14 minutes duration).

September 2005
I received a phone call from Athenry Garda Station where I was asked to present at the Station and sign off a warrant that had been forwarded by Dublin Offices to appear in court in Amsterdam (my wife and I remember being told that the Warrant had been some weeks in Dublin prior to being sent on to Athenry). My wife accompanied me to the Station and we met with a Garda on duty where we outlined background to the case to him.

September 9th 2005
Mobile phone call made (6.47 minutes duration) from our car whilst in transit made to Mr. MHB 1, HSE, re invitation to present at Athenry Garda Station to answer Summons which had been forwarded from Dublin. Ms. A made the
call and spoke with Mr. MHB 1 thanking him for his understanding on matters related to the case and work with the HSE and then I informed Mr. MHB 1 that the Court Case was imminent as per the Garda’s brief conversation with us.

This call is crucial as it illustrates Mr. MHB 1 and the HSE was made aware by us that the trial had been scheduled in Amsterdam in under two weeks. The HSE would have been aware that a judgement was imminent.

Sept 12th 2005
My wife, my brother and I travelled over to Amsterdam to attend a scheduled Court Case. The legal officials, a translator and ourselves were the only people present. Following the deliberations, we were informed by my Dutch Lawyer in the court lobby that there was nothing else for us to do but to go back to Ireland and “try to live our lives as normal”. He also told us again there was no European register.

September 26th 2005
I received an email from my Dutch Lawyer confirming that I received a conviction, a €2000 fine and a conditional three months prison sentence.

September 27th 2005
Phone call made from home landline to my Dutch Lawyer (2.41 minutes duration).

Early October 2005
I made Mr. MHB 1 aware of my conviction during the course of a phone call in early October 2005. In fact, my wife also confirmed the conviction with Mr. MHB 1 first and then I took the call.

October 10th 2005
I receive an email from my Dutch Lawyer confirming that the Prosecutor did not appeal the decision of the judgement. It further states, “You do not have to do anything now” (bold my emphasis). At one point in the future, you will receive a letter from the authorities in The Netherlands asking for payment of the fine which was imposed on you. This could take a while, probably a couple of months or maybe even longer…”

- This email post conviction is important as I understood that I did not have to do anything further in relation to authorities.

October 26th 2005
Meeting with Mr. MHB 1 at the HSE Offices in Tullamore (before a scheduled youth resiliency team meeting) where I informed him of the convictions and penalties.
November (?) 2005
I receive documentation from Amsterdam requesting that I pay €2,000 fine. I do this through bank transfer. No mention is made of having to inform Irish authorities or my employers.

November 22nd 2005
Phone call made from home landline to my Dutch Lawyer (7.52 minutes duration).

November 25th 2005
Phone call made from home landline to my Dutch Lawyer (3.18 minutes duration).

November 30th 2005
Five phone calls made from home landline to my Dutch Lawyer (3.16 + 2.59 + 1.51 + 2.05 + 4.37 minutes duration). These calls primarily concerned translation and bank account transfer details.

December 7th 2005
Phone call made from home landline to my Dutch Lawyer (6.25 minutes duration).

December 15th 2005
Phone call made from home landline to my Dutch Lawyer (5.27 minutes duration).

2007

June 28th 2007
A phone message is left at my work phone in Athlone Institute of Technology from a journalist of the Sunday World Newspaper stating he had come into possession of court papers relating to Amsterdam.

June 29th 2007
My wife and I travel to Dublin to meet with (named law firm). We walked over to the Four Courts and had a meeting with our Solicitor, (named solicitor) and a Senior Counsel, (named lawyer), provided by him. We came to this meeting with a list of questions that we specifically wanted answers to including whether or not I should inform my employer of the convictions (we specifically mentioned the Marketing and Communications Manager at the College with whom I enjoyed a solid professional relationship), how we should deal with the Sunday World newspaper etc. Mr. MHB 1 phoned my Dutch Lawyer and ran through the case details again. We were again advised not to inform my employer and are not advised of the requirement to register my details with the Gardai.
July 2007
I sent an email to (named solicitor) seeking clarification re registering.
July 18th 2007
(named solicitor) emailed me back stating he now thought I should register and attached two generic letters. Unfortunately, I did not open the attachments at that time as I was in a state of anxiety (I had a medical certificate for this period).

July 26th 2007
I was ill with a stomach bug and staying with my wife’s family in Limerick. I visited a friend of my wife in County Limerick late that night who has access to email and open the attachments sent on from (named solicitor) dated July 18th. I note the contents which provide details re registering.

July 26th 2007
I email (named solicitor), Solicitor, seeking confirmation of details around the relevant Act ((named solicitor) had been recommended by a colleague and was dealing with my resignation from the College).

July 27th 2007
I receive an email from (named solicitor), Solicitor, in the early morning who confirms that I should register.

July 28th 2007
I meet with the Gardai in Loughrea with my brother and father. They are asked to remain downstairs and I have a meeting with Sgt. GS6 and register my details.

August 1st 2007
I am interviewed by Supertindent GS2 and provide a formal statement. Two of my brothers attended the interview.

September 11th 2007
I receive a letter from my Dutch Lawyer, (named lawyer), where he states, and I quote, “After the rendering of the judgement I advised that there is no European register in place, but that your details were to be held in a central database in The Netherlands and there was no requirement on you to inform any other authority” (see attached letter).

Summary

Since June 2004, I followed the professional advice of both my Lawyers on all aspects pertaining to this case. You will note their letters dated August 14th 2007 and September 11th 2007 (see attached). I was advised not to inform my employer and not to inform “any other authority” and I, naturally, took this to be the correct advice. This advice was given in 2004, 2005 and again in 2007.
Nonetheless, in an attempt to be responsible to my position, I immediately phoned the Gardai and the HSE on June 26th 2004 to explain my arrest, I met with a senior HSE Officer on June 30th 2004 in Offices in Tullamore to detail the case, I attended the court case in Amsterdam in September 2005 and I informed the HSE of the outcome of the case in phone calls and in person on October 26th 2005 and subsequently in conversation in 2006.

11.2.4. Dr A provided a clarification on certain issues arising from his interview on 18 September 2007-11-29

“Clarification for Mr. Devine on Two Issues Raised at Meeting in Dublin

Dr. A

10th October 2007

Knowledge of Specific Legislation/Procedures

At our meeting, Mr. Devine raised the issue of ‘knowledge around protocol’ and mentioned specific documents and legislation that he felt I might have been aware of given my academic position(s).

I would like to point out that I was employed as a Lecturer in Sociology at the Waterford Institute of Technology from 1992-2001 and I was employed as a Head of Department of Humanities at Athlone Institute of Technology from 2001-2003. I was then employed as a Senior Lecturer in the School of Humanities from 2003-2007. At no time did legal studies form part of my career scholarship to date and I hold no formal qualifications in law.

Elements of the academic course dealing with Health Board/Garda protocol etc. were dealt with not by me, but with appropriately qualified social care workers, social workers and by expertise brought in from the relevant health
board areas. This can be verified from the relevant Heads of Departments in Athlone and Waterford.

As I have stated in my evidence, at all times on the matter of informing authorities, I accepted the professional advice of my eminent Lawyers, (named lawyer) and (named solicitor) on whom, as any client, I would be entitled to rely.

**The Gower Child Abuse Atlas**

I believe I provided a sound defence of my use of the Gower package and I would appreciate that Mr. Devine takes into context that I used the material over a decade ago when social care courses were being developed and moving into new areas which were previously the domain of more established professions with long histories of theoretical and practical materials.

Nonetheless, Mr. Devine also mentioned in passing that it was “a matter of opinion” as to use of the educational package – which I accept - as this is the case with much educational instruction. However, I wish to re-iterate that all present members of the relevant social care academic course board held at Waterford Institute of Technology validated its use by me as being appropriate given the emerging knowledge at that time in the mid 1990s and I took the views of my immediate colleagues as being the ones I should listen to and act upon.

Mr. Devine seemed to feel that those staff that supported the educational package at academic course board, and in the supporting letters, all came from ‘social care’ models and not ‘medical’ models of discourse – but this is not the case. I would like to point out that the support letters came from qualified Psychiatric Nurses, a Cognitive Behavioural Therapist, a Gestalt Therapist, a Law Lecturer, Sociology Lecturers and a Psychology Lecturer/Head of Department to name but some of the non social care backgrounds.
Also, the letter of support from Mr. D5, then advisor to the South Eastern Health Board on child protection policies, was considered to be crucial at the time by the School of Humanities management and should, I venture, remain so. It seems somewhat at odds that a key advisor to the South Eastern Health Board would give contrary opinion to an academic course board.

I also mentioned in my submission that it is common practice for child and youth care, or social care courses, to avail of medical materials under the guise of several course modules such as ‘principles and practice’, ‘paediatrics’, ‘child abuse and neglect’ and ‘child protection’. As an example, I discussed the Gower Educational Package with a Canadian lecturer colleague in child and youth care located in New Brunswick who informed me that she has (to quote directly) “taken pictures off the Internet which depict a “Mongolian Blue Spot” this is often found in children of Black, Oriental or First Nations origins. I use this to demonstrate to students that many people will see these marks (usually on the base of their spine...not a common area for bruises) and suspect abuse”. Thus, there are many ways to present sensitive material to adult learners.

Terms of the Inquiry

There has been some discussion in public fora (newspapers and websites) with regard to female ex-colleagues from Waterford Institute of Technology who have made claims around my alleged negative treatment/relationship with them and my appointment and elevation to L2 status and their desire to give evidence to the Inquiry. Such relationships are outside the terms of the Inquiry and I expect any submissions/evidence on this matter to be disregarded or struck from the record. Such matters rest between the complainants and the Waterford College management.

In any case, I was never in a management position in Waterford (the course directorship being only an administrative role which I was invited to assume) so exercised no ‘power’ over fellow staff. In fact, the employment history and
conditions of these ex-colleagues should be discussed with the appropriate individual – Dr. WIT 4, Head of School of Humanities at Waterford Institute of Technology for an accurate and more balanced picture.

Relationships with HSE Staff

Mr. Devine raised the issue of my co-author of the publication Darkness on the Edge of Town, Ms. MHB 5 not being informed of all the details around my arrest in Amsterdam in our meeting of June 30th 2004. I stated that I was specifically asked by her line manager, Mr. MHB 1, not to go into any detail around my arrest with her as he was her line manager and would make such decisions. Whether I agreed with this or not is not really the point as I took it as a direct request made of me from a senior HSE Officer in terms of moving the project forward given the circumstances. Also, between June 2004 and early 2005 I did not know what direction the case file might take; indeed I was genuinely of the opinion that it might be dropped as my Lawyer had undertaken to plead with the Dutch Prosecution on my behalf.”

11.2.5. Response by Dr A on 4 December 2007 to documentation provided by The HSE South outlining concerns regarding an interview conducted 29 January 1998 between Dr A and a young person previously in care of the Health Board as part of a research project on “Prostitution in Waterford”.


Introduction

Some time after the book Prostitution in Waterford City was published, the South Eastern Health Board in a phone call to my Office, brought it to my attention that it was ‘annoyed’ with aspects of its contents. As co-authors, we perhaps expected this because we were looking at a controversial area of
discourse and nothing of its like had been published in Waterford prior to our study. It came at a time of emerging Irish social care literature. I did have a brief informal meeting with a HSE representative and informed my colleague, (named academic) of this. No notes were taken to my knowledge and I was not given any documentation.

Nonetheless, best practice ethical guidelines were observed from the very outset of the study with (named academic) from the Dublin Institute of Technology taking the lead on this as he had significant experience interviewing children and youth at Doctoral status. (Named academic) attended at Waterford Institute of Technology and hosted a workshop for our entire research team.

Neither I, nor (named academic), was made aware of the specifics outlined in the letter of 5.2.1998 which came into my possession only on 14.11.2007 nearly ten years later. I find this staggering and would have been more than happy to answer any detailed concerns at the time as a co-author still resident and working at that time in Waterford ((named academic) was employed in Dublin).

A full draft of our book was read by a Law Lecturer in Waterford Institute of Technology prior to it being published and its contents and layout were deemed to be appropriate (see page 1 of the book).

**The Interviewee Mentioned in the Letter of 5.2.1998**

The interviewee was not a minor at the time of interview and we were informed that she was no longer in the care of the SEHB. Thus, an entirely different set of ethical guidelines would have applied to her interview than would be the case with a child or minor in care (I have presented and attended several training workshops on research etiquette in Ireland and abroad and have written extensively on this post 1998). In fact, several reports and books were published around this time (1997-2000) and all used varying methodologies and defences.

Page 36 of the book details the methodology and notes that we obtained the services of four of our female social care graduates to assist in the study. It is noted on page 37, “Dr. A also asked the full-time and part-time students of applied social studies at the Waterford Institute of Technology to enquire (discretely) in their practice placements if anyone knew anything about prostitution in the city. No (further) concrete information was obtained…” This last sentence (my italics) illustrates that information came from our interviewees and the research team. Again on page 38, it states, “The four female data collectors engaged in a preliminary training session early in March 1997 where issues such as questionnaire construction, confidentiality, developing rapport, record keeping, a non-judgemental approach and personal safety were discussed”. 
My memory (and I am going back over a decade) of the particular interviewee is in line with the SEHB documentation was that she was suggested to the team as a potential interviewee by (named person) who was, at that time, a mature student in her forties of the social care programme at Waterford Institute of Technology, a foster carer with the SEHB and who later worked with the DORAS Befriending People in Prostitution project. Thus, negotiations for the potential interviewee to partake in the study were made by (named person) who had both a personal and professional relationship with her – and not by (named academic) or me who did not know the young woman.

At the point of interview, I was accompanied by (named person) and subsequently furnished (named academic) with a draft of the transcript as with all transcripts for the study for comment and co-analysis.

In terms of best practice methodology, it was explained to all potential participants that some aspects of their biographies and their ‘stories’ would be changed/merged to ensure confidentiality. All agreed to this. I have used this approach in all of my empirical studies to date including the one I had published directly before the prostitution study (Children at Risk, 1996) so was familiar with such methodology and many of my colleagues in child and youth care also employ such an approach.

It is correct that the interviewee signed off the interview notes – as is common best practice. Consent was fully explained to all interviewees and all signed off their transcript/transcript notes which were co-signed by the interviewer(s).

Commentary

Neither (named academic) nor I were, as far as our collective memories can be sure, ever made aware that there was formal written correspondence in the SEHB in relation to one of our 1996/1997 interviewees. I have spoken with him on 14.11.2007 to confirm this. Both of us would, of course, make every effort to ensure the well-being of any of our interviewees as we believe their stories deserve to be heard. It seems to me natural justice that one would be made aware of such documentation so that one could provide a rigorous defence of methodologies employed.

In any case, it would be unfair of the inquiry to embrace a tempocentric position on this matter as there were no published guidelines at the time (i.e. 1996 & 1997) governing our study from either the Sociological Association of Ireland (academic association) or the Irish Association of Care Workers (practice association). We did attempt balance by drawing on external professional associations and on accepted best practice.

Finally, I was co-author, not sole author, and all involved in the publication signed off their agreement to its contents. We all remain proud of this innovative publication.”
11.3. Mr. MHB 1 (HSE)

11.3.1. Mr. MHB 1 furnished the following written account of his role relevant to the Terms of Reference of the Review Inquiry following a preliminary meeting with him and his IMPACT Trade Union representative on 2 August 2007.

31.07.07

"Midlands Regional Drug Taskforce

The Regional Drug Taskforce’s (RDTF) were established as one of the key strands of the National Drug Strategy. There was a significant delay in establishing the RDFT; this related to employment ceiling levels and governance structures. It was agreed between the Department of Health & Children (DoHC) and the CEO’s Group (Health Boards) that the Health Board’s Regional Drug Co-ordinators or equivalent* would on an interim basis act as Interim Coordinators for the RDTF and establish RDTF in their respective health board area.

* There was no Regional Drugs Co-ordinator’s post in the Midlands, however as Senior Health Education Officer for Substance Misuse, I carried the function with the exception of treatment services. I was asked to take on the role of Interim Taskforce Co-ordinator and establish the Regional Drugs Taskforce in the Midlands in addition to my current duties.

The membership of the RDTF was clearly outlined within the National Drug Strategy (Statutory/Voluntary/Community Sector and Local Authority members chosen through the Regional Authority). Once the first meeting of the RDTF was arranged, the principle task was to elect a Chairperson, it was the choice of the RDTF that the person should be independent and a number of names were put forward. I contacted those suggested and two allowed their names to go forward. Mr. D1 was elected as RDTF Chairperson.

The Interim Co-ordinators meet with the National Drugs Strategy Team (NDST) in the early stages of the establishment of the RDTF’s, on a regular basis, however there was then a change in policy and the NDST meet the Chairs in instead. There is a link person nominated by the NDST to each RDTF, in the case of the Midlands this was Mr. D2, Principle Officer, Dept of Justice, Equality and Law Reform. Mr. D2 attended most meetings of the RDTF and was the conduit for the flow of information between the RDTF and NDST.
Due the delay in funding coming through and the appointment of the permanent co-ordinator, there was considerable disillusionment among the members in relation to progress and membership fell off at different points. It was my view that if I stopped calling meeting, no one would have complained too much.

The RDTF also established 4 sub-group under the pillars of the National Drugs Strategy. The sub-groups were supported by the MHB Health Promotion Project Workers – Substance Misuse.

We had a limited amount of funding, (50,000.00) which had been allocated by the DoHC for the salary of the Co-ordinator, this funding had not been spent in year one, and it was suggested that we might allocated small grants, I advised against this approach as it was not clear when the Co-ordinator’s post would be agreed and there might not be funding available to follow through on projects in year two. In addition, there were questions in relation sustainability and capacity to carryout substance misuse initiatives by community sector.

The knowledge of the RDTF memberships with some exceptions was limited in relation to field of substance misuse. These added additional issues for myself and much work fell back on me. I identified the training needs of the membership and was asked by the NDST to hold back doing anything as they were going to employ a project officer at a national level which would address this matter in a national context.

**Connection with Athlone Institute of Technology**

My initial assignment within the Midland Health Board was to the Athlone Area, where I was responsible for Substance Misuse Education & Prevention. Over the following years I lead out a night course programme in the Institute and also became responsible for a health promotion project which eventually became the Healthy Campus Initiative.

I heard about the Centre in the Institute which Dr. A was Director of. I was interested in the work of the Centre given that a lot of Health Promotion Services work related to youth and families. I did not initial get an opportunity to setup a meeting due to my work load.

Ms. MHB 5, Health Promotion Project Worker – Substance Misuse applied to complete her third level education, and I agreed that the Health Board would facilitate this request in terms of giving her one afternoon a week to attend lectures from her work time. During her studies she met Dr. A as he supervised some of her studies.

Ms. MHB 5 noted to me at one of our supervision session, that Dr. A was interested in carrying out research into Heroin in the Athlone
Area. I agreed to meet with Dr A and Ms MHB 5 to discuss the research.

Meeting with Dr A in relation to Heroin Research (Proposal)

General Context:

Why would we consider such research?

Over the previous few years there was much misinformation in relation Heroin use in the Athlone Area, much of the information focused on numbers, lack of services, and the role of Marist Rehab in bringing drug users to Athlone.

Dr A, proposed taking a different approach, the research would look at the stories of heroin users and those working with them in the Athlone Area. This approach would address many of the myths, (imported users or local users, connectedness with family groups and would facilitate the story of heroin users to he heard)

During the meeting we discussed different aspect of the research and approaches to be taken. I also asked if he saw a role of Ms MHB 5 in the research and it was agreed there was.

I agreed in principle that we would fund this piece of research subject to a project proposal. I also ran the proposed research by the NDST and they asked me to forward it to The National Advisory Committee on Drugs (NACD) - Clearing House for Drugs Research. The NACD wrote back with a number of comments which were included in the research proposal.

The initial work began and I then brought it to the RDTF and they agreed that this was valuable and asked for the research to be extended to Portlaoise (increasing being highlighted as a problem area). The research was seen as supporting the regional plan. Dr A and Ms MHB 5 presented at this meeting of the RDTF.

The research initiative began and was going very well. I was updated regularly by Dr A in respect of progress.

Work of the RDTF

A second piece of research was also underway in the Portlaoise Area. This had been commissioned in 2003 and there was a considerable delay in getting the final draft. The title of this Research Report is 'Stepping In – Young People & Heroin Use: Findings an Adequate Response for Portlaoise'.

This piece of research was commissioned following a meeting with and considerable press coverage generated principle by (named judge).

My attention then primary turned to the development of the Regional Action Plan. It was agreed that given there were no progress on the
permanent positions that this could be contracted out. The process for this began and I led on this.

There was considerable confusion in the Midland’s in relation to my role in respect of Substance Misuse. I had for 4 years been the principle person in the media and representing the health board in relation to drugs with local agencies and communities. My additional role with the RDTF lead to confusion. The views of the RDTF and the Health Board were not necessary the same. Hence the confusion in relation to Sgt GS1 stating the Health Board had invited him.

**Incident Holland 23rd – 26th June 2004.**

The Regional Drugs Taskforce contracted the Centre for Family & Childhood Learning, Athlone Institute of Technology to carryout research into Heroin use in Athlone and Portlaoise. As part of the research there were two international visits. During the visit to Holland an incident took place where Dr A was taken in custody by police for questioning. During this visit Dr A was accompanied by Detective Sergeant GS1, a Garda Officer working in the drugs field in the midland area. Both men were to attend a conference and some individual meetings were also arranged.

**Initial Telephone Conversation with Sgt GS 1 (Friday 25th of July)**

I received a phone call from Detective Sergeant GS1 to inform me that an incident had taken place in the hotel (Dr A & he) were staying. Sgt GS1 informed me that he was not involved in the incident but was requested to help police with there enquires.

Sgt. GS1 informed me:

- Dr A had entered the room of a group of American Students.
- Having entered the room he removed his clothing.
- He attempted to get into the bed of the students.
- He attempted to kiss one of the students.

Sgt. GS1 informed me that they had met the students earlier in the evening and the age profile was 15 to 18 years. He also told me that Dr A had a significant amount to drink before the incident.

In addition, we discussed the following:

- Cancellation of the remaining part of the visit. It was my understanding from Sgt GS1 that they would be meeting police and other officials and given what had happen he felt it was appropriate to determinate the visit, I concurred with this position.

- I also discussed reimbursing him for any additional expenditure incurred due the incident. (Early return home etc.)
- We also discussed that this could break in the media depending on the outcome.

I agreed to meet with him when he returned to Ireland.

**Actions taken by Mr. MHB 1 once notified of the incident**  
(Friday 25th – Tuesday 29th June)

The governance structure for Regional Drugs Taskforce was to the National Drugs Strategy Team.

My reporting relationship in terms of the health service at the time of the incident was to Dr. MHB 2, Director of Public Health, as I was Acting Regional Health Promotion Manager.

On drugs related matter I linked with Dr MHB 2 on strategic matters and on operation matters I linked with the relevant manager in community care, previously mental health services.

I was notified of this incident in the afternoon, and between then and 29th of June I informed those listed below.

Mr. D1, Chairperson of the Regional Drugs Taskforce  
Ms. D4, Director of the National Drugs Strategy  
Dr. MHB 2, Director of Public Health, MHB.  
Ms. MHB 4, Acting Asst. CEO, MHB.  
Ms. MHB 3, Director of Communications MHB. (In case this was pick up by the media.)  
**Ms. HSE 1, Asst. National Director Population Health (only informed after taking up current post {06} in the context of Historical Information.)

In all cases I explained the context, the incident itself and discussed what might happen next.

<p>| <strong>Lines of Communication</strong> |</p>
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Conversation with Dr A from Holland. (Over the Weekend 25th June)

Following his release from Police custody, Dr. A rang me from Holland. From his tone, and what he said, I noted that he was upset and embarrassed by what happened. I informed him that Sgt GS1 had told me of events. I told him that I believed the visit should not continue given the circumstances. Dr. A listened and did not make much comment. I asked him when he was due to return to Ireland, he said he needed a few days to get his head around what had happened and would then return home. I suggested to him that he needed to discuss this with his family.

I asked him to ring me when he returned to Ireland and set-up a meeting.

Week of the 28th June

I informed Ms. D4 of what had taken place. Ms D4 said she would speak with Supt. D3 of the Garda National Drugs Unit, who was the Garda rep. on the National Drugs Strategy Team (NDST). She also said that Mr. D2, Principle Officer, Dept of Justice who was the NDST rep. on the Midlands Regional Drugs Taskforce should be informed. I cannot recall whether I made the initial contact with Mr D2. I do recall a conversation with Mr. D2 at a later stage.

Telephone conversation with Supt D3

I did speak with Supt. D3 briefly.
- It was unclear how authorities in Holland might proceed.
- We spoke about any issues for Sgt. GS1

Conversation with Second Garda based in Holland (Week of 28th June)

I also spoke to a second Garda, I cannot recall his name, and I understood it he was based in Holland. I had a short conversation with this officer. He explained to me issues around the incident and that periods of questioning in Holland were longer. He did not know what the result of the questioning would be and that the Dutch Police were not sharing significant information. I also understood his role was to support Sgt. GS1.

Meeting with Ms. MHB 4 - Week of the 28th of June

I recall a meeting with Ms. MHB 4 early the week of (Monday 28th of June). This meeting took place in my office in Tullamore.

It was agreed that I would meet with Dr A. I had informed Ms. MHB 4 that I had asked him to contact me upon his return.

We also discussed who could be informed of this incident. One of the key issues in our discussion related to the fact that Dr A had been questioned on allegations relating to incident that took place but had not be charged
or convicted. From the conversations I had with gardai it was not clear how things might progress.

It was agreed that I would meet with Dr A and discuss
(A). What had occurred
(B). Put restrictions around the piece of work he was carrying out.
(C). I was to keep her informed of any developments.

I reported back to Ms. MHB 4 following the meeting and confirmed what I was told and that Dr A had agreed to co-operate.

I informed Dr MHB 2 that I was linking with Ms. MHB 4 on this matter.

**Meeting with Detective Sergeant GS1 (1st July 2004)**

I agreed to meet with Detective Sergeant GS1 upon his return to Ireland. I understood that I was meeting him to discuss what had happen, in the context he had been caught up in this incident by no fault of his own and that he had been invited by the RDTF through myself to attend. I meet Detective Sergeant GS1 for lunch.

1. I understood this to be an informal meeting to discuss the events. If it had been a formal meeting, I would have held it in my office or the Garda Station.

2. Sgt. GS1 explained to me:
   - They had meet the students earlier in the evening
   - Both Dr A and he had been out socialising (Some mention of football)
   - When they returned to the hotel Dr A was intoxicated
   - There were some students in the lobby area?
   - Dr A wanted to party
   - That he had convinced him to go to his room. I understand that both men retired to their respective rooms.
   - Police had interviewed the girls involved and they had left Holland.

Sgt. GS1 only knew about what was happening when he was awakened by a call from police in reception. He informed me that the police were professional but were sharing limited information and that he agreed to help them with their enquiries.

He went through the information that he had shared already, additional information related to damage to the hotel room where the girls were staying
We discussed what the outcome might be; it was unclear as to how the authorities would deal with the matter, under what headings and what might emerge in police enquiries.

In addition we discussed the leaking of information. Sgt. GS1 was concerned that rumours might circulate in relation to his role. Sgt. GS1 informed me that he had paid for his flights etc. and that he was to be reimbursed for this upon his return and there was also additional funding expenses surrounding the incident. I agreed that I would speak with Dr A in relation to this and there would be no issue in relation money that he was owed.

Sgt. GS1 informed me that he had told the Garda Authorities about the incident.

No paper work relating to the incident was handed over.

**Meeting with Dr A (Week of the 5th July)**

I meet Dr A in my office in Tullamore. I think this was the 6th of July.

- He apologised about what had happened
- He noted that he had been under significant pressure in the Institute over the last 12 months and this had caused him a lot of stress
- He told me that he had informed his family (Wife) and that she was standing by him
- He suggested that he would pay for the cost of the visit to Holland.
  - He noted that this would be a personal visit. (I noted to him that Sgt. GS1 had been present and it would not be appropriate to describe it as so).
- I suggested to him that he should inform his employers. He was concerned about this and I suggested he sought advice from someone he trusted within the Institute. He told me that he would look into this.
- He informed me that he had employed a lawyer in Holland and would know within 3 - 6 months.
- I asked him if he had been charged and he told me ‘no’
- He informed me that he may have to return to Holland depending on what was decided.
- I suggested to him that it would be appropriate given the stress that he said he was under to seek counselling and he informed me that this was in hand.
- I also informed him that I was going to withhold funding for another project until this matter was resolved.
- We then discussed the research, and I proposed he take a back sit in respect of the research, that he would begin to write up what had been done to date and that the others involved would continue with the field work. If it was necessary to meet with a group that he ensure that one of the other people involved in the research be present he agreed to this.
- I agreed to meet with Dr A in September to review the research and I asked him to keep me informed in relation to any developments.

Second Meeting with Dr A (September)

This meeting happen in the context of managing the heroin research. Before the other staff arrived, I asked him how things were and if he had heard anything from Holland.

He informed me that:

- Things were going well with his family
- The counselling was going well and very valuable
- He had not be given a date to return to Holland and that his lawyer did not think that the case would progress
- He also told me that he had spoken to (named academic) (a Canadian colleague of Dr. A) about the incident.
- He informed me that the research had fallen back significantly and that he would need extra support. He asked if I could provide additional support through one of my staff. (I agreed to discuss this with the staff member.

Third Meeting with Dr A (November 05.11.04)

The context of the meeting was the heroin research initiative.

- He informed me that the case in Holland would not be proceeding.
- I remembering commenting that this would put a different completion on Christmas for him and his family.

Following the November meeting I asked Dr. A to update the original proposal document. This was to take account of additional people becoming involved in the research. He did this and forward it a few days after 08.11.04

I spoke with Ms. MHB 4 shortly after the above meeting. I informed her of what Dr A had said in relation to matters not proceeding. We spoke about how foolish he had been. This was at the back end of another meeting.

I thought this was the end of the matter.
Launch of Darkness on the Edge of Town.

The Report was published on Monday 17th of January 2005.

There was considerable media attention in relation to the launch; this was due to a number of other public meetings in the Athlone Area in the lead up to the launch.

Meeting with Ms. MHB 5:

I spoke with Ms. MHB 5 (MHB Employee) who was working with Dr. A on the study, I informed her that an incident had taken place in Holland which was inappropriate. I asked her if she had any concerns in relation to Dr. A and she had not.

A second reason for consulting with Ms MHB 5 was that she was due to travel to Canada with Dr A later in the year. I wanted to give her the opportunity to withdraw for this trip. She said that she had no concerns.

I understood from Dr A that he was going to visit a number of projects on the back of visit to Canada. I did not want to disadvantage Ms MHB 5, and proposed if this visit was to go ahead that a second Health Promotion Project Worker (HHPW) accompany them. This was agreed.

I consulted with Ms. MHB 6 and informed her that an incident had taken place on a previous trip but Ms MHB 5 was happy to go ahead with the visit. I asked Ms MHB 6 to accompany them and as she agreed.

This trip went off without any problems.

Knowledge of the Conviction:

- At no time did I know that he was formally charged or convicted.
- At no time did Dr A inform me of a conviction.

I learnt of the conviction on 9.00 RTE News on Thursday 12th of July 2007. I contacted my line manager, that evening and informed her that I was involved with events in relation to this incident. I suggested that I would contact Ms. MHB 3 as Director of Communications Dublin Mid Leinster, I was unable to contact and left a message with her assistance. I was then contacted by the HSE Press office and subsequently by Mr. HSE 2.

Funding of additional work:

I did fund other work in 2005, but did so on the grounds that the matter in Holland was resolved. I am happy to provide additional information, if not already available.”
11.4. **Ms. MHB 4 (formerly HSE)**

11.4.1. In light of clear differences in recollection of events as between Ms. MHB 4 and Mr. MHB 1, Ms. MHB 4 was furnished with Mr. MHB 1’s written statement and interview summary for comment following her interview on 28 August 2007. She responded with the following document on 16 September 2007.

11.4.2. With regard to actions taken by Mr. MHB 1 once he was notified of the incident (Friday 25th – Tuesday 29th June), Ms. MHB 4 stated that she was not “informed” in the context suggested in Mr. MHB 1’s written statement and that she was advised by Mr. MHB 1 at the end of a meeting in her office sometime towards the latter half of 2004, that Dr. A, while on a trip abroad with others to Amsterdam, had been involved in an incident in a hotel. According to Mr. MHB 1, Dr. A had “behaved badly” late at night in a hotel. Ms. MHB 4 said that she was told that the incident involved women. She stated that she advised Mr. MHB 1 to follow the matter up as appropriate and to keep her appraised of progress or any relevant issues and no further mention of the matter was made to her.

11.4.3. Ms. MHB 4 denied that she was informed by Mr. MHB 1 or any other person of the context of the incident apart from as set out in 10.4.2 above. She further said that there was never any discussion between Mr. MHB 1 and herself about the matter apart from her advising him to keep her appraised.

11.4.4. Ms. MHB 4 denied that any such meeting took place in the week of 28 June in Tullamore, as described by Mr. MHB 1, either in Mr. MHB 1’s office as alleged or at all. Ms. MHB 4 has no recollection of meeting in Mr. MHB 1’s office which was in a different building to hers. According to Ms. MHB 4, as she was Asst. CEO at the time, any meetings (if they took place) would most likely have been in her office and not in Mr. MHB 1’s. Ms. MHB 4 also denied that she had agreed that Mr. MHB 1 would meet with Dr. A.

11.4.5. Ms. MHB 4 denied that allegation that she had agreed that Mr. MHB 1 would meet with Dr. A or that any such information was imparted to her by Mr. MHB 1. She stated that Mr. MHB 1 did not inform her that he had asked Dr. A to contact him on his return or at any time.

11.4.6. Ms. MHB 4 denied that any discussion took place with her regarding who could be informed of the Dutch incident.
11.4.7. Ms. MHB 4 denied having any discussion with Mr. MHB 1 about the fact that Dr. A had been questioned but not convicted. She stated that she was simply informed in an “off the cuff” manner at the end of another meeting that Dr. A had behaved badly with women in a hotel late at night in Amsterdam.

11.4.8. Ms. MHB 4 said that she had no knowledge of discussions between Mr. MHB 1 and the Gardai.

11.4.9. Ms. MHB 4 denied agreeing that Mr. MHB 1 should meet with Dr. A to discuss what had occurred and to discuss the placing of restrictions on the work that Dr. A was carrying out.

11.4.10. Ms. MHB 4 stated that she categorically denied that Mr. MHB 1 ever subsequently reported on the matter to her. She reiterated that the only time that Mr. MHB 1 ever mentioned the matter to her was on the one occasion. She denied that Mr. MHB 1 ever reported back to her as he has stated or at all, and she denied that Mr. MHB 1 informed her of the content of anything Dr. A may have said to him. She further denied that it was reported to her that Dr. A had agreed to co-operate. She also stated that she was unaware as to what Mr. MHB 1 may have informed Dr. MHB 2.

11.4.11. With regard to Mr. MHB 1’s third meeting (5 November 2004) with Dr. A, Ms. MHB 4 stated that she has no knowledge of any meeting that Mr. MHB 1 may have had with Dr. A. She also denied that any conversation took place between her and Mr. MHB 1 following this meeting or that Mr. MHB 1 informed her on the content of his conversation with Dr. A as alleged or at all.
11.5. An Garda Síochána

11.5.1. The following questions were put to Detective Sergeant GS1 prior to his interview on 28 September 2007

Dear Inspector GS1,

“I refer to our telephone conversation of 23 August 2007. I wish to outline in broad terms the issues that you may be in a position to assist in establishing the facts and the background relating to matters encompassed within the terms of reference of the Review Inquiry. I also attach with this letter, Terms of Reference and Methodology for the Review/Inquiry.

The first issue which you may be in a position to assist with, relates to any knowledge you might have of the circumstances surrounding the commissioning by the Regional Drugs Task Force, Midland Health Board Area, of Dr. A to undertake research into heroin use in Athlone and subsequently in the Portlaoise area. Your understanding/perception at the time of the relationship between the Midland Health Board/HSE Midlands and the Regional Drugs Task Force, Midlands Area would be welcomed.

The second issue surrounds the circumstances giving rise to the study visit by you and Dr. A to The Netherlands in June 2004 with particular emphasis on the authorisation for the study visit and the composition of the study team. You may wish to place on record, the events giving rise to Dr A’s questioning by Dutch police in the course of that study visit. You might also be in a position to indicate whether you had any contact with representatives of the Regional Drugs Task Force or the Health Service Executive in the course of the study visit and in particular after the Dutch police had questioned Dr. A. You may also be in a position to indicate whether, apart from yourself, were any other member of An Garda Síochána assisting the Dutch police with their inquiries at that time or assisting either you or Dr. A in The Netherlands?

The third issue relates to contacts which you may have had with Mr. MHB 1, HSE and Regional Drugs Task Force on the following dates

- By telephone 25 June 2004
- A meeting on 1 July 2004
You may also be in a position to indicate whether you notified/communicated/disclosed any details of the circumstances relating to Dr A’s questioning by Dutch police to any other Officer of the HSE.

The fourth issue relates to a study visit funded by the Regional Drugs Task Force which was made by Dr A to Canada in 2005 and whether there was any discussion with you by the HSE or Regional Drugs Task Force on the advisability of that visit having regard the behaviour of Dr A in Holland in June 2004.

The fifth issue is whether you can indicate at what point you were informed that the Dutch authorities were charging Dr A with attempted indecent assault and whether you disclosed this detail to any member of the Regional Drugs Task Force or any Officer of the Health Service Executive. The same question applies to the trial and conviction of Dr. A in September 2005. You might also indicate whether you were present in The Netherlands for that trial, and in what capacity. Did you discuss the outcome of that trial with any member of the Regional Drugs Taskforce Team or the HSE? Are you aware of any notification by An Garda Siochana to the HSE on the outcome of Dr A’s trial?

As a subsidiary issue, and in order to establish a precise chronology of significant events surround this matter, you may also be in a position to indicate, to your knowledge, whether the Dutch authorities communicated with any public authorities in this jurisdiction either leading up to or following Dr. A’s trial and conviction.

There may, of course, be other issues which you may wish to contribute and you would be invited to do so subject to such matters being consistent with the terms of reference and/or salient matters which will assist in establishing a chronology of significant events.

Perhaps when you have considered the above matters you might revert to me to discuss possible dates to arrange for you to meet with the Review/Inquiry Team.”

11.5.2. Questions for the Garda Liaison Office, the Irish Embassy, The Hague, were requested to be re-directed to the Assistant Commissioner, Crime and Security, An Garda Siochana

Dear Assistant Commissioner,
I wish to advise that I have been in correspondence with the Garda Liaison Office, Irish Embassy, The Netherlands, in respect of the above mentioned Review/Inquiry and have been requested to refer relevant queries to your office.

You may be aware that I am currently undertaking a Review Inquiry on behalf of the Health Service Executive in Ireland in respect of the above matters and attach for your attention a copy of the terms of reference and methodology of the Inquiry.

In the course of the Review Inquiry process certain matters have emerged from interviews undertaken about which you might be in a position to assist in establishing matters of fact.

I am aware that Detective Sergeant GS4, Garda Liaison Officer, was providing liaison support to the Dutch authorities and to Inspector GS1, who had accompanied Dr. A on a study visit to Amsterdam in June 2004. Neither Inspector GS1 or Detective Sergeant GS4 were involved in any of the incidents that gave rise to charges being brought against Dr. A. I am also aware that Detective Sergeant GS4 facilitated the reporting of the incident involving Dr. A to the Garda authorities in Ireland in June 2004.

Arising from Detective Sergeant GS4`s involvement in these matters I would be grateful if you could provide information in respect of the following matters.

1. Did either Inspector GS1 or the Dutch authorities in June 2004 advise Detective Sergeant GS4 that one of the female American students that had made a complaint of sexual assault against Dr. A, was a young person of 15 years of age?

2. To your knowledge, in the summer of 2004, were either the Garda authorities in Ireland or the Statutory Bodies responsible for Child Protection within the Health Services in Ireland advised from any official source in The Netherlands that one of the young persons making the complaint was 15 years of age?

3. Did the Dutch authorities liaise with the Garda Siochana in respect of the transmission of a file relating to Dr. A to the Department of Justice, Equality and Law Reform in July/August 2004?

4. Did the Dutch authorities advise the Garda Liaison Office in the Irish Embassy in The Hague of the pending trial of Dr. A in September 2005 and did those same authorities issue any advice or notice in respect of the conviction of Dr. A that same
month? Did any other official Body or person provide such information to the Garda Liaison Office?

I would be most grateful if you were in a position to provide responses to the above points. “

The Assistant Commissioner replied as follows......

“Dear Mr. Devine,

With reference to above and your correspondence dated 28 September 2007, and following communications with Detective Sergeant JC, I am to advise as follows:

- Neither Inspector GS1 nor the Dutch Authorities in June 2004 informed Detective Sergeant GS4 that one of the female American students that had made a complaint of sexual assault against Dr. A, was a young person of 15 years of age. The only information provided by the Dutch police was that they were in a group of students who had been staying in the same hotel as Dr. A, with an average age of 17 years, on a tour of Europe.

- Detective Sergeant GS4 states that, to his knowledge, in the summer of 2004, neither the Garda Authorities nor the Statutory Bodies in Ireland responsible for child protection within the Health Services were advised from any official source in The Netherlands that one of the persons making the complaint was 15 years of age. To his knowledge the only reports concerning these events were those made by him and Inspector GS1.

- Detective Sergeant GS4 states that the Dutch Authorities did not liaise with the Garda Liaison Office regarding the transmission of any file relating to Dr. A to the Department of Justice, Equality and Law Reform in July/August 2004.

- Detective Sergeant GS4 states that the Dutch Authorities did not advise the Garda Liaison Office in The Hague of the pending trial of Dr. A and did not issue any notice or advice of the conviction of Dr. A in September 2005. No other official body or person provided information regarding the conviction of Dr. A in The Netherlands to the Garda Liaison Office. The Garda Liaison Office only became aware there had been a trial and conviction of Dr. A in The Netherlands, following publication in the Irish media of reports concerning Dr. A on 13 July 2007.”

Yours sincerely,
GS3, Assistant Commissioner
11.5.3. Copies of statements provided by Inspector (formerly Sergeant) GS1 and the Garda Liaison Officer in The Netherlands were furnished to the Review/Inquiry, and are summarised below

- **(a) Report from Garda Liaison Officer to D/Chief Superintendent, Liaison and Protection on 25 June 2004 regarding the arrest of Dr A**
  This report provided an outline of the allegations against Dr A under the heading “alleged rape”. The reference to the age of the female complainants is expressed as follows “They are a party of a tour of 70 Americans, mostly female students who are on a tour of Europe. The average age of the students is 17 years.”

- **(b) Report by Detective Sergeant GS1 to Superintendent, Athlone 4 August 2004**
  This Report outlined the background to the study visit, the manner in which GS1 learned of the allegations against Dr. A and was headed “Arrest of (Dr. A)….. Alleged Rape”. The report indicated that MHB 2 was advised by Dutch Police that allegations of Rape and Sexual Assault had been made against Dr. A by a number of female American students staying in the hotel and added…”Their tour party totalled 70 with an average age of the students being 17 years.” The Report concluded with the following remarks
  “I have not had any further contact with Dr A and have met with and spoken briefly to (Mr. MHB 1)….. “

- **(c) Report by Inspector GS 1 to Superintendent, Athlone, 13 July 2007**
  Inspector GS 1 described a meeting with Mr. MHB 1 in August 2004 as follows:


In the penultimate paragraph, I refer to meeting and speaking briefly to Mr. MHB 1, Regional Health Promotional Manager, Midlands Health Board (Now HSE)

I am to state that I met Mr. MHB 1 by appointment at The Grand Hotel, Moate, in August 2004 on the latter end of the week 9th – 13th. I discussed with Mr. MHB 1 my visit to Amsterdam with Dr. A and informed Mr. MHB 1 of the totality of events occurring in relation to the arrest and detention of Dr. A. Mr. MHB 1 informed me that he would be addressing these issues with Dr. A in light of his role within the
Regional Drugs Task Force on behalf of the Midland Health Board. I was satisfied from this meeting that the appropriate measures would be taken by the HSE.

GS 1, Inspector”

- (d) Report by Inspector GS 1 to Superintendent, Athlone, 17 July 2007, outlining his recollection of the detail of the allegations against Dr A as advised by GS 1 to Mr. MHB 1 on a dates between 24 June and 13 August 2004. There is no reference to the ages of the girls making the allegations or any reference to “average” ages. GS 1 added:


In regard to the incident which occurred in Hotel Casa 400 Amsterdam, The Netherlands on 23rd/24th June 2004 involving Dr. A I made contact with Mr. MHB 1, Regional Health Promotion Manager, Midlands Health Board. Mr. MHB 1 had made the original request for my attendance on this trip to Amsterdam as part of a comparative study in regard to combating Heroin abuse. File No. FG 2/323/04 – LW 162.20/04 refers.

To my knowledge Mr. MHB 1 from the Midland Health Board was responsible for the organisation of this trip and I believed that Dr. A was employed by the Midland Health Board via the Midland Regional Drugs Task Force for the compilation of this study which was to be included in the publication of the book “Darkness on the Edge of Town”. Mr. MHB 1 at the time was also a pivotal figure in the Midland Regional Task Force. I had met both persons in an official capacity as part of the multi agency initiatives in which I represented the Longford/Westmeath Divisional Drugs Unit in my position as Detective Sergeant.

My first contact with Mr. MHB 1 was on Thursday 24th June 2004 while I was in the company of Sgt GS4 Liaison, Holland. At this time I informed Mr. MHB 1 of the following:

(1) That Dr. A had been arrested in Amsterdam following an allegation of rape.

(2) That he was detained at Maarnickstraat Police Station and that it was unclear when he would be released.

(3) That I had assisted the investigation and supplied a statement to the Dutch Police.
(4) That the allegations followed an incident in the Hotel Casa 400 in which it was alleged by American students that Dr. A had:

- Entered a room in the Hotel occupied by two American Students who pushed him out of the room
- Entered another room and met one American girl and allegedly gave her a French kiss which could be regarded as rape in Holland
- That he also entered a room with other American Girls and removed his clothing from the waist down and got into bed with one of these girls who raised the alarm.

(5) I also informed Mr. MHB 1 that I had informed my own Authorities and that I was presently with the Liaison section of An Garda Siochana receiving assistance to return to Ireland early and that all arranged appointments had been cancelled.

(6) I also informed Mr. MHB 1 that I had not had any contact with Dr. A since his arrest. I reiterated to Mr. MHB 1 my dismay at being in this position and my disappointment at the turn of events which put me in a very undesirable position. Mr. MHB 1 apologised to me for the inconvenience and we arranged to meet on my return to Ireland.

I also informed Mr. MHB 1 that prior to this incident and on our arrival to Amsterdam we had booked into our accommodations (two separate rooms) in the Hotel Casa 400. We had then gone for refreshments in the city centre and returned to the Hotel at approx 1am on the 24th July 2007 whereupon I had booked an early morning call at reception. I further informed him that it was after retiring to bed that I was notified of the arrest of Dr. A at approx. 4.30 am on the 24th June 2004.

I had further contact with Mr. MHB 1 by mobile phone from Dublin airport on arrival on the 25th June 2004 when my luggage failed to arrive and I had no access to my car to drive home. Mr. MHB 1 arranged for me to book into the Great Southern Hotel under the account of the Midland Health Board and I stayed there until the following morning when my luggage arrived from Holland. At this point I made arrangements to meet Mr. MHB 1 at a suitable time and location on my return to work in the Division.

I met with Mr. MHB 1 by appointment in the Grand Hotel in Moate, Co. Westmeath on a date between the 27th June 2004 and the 13th August 2004 where I reported to Mr. MHB 1 the full circumstances of the matter in detail and outlined in points (1) to (6) page 2 of this report and I was assured that appropriate actions were being undertaken. I am unclear exactly what dated this meeting took place however I am sure it occurred within a two week period of my return and before the 13th August 2004. I
recall that Mr. MHB 1 informed me that he had spoken to Dr. A and was aware that the Dutch police were conducting an investigation into the incident. He also informed me that Dr. A had returned home following release from custody, that prior to this trip Dr. A had been under considerable stress and that he was taking time off and may avail of some counselling and that he had the full support of his family. I also discussed with Mr. MHB 1 the matter of my out of pocket expenses which he undertook to reimburse as this trip had been funded by the Health Board as it was known at the time.

This book was launched from the AIT Athlone in early 2005 and was attended by local Gardai from both Longford/Westmeath and Laois/Offaly along with all the Statutory and voluntary bodies combating drug abuse in the Midlands Region. It was launched under the auspices of the Midlands regional Drugs Task Force. Both Mr. A and Mr. MHB 1 sat at the top table for the launch.

Apart from my attendance at this official Launch of the above named book I have had no further contact or interactions with either Mr. MHB 1 or Mr. A and on the date of that official launch I did not have any interaction with either of these persons nor was I aware at any time that Mr. A had been convicted of any of the allegations made at the time of his arrest in Amsterdam.

Forwarded for your information, please.
GS 1, Inspector”

11.6. The Dutch Police

11.6.1. The name of the individual Amsterdam Police Officer who was part of the investigation team into the allegations against Dr A and who liaised with Detective Sergeant GS 1 and the Garda Liaison Office in June 2004, was indicated at interview with Inspector GS 1. The identity of this Officer was established through inquiries with the Dutch Police and direct contact was made by telephone with the Officer, Detective Sergeant NL 1. A letter was issued to Detective Sergeant NL 1 on 26 October 2007 as follows

Detective Sergeant NL 1
Post Box
Zedenpolice
CG Amsterdam
The Netherlands
Re: Review Inquiry on matters pertaining to Child Protection issues touching on or concerning Dr. A

Dear Detective Sergeant NL 1,

Thank you very much for taking my call today in respect of matters of fact relating to your liaison with Irish police officers in June 2004 in connection with the arrest of Dr. A.

I have been commissioned by the Irish Statutory Authority for Child Protection matters, the Health Service Executive, to Chair a Review Inquiry into any matter pertaining to child protection issues touching on or concerning Dr. A.

The Inquiry is focused on whether the relevant State agencies in Ireland took appropriate steps in accordance with child protection notification requirements on the basis of the information available to them relating to the allegations against Dr. A in June 2004 and his subsequent conviction in The Netherlands in September 2005.

In the course of the Inquiry, Irish police officers who were present in Amsterdam in 2004 in connection with either Dr. A’s visit or the subsequent questioning by Amsterdam police, have been interviewed. In the course of those interviews it has been suggested that you would have spoken to both police officers, Sergeant GS1 and Detective Sergeant GS4, around the time of the questioning of Dr. A in respect of the then alleged assault against four young female American students. A question now arises as to whether at that time you, or to your knowledge, any of your Amsterdam police colleagues, would have disclosed to either Detective Sergeant GS4 or Sergeant GS1 either the ages of the four students involved or the fact that one of the students was aged 15 years.

I attach some background reference documentation including the terms of reference for the Review Inquiry and the press announcement of the Review Inquiry for your records. I also attach a copy of the summary of the Judgement made in the Amsterdam Court against Dr. A in September 2005 for your own records.

I would be grateful if you could outline your recollection of what you said, or to your knowledge, what your Amsterdam police colleagues said to Detective Sergeant GS4 and Sergeant GS1 relating to the ages of the students making the allegations against Dr. A in June 2004.

Thank you for your cooperation in this matter and I look forward to hearing from you.
11.6.2. Detective Sergeant NL 1 responded by e-mail as follows on 8 November 2007:

“Dear Mr. Devine,

Thank you for your sending me information about your inquiry. There seems to be no problem for me to answer your questions, as far as my recollection may reach. Please inform me about the way you would like to be answered, by mail, letter or phone. I will be on duty 13/11/2007, 15:00-23:00, 14/11/2007, 08:00-17:00, 14/11/2007, 08:00-17:00 but I can also be reached by email.

Yours sincerely,
Detective Sergeant NL 1”

11.6.3. A further e-mail was issued to Detective Sergeant NL 1 on 12 November 2007

“Dear Mr. NL 1,

I refer to our recent correspondence on the above matter and to your email of 8 November 2007.

As stated in my letter of 26 October 2007, I need to establish as fact whether or not you, or to your knowledge, any of your Amsterdam police colleagues, would have disclosed to either Detective Sergeant GS4 (the liaison officer attached to the Irish Embassy) or to Sergeant GS1 (who accompanied Dr. A on the study trip to Amsterdam in June 2004) either the ages of the four students involved or the fact that one of the students was aged 15 years, or any comment that one or more of the students were under age/below the age of consent.

I would be grateful if you could outline your recollection of what you said, or to your knowledge, what your Amsterdam police colleagues said to Detective Sergeant GS4 and Detective Sergeant GS 1 relating to the ages of the students making the allegations against Dr. A in June 2004.

One additional issue you might be in a position to assist with is whether Dr. A was initially being questioned in respect of sexual assault or sexual harassment of the young persons.
I would be grateful if you could respond in writing to the address outlined below or by return email.

Thank you again for agreeing to assist with this Inquiry.

Yours sincerely,

Conal Devine
Chairman, Review Inquiry Team

11.6.4. Detective Sergeant NL 1 issued his response by e-mail on 13 November 2007

“Dear Mr. Devine,

These are my recollections of the events concerning the Dr. A case as far as I can remember.

In the period following the offence I spoke to both Mr. MHB 2 and Mr. GS 4. I interrogated Mr. MHB 2 as a witness. Mr. GS 4 contacted me shortly afterwards to ask for information concerning this case. As far as I know none of my colleagues had contact of any importance with the Irish authorities in this matter, except for one of my uniformed colleagues who took a short statement of Mr. MHB 2 shortly after the police arrived at the hotel.

There has never been any doubt about the fact that the victims were young girls. In the conversations I had with Mr. MHB 2 and Mr. GS 4 the victims were always referred to as 'girls' and never as 'women'. Furthermore we were all aware of the fact that the victims were American schoolgirls, visiting Amsterdam with their college. Mr. MHB 2 did see a number of these students in the hotel-lobby, where we first met. I do however not recall having mentioned the exact age of the victims. For the conduct of the Dutch law at that time the exact age of the victims being fifteen or seventeen was of no importance for the police investigation.

I seem to recall at any moment receiving a phone call from Mr. GS 4 or someone else from the Irish authorities who asked for the exact dates of birth of the victims and whether all three victims had actually filed a complaint or not. This memory is, I must say, rather vague at this time.

I do hope this information may be of any use in your inquiries.

Yours sincerely,
11.7. **Department of Justice Equality and Law Reform**

11.7.1. Documentation provided by Athlone Institute of Technology to the Review/Inquiry in late July 2007 made reference to claims made by Dr A to colleagues in AIT that the Dutch Authorities had furnished a file to the Irish Authorities prior to September 2005 relating to the allegations against Dr A. Reference was also made to this file being returned to the Dutch Authorities “without taking any action”. Initial correspondence on this matter was issued by the Review/Inquiry to the Civil Servant who was the Department of Justice Equality and Law Reform nominee to the National Drugs Task Force. This individual (Mr. D2) also attended meetings of the Midlands Regional Drugs Task Force, which had commissioned the Dr. A drugs study in 2004. The relevant extract from a letter from the Review/Inquiry to Mr. D2 dated 13 August 2007 is outlined below:

“Private & Confidential

Mr. D2
Department of Justice, Equality and Law Reform
94 St. Stephens Green
Dublin 2

Re: Review Inquiry on matters pertaining to Child Protection issues touching on or concerning Dr. A

Dear Mr. D2,

I refer to our telephone conversation of 13 August 2007 in respect of the above.

As discussed, I would be anxious to establish your own recollection of matters raised with you individually or with the Regional Drug Task Force, Midland Area, in respect of Dr. A and any child protection concerns, including matters relating to Dr. A’s actions in Holland in June 2004 and his subsequent conviction in September 2005.
The second matter relates to a suggestion that the Dutch authorities had made contact with the Department of Justice in Ireland on the then allegations prior to Dr. A’s trial in September 2005. I understand that the second matter is outside of your immediate area of responsibility and wish to thank you for undertaking to make enquiries with the relevant section in the Department to determine whether there is any record of contact from the Dutch authorities.

I wish to advise that formal meetings will take place with relevant parties on the following dates:
28 and 29 August 2007
6 and 7 September 2007

I wish to extend an invitation to you and any other relevant colleagues from the Department of Justice, Equality and Law reform meet with the Review Inquiry Team on one of those dates and you might indicate on which of those dates you would be most available.

I attach for your attention a formal copy of the terms of reference and methodology for the Review Inquiry. “

11.7.2. Mr. D2 responded to the Review/Inquiry on 16 August 2007 as follows:

“Dear Mr. Devine

As per our recent telephone call and your follow up correspondence concerning the above, please be advised of the following.

I have checked with my colleagues the position concerning the suggestion that the Dutch authorities had made contact with this Department prior to Dr. A’s trial in September 2005.

The Central Authority for Mutual Assistance in legal matters is based in the Department and deals with both incoming and outgoing requests for assistance under the various international instruments governing mutual legal assistance.

I am advised that on 27 July, 2004 the Directorate-General for International Affairs and Immigration of the Dutch Ministry of Justice wrote to the Central Authority here asking whether it would be possible to transfer criminal proceedings against Dr. A to this jurisdiction.

Subsequently, a reply issued from the Central Authority indicating that the Director of Public Prosecutions ‘Office had concluded that any criminal proceedings arising from the matters would more
appropriately be disposed of by the competent authorities in The Netherlands.

On 15 August, 2005 the Dutch Directorate General forwarded a request, under the European Convention on Mutual Legal assistance, asking to have a summons served to Dr. A for a court session on 13 September, 2005. The Central Authority forwarded the papers to An Garda Síochána for service and the Gardai indicated that they served on Dr. A on 9 September 2005. The Dutch Directorate General was informed of this.

If there are any further matters insofar as the Inquiry is concerned relating to the requests dealt with by the Central Authority you might let me know and I will pass them on to the relevant people.

In relation to my own recollection of matters in connection with the Midland Regional Drugs Task Force, I would be happy to meet with the Review Inquiry Team on Friday 7 September 2007 to fully assist its work in any way possible.

I would be grateful if you could contact me at ********** to confirm the necessary arrangements.

Yours sincerely,

Mr. D2, Assistant Principal”

11.7.3. In the course of interviewing Dr A on 19 September 2007, it was suggested to the Review Inquiry that there had been a period of up to six months between the furnishing to the Irish Authorities of detail relating to the allegations against Dr A and the communication from the Irish Authorities that the matter would be more appropriately dealt with by the Dutch Authorities (27 July 2004 to February 2005). In order to establish whether this time frame was factually accurate, and in order to provide the Department with an opportunity to deal with questions arising, a letter was issued to the Secretary General of the Department on 8 October 2007, which is outlined below.
Re: Review Inquiry on matters pertaining to Child Protection issues touching on or concerning Dr. A

Dear Mr. J3,

You may be aware that I am currently undertaking a Review Inquiry on behalf of the Health Service Executive and attach for your attention a copy of the Terms of Reference and Methodology for the Inquiry.

In the course of the Review Inquiry process, certain matters have emerged from documents examined and interviews undertaken which your Department might be in a position to assist in establishing matters of fact.

I am aware that on 27 July 2004 the Director General for International Affairs and Immigration of the Dutch Ministry of Justice wrote to your Department asking whether it would be possible to transfer criminal proceedings to this jurisdiction, against Dr. A, of alleged sexual assault of four young women in Amsterdam. A file relating to the prosecution was also forwarded by the Dutch authorities.

My understanding is that in or around February 2005, the Dutch authorities were advised by your Department that any criminal proceedings would be more appropriately disposed of by the competent authority in The Netherlands and the file relating to the prosecution was returned to the Dutch authorities.

I also understand that on 15 August 2005 the Dutch Director General forwarded a request to your Department to have a summons served on Dr. A for a Court session on 13 September 2005 and that this was forwarded to An Garda Síochana for service. The summons was served on Dr. A on 9 September 2005.
The Terms of Reference of the Inquiry provide for the compilation of a chronology of what information was in the possession of the Health Service Executive from sources such as An Garda Síochana and Government Departments in regard to any matter pertaining to child protection issues touching on or concerning Dr. A. To that end I would be grateful if you could clarify the following matters which will be admitted onto the record of the Review Inquiry Report.

1. Whether the involvement of your Department in this matter, as set out above, is accurate?

2. Did the file forwarded by the Dutch authorities in July 2004 indicate the ages of the young women who were the subject of the then alleged assault by Dr. A?

3. Did the Department of Justice, Equality and Law Reform furnish any information on the alleged behaviour of Dr. A to either the Garda Síochana or the agency charged with statutory child protection responsibilities, the Health Service Executive?

4. Did the Department of Justice, Equality and Law Reform furnish any information relating to the allegations against Dr. A to either the Department of Health and Children or to any State agency responsible for third level education?

5. Did the competent authorities in The Netherlands furnish any details to your Department on the conviction of Dr. A for sexual assault in September 2005?

6. Did the Department of Justice, Equality and Law Reform outline its knowledge, if any, of Dr. A’s conviction to any of the State agencies and authorities outlined in questions 3 and 4 above?

The co-operation of your Department in responding to the above questions would be greatly appreciated.

I also wish to advise that once a draft chronology of events relevant to the Terms of Reference has been prepared it will be forwarded to you for comment prior to finalisation.
11.7.4. An Assistant Secretary responded on behalf of the Department of Justice Equality & Law Reform by letter dated 30 October 2007, as follows:

"Dear Mr. Devine,

I refer to your letter of 8 October 2007 addressed to the Secretary General of this Department in relation to the above matter.

In regard to the specific questions which you raise the position is as follows:

i. A file in regard to the prosecution of Dr. A was not received by the Central Authority for Mutual Assistance in Criminal matters (C.A.) of this Department. A short letter with an enquiry as to whether it would be possible to transfer criminal proceedings against Dr. A was received on 27 July 2004 from the Director General for International Affairs and Immigration of the Dutch Ministry of Justice.

The Dutch authorities were informed by the C.A. of this Department by letter dated 22 October 2004, not “in or around February 2005”, that the Office of the Director of Public Prosecutions had concluded that any criminal proceedings arising from the matter would be more appropriately be disposed of by the competent authorities of The Netherlands.

ii. The letter from the Dutch authorities states that Dr. A “sexually harassed American girls, two of them being 18 years old and 1 16 years old”.

iii. The letter from the Dutch authorities was furnished to the Garda authorities, the Office of the Attorney General and the Office of the Director of Public Prosecutions. It was not furnished to the Health Service Executive. As you are aware the Garda Síochána would also have been provided with the summons from the Dutch authorities to be served on Dr. A. This summons sets out the details of the charges against him.

iv. The C.A. of this Department did not furnish any information to the Department of Health and Children or to any State agency for third level education. The occupation of Dr. A was never furnished to the C.A. by the Dutch authorities.
v. The Dutch authorities did not furnish any details of the conviction in September 2005 of Dr. A to the C.A. of this Department.

vi. The C.A. of this Department was not in possession of any information regarding the conviction of Dr. A.

If this Department can be of further assistance in this matter please do not hesitate to contact me.

Yours sincerely,

Mr. J1, Assistant Secretary"

11.8. **Athlone Institute of Technology**

11.8.1. Athlone Institute of Technology tabled the following documentation following a preliminary meeting with the Review/inquiry on 26 July 2007.

- A copy of a chronology of events from Tuesday 3 July 2007 when Dr A first informed Athlone IT of the incidents in Amsterdam in June 2004 in the course of the study visit and his subsequent conviction in September 2005.
- The chronology outlined the circumstances giving rise to Dr A’s resignation on Friday 6 July 2007 and outlined other actions taken by the Institute up to the receipt of a report from a company which undertook a forensic examination of Dr A’s Personal Computer in the Institute. That report was described as finding the PC “clean”.
- A copy of an anonymous e-mail dated 10 July 2007 purporting to have been issued by a person connected to one of the young persons who was subject to the attempted indecent assault by Dr A in Amsterdam in June 2004. That e-mail included an abridged translated version of the decision of the Dutch Court against Dr A in September 2005.

11.8.2. Athlone Institute of Technology also tabled a copy of the Research Application for the study on heroin misuse in the Midland Health Board area dated November 2004. This document set out the costings in respect of the study amounting to Euro 30,000 from the Regional Drugs Task Force with the publication and launch of the Report stated as being funded by Mr. MHB 1 of the Midland Health Board. The figures do not
feature any expenditure figure for Dr A’s costs in respect of the Amsterdam study visit in June 2004, Detective Sergeant GS 1’s costs are indicated.

11.8.3. A request was issued to Athlone Institute of Technology on information made available to the Review/inquiry which suggested the a senior officer from Waterford Institute of Technology had been on the interview board which appointed Dr A to Athlone IT in June 2001. The Secretary/Financial Controller of AIT confirmed on 19 December 2007 that no officer of Waterford Institute of Technology was on the interview panel which appointed Dr A to Athlone Institute of Technology in June 2001.

11.8.4. A request was issued to Athlone IT to clarify its understanding of the arrangement entered into by Mr. MHB 1 with Dr A in respect of the funding of a study relating to “A Youth Resilience” Project in 2005 apparently by way of agreement through Dr A’s private consultancy. This emerged in the course of an interview with Mr. MHB 1 on 9 November 2007. Athlone IT responded on 15th November 2007 as follows …..

“Further to our conversation last evening, I wish to inform you that on Dr. A being appointed to the SL1 position at the Institute the issue of outside consultancy work was addressed. The Human Resources Manager wrote to Dr. Mc E on 6th April 2004 with the Conditions of Service attached to the position. Included was the following:

“In order to ensure that a conflict of interest does not arise, the Director of the Centre will notify, as a matter of course, the Director of the Institute of such involvement in projects. The Director of the Centre may, from time to time, work back hours for approved external work completed in formal term time. Where such external work is undertaken during formal term time, the Director of the Centre is required to notify the relevant Head of School/Head of Department of this fact in advance”.

I can confirm that Dr. A did not inform me of any involvement by him with private work either with the Midland Health Board/HSE or other parties. I can also confirm that neither the Head of School nor the Head of Department were notified of any such consultancy work.”

Yours sincerely,

Professor AIT 1
President”
11.8.5. Athlone Institute of Technology responded to draft report on 19 December 2007 and confirmed that no officer of Waterford Institute of Technology was on the interview panel which appointed Dr. A to Athlone Institute of Technology in June 2001.
11.9. **Waterford Institute of Technology**

11.9.1. WIT furnished the Review/Inquiry with full documentation relating to the internal inquiries conducted by WIT into alleged use by Dr A of inappropriate teaching materials relating to Child Sexual Abuse. The documentation included a reference to a meeting between the Registrar and Dr A on 16 December 1998 where the Registrar expressed the view that the teaching materials in question may not be shown until the Institute was satisfied that the checks and balances were in place to ensure the appropriateness of the material concerned. The documentation tabled suggests that Dr A had ceased to use the materials in the period prior to June 1998.

11.9.2. The documentation provided by WIT indicates that Dr. A took issue with a number of issues in respect of the internal process and highlighted the correspondence received by him from the South Eastern Health Board relating to the use of the materials. Those issues were raised with the then Director of the College on 24 January 1999:

> “….The leaking of internal college information and discussion of matters of conduct externally is most serious. I received a letter from the South-Eastern Health Board commenting on my use of such materials just prior to Christmas. The question must be asked did this individual receive permission from his superiors to send such a letter to a member of staff in a third level institution? I hardly need to remind anyone of the amount of inquiries into child abuse over the past ten years (The SEHB has not fared well in any of these!) One might have thought that the South-Eastern Health Board would have fully supported my innovative teaching on this issue as practitioners in other health board areas do as is obvious from the letters of support from practitioners.”
11.9.3. The documentation provided by WIT indicates that its internal process relating to the use of the materials concluded with the following recommendations made by the Registrar to the Institute’s Director on 18 February 1999.

“i  There is a serious doubt as to the suitability of some of the slides shown by Dr. A. (The Accident and Emergency consultant), whose slides they were, confirmed to me that he used them on one occasion only. He showed them to 2nd and 3rd year Social Care students. He was selective as to which slides were shown as some were not relevant and others too explicit

ii  Dr. A should have discussed their use with (The Accident and Emergency consultant) and other colleagues prior to showing the slides. (The Accident and Emergency consultant) would I presume give the same advice and opinion to Dr. A as he gave to me i.e. that they should only be shown by someone with a medical background, that great sensitivity is needed in selecting particular slides.

iii  Such slides should not have been shown to part-time students on the Foundation Certificate in Care Studies as the aims and objectives of this course are different to the full-time diploma. There is a much broader cross-section of age group attending this course.

iv  I could find no evidence that the numbers of Social Studies students attending counselling increased significantly as a result of showing the slides.

v  Efforts were made by Dr. A and others to minimise the effects of shock or upset resulting from showing the slides, including the option not to attend class. These unusual arrangements should of themselves have sounded a warning bell leading to a more cautious approach.

vi  There is no evidence to suggest that Dr. A’s use of this material was for other than sound pedagogic reasons based on the belief that future professional care workers should be exposed to such material within their course, so that they could recognise the signs of abuse as care worker professionals. The number of letters of support to this effect is impressive.
vii The allegation that a request was made by Dr. A to install a hidden camera to record students without their knowledge is not confirmed by the member of support staff who was supposed to have been approached about this.

viii I recommend that the slides in question are not used in the future and alternative methods of informing students about the subject matter concerned be found.

ix I have monitored the operation of the Course Board since September 1998 and I am satisfied that it is functioning well

11.9.4. In response to a direct question from the Review Inquiry, WIT confirmed by e-mail dated 10 October 2007, that a Senior Officer of the College was not part of the Interview Board that recommended Dr. A for his post in Athlone Institute of Technology in June 2001.
11.10. **National Drugs Task Force (NDTF)**

11.10.1. Mr. D2, a member of both the NDTF and the Midland Regional task Force tabled minutes of the Regional Meetings dated 19 February and 20 May 2004 as well as his own handwritten notes of the May meeting.

11.10.2. The Director of the National Drugs task Force tabled the terms of reference for both the National and Regional Drugs Task Forces as well as other details relating to the organisational and staffing structure of the NDTF.

11.11. **Documentation Furnished by Individuals**

11.11.1. Former colleagues of Dr. A furnished documentation to the Review Inquiry, much of which dealt with internal matters within Waterford Institute of Technology and Athlone Institute of Technology. This documentation included details of alleged practices surrounding the appointment to academic posts.

11.11.2. Correspondence was received from an academic formerly employed in Waterford Institute of Technology relating to the internal WIT inquiry into teaching materials being used by Dr A in 1998/1999. Other documents were also tabled which related to matters which are outside of the Terms of Reference of the Review/Inquiry.
12. **Findings of Fact**

12.1. **Introduction**

12.1.1. The Findings of Fact have been arrived at having regard to the interviews undertaken, written responses received to direct questions, and the documentation examined in the course of the Review. The Review Inquiry Team wishes to place on record that all of the parties approached as part of this Review gave their full co-operation.

12.1.2. Responses to Preliminary Findings of Fact issued to all relevant parties were provided by the following parties and were taken into account in revising the interim report.

- Dr. A
- Ms. MHB 4
- Dr MHB 2
- Detective Sergeant GS4
- Department of Justice, Equality and Law Reform
- Athlone Institute of Technology
- Waterford Institute of Technology

These responses are attached to the report as appendix I

- Mr. MHB 1

Mr. MHB 1’s response is attached to the report as appendix II.

12.2. **Documentation and Information in the Possession of the Health Service Executive/Former South Eastern Health Board in the Period 1997-1999**

12.2.1. That Dr. A arranged through a student of his, who had been a foster parent of a young person, to interview that young person as part of academic research being undertaken on prostitution in Waterford. The Young Person had recently been the subject of a Care Order. The former foster parent arranged to meet the young person in a hotel in Waterford on 15 March 1997. The young person was 18 years of age at the time. When the young person arrived she was introduced to Dr. A and apparently agreed to be interviewed by Dr. A. It is reported that Dr. A purchased an alcoholic drink for the young person. This is denied by Dr A. The young person subsequently raised concerns with South Eastern Health Board Social Work staff when this study was published and disputed the accuracy of some of the material which she understood was attributed anonymously to her. It is a matter of fact that Social Work staff inquired into this matter at the time and although there were concerns in relation
to a possible breach of confidentially by the foster carer, no formal investigation was undertaken. The factors influencing that decision were stated as being...

a. the foster carer was no longer actively providing the service to Waterford Community Care
b. the young person concerned was over 18 and had engaged in an interview with Dr. A

12.2.2. That the Regional Co-ordinator Child Care Services South Eastern Health Board, (Mr. SEHB 2), was notified through a colleague of an anonymous complaint from a student in Waterford Institute of Technology at the end of 1998 relating to the use of teaching materials by Dr. A showing injuries consistent with child sexual abuse. That Mr. SEHB 2 wrote directly to Dr. A on December 21st 1998 outlining his concerns regarding the use of such materials. That Dr. A responded on 22nd December 1998 indicating that he had not used the slide material in two years and that Mr. SEHB 2 in a letter dated 8 February 1999 indicated that his response more than adequately clarified the matter. It is a matter of fact that the South Eastern Health Board did not convey these concerns directly to Waterford Institute of Technology. It is also a matter of fact that Waterford Institute of Technology first became aware of the interest of the South Eastern Health Board in this issue when Dr. A wrote to the President of WIT on 24 November 1999 referring to the letter from Mr. SEHB 2.

12.2.3. That the Child Care Manager, Waterford, confirmed on 19 October 2007 that no child protection matters were notified to Waterford Community Services Area touching on or concerning Dr. A but indicated that concerns in respect of Dr. A’s professional boundaries were expressed by HSE personnel.

12.2.4. It is a matter of fact that there is a record of the outcome of the internal inquiry undertaken by Waterford Institute of Technology into the use of education slides dated February 1999 and signed 25th February 1999 by the Registrar. Dr. A disputes that the detail of this report was ever brought to his attention. (see paragraph 11.9.3 above)
12.3. **Documentation and Information in the Possession of the Health Service Executive/Former Western Health Board in the period 2003 – 2004**

12.3.1. That Dr. A applied for a twelve month placement in a Children’s Residential Home managed by the Western Health Board, Aras Geal, in November 2003. That Dr. A received Garda clearance and appropriate references to permit the placement to commence in February 2004.

12.3.2. That Dr. A continued his placement for one shift per week in Aras Geal until 11th June 2004 when he concluded the placement, giving as a reason his commitments to the Athlone/Portlaoise drugs study.

12.3.3. That a comprehensive safety review of young people living at Aras Geal in the period 2003 – 2004 was carried out in July and August 2007 by the Inspection and Monitoring Officer at the request of the LHO Manager, Galway. That no child safety issues arising from the presence of Dr. A in Aras Geal in the period were identified in that report.

12.3.4. That Social Work staff, Galway, interviewed both Mrs. A and Dr. A as part of a risk assessment in October 2007 and deemed that no further action was required.

12.4. **Documentation and Information in the Possession of the Health Service Executive / Former Midland Health Board in the period 2004 – 2006**

12.4.1. That Mr. Mr. MHB 1, Health Promotion Manager Midland Health Board, and Acting Co-ordinator, Midland Regional Drugs Task Force, met with Dr. A and Ms. Ms. MHB 5, a Health Promotion Project Worker with the MHB who was also a student of Dr. A’s, in late 2003/ early 2004. That Mr. MHB 1 agreed to fund research into heroin use in the Athlone area utilising unexpended funds which had been allocated to appoint a permanent Co-ordinator for the Regional Drugs Task Force. That no tendering process was entered into prior to the commissioning of Dr. A under the auspices of the Centre for Child and Youth Care Learning, Athlone Institute of Technology.
12.4.2. That the Regional Drugs Task Force was notified about the proposed drugs study on 19 February 2004 and it was agreed that the study would be extended to include Portlaoise as well as Athlone. That the RDTF was further advised on the 20th May of the methodology for the study through a presentation made by Dr. A and Ms. MHB 5.

12.4.3. That discussion took place between Dr. A and Mr. MHB 1 in May 2004 regarding the composition of a study group to visit Amsterdam as part of the drugs study. Mr. MHB 1 recommended the inclusion of Detective Sergeant GS 1, Athlone. Dr. A had suggested Mrs. A, who worked in private practice with him, as a participant in the study group but this was not deemed by Athlone Institute of Technology to be appropriate.

12.4.4. That on 25 June 2004, Mr. MHB 1 was advised by telephone by Detective Sergeant GS 1 of an incident involving Dr. A and a number of young girls in the hotel where both Dr. A and the young girls were staying, in Amsterdam. Mr. MHB 1’s account is that he was advised by Detective Sergeant GS 1 of the ages of the young girls who were the subject of an alleged assault by Dr. A and that the age profile of the girls making the allegations was between 15 and 18 years. This account is disputed by Detective Sergeant GS 1 who has stated that he was unaware of the ages of the young girls at the time of the call.

12.4.5. That on 26 June 2004 Dr. A telephoned Mr. MHB 1 and advised him of the details of the incident and the allegations against him and further advised Mr. MHB 1 that the age profile of the young girls making the allegations was 15-18 years of age.

12.4.6. That it can be established as a matter of fact that the following individuals were notified in the period 26 - 30 June 2004 of the involvement of Dr. A in an incident in Amsterdam.

- Dr. MHB 2, Director of Public Health and Mr. MHB 1’s line manager, who was advised of the incident including the fact that one of the young persons making the allegation was underage. No action is recorded on the part of Dr. MHB 2 in respect of making contact with Child Protection expertise within the Midland Health Board or liaising with the Gardai or formally notifying the Gardai, contacting Dr. A’s employer, or carrying out a risk assessment, or directing Mr. MHB 1 or any Officer of the Health Board to carry out such actions. On the
other hand, Dr. MHB 2 in his response to the interim Findings of Fact (see appendix I) stated that “I had assurances on two occasions that Mr. MHB 1 had met Ms. MHB 4 to inform her of the matter. Mr. MHB 1 was a very Senior Manager in the system who had been invited, and to the best of my knowledge at that time, had availed of awareness training on child protection issues, which would have clearly and comprehensively outlined the responsibility of everyone who had suspicions of child abuse. This awareness training, as far as I can now recall, consisted of a two day course, although shorter modules were available. The assurances I was given, concerning a meeting with Ms. MHB 4 having taken place in an office were very explicit and were given to me within 24 hours of the meeting with Ms. MHB 4. I was also given to understand that the incident had been documented. When Mr. MHB 1 reported to me after his meeting with Ms. MHB 4, I said that was fine as long as the child care people know. I said to him that the importance of her knowing was the fact that she was the Senior Manager responsible for child care...”

- Ms. MHB 3, Communications Manager, MHB, who recalls being advised by Mr. MHB 1 that there was an incident in Amsterdam with ladies in a hotel bedroom. No action was recorded arising from the disclosure to Ms. MHB 3.

- Mr. MHB 1 made contact with Superintendent D3 of the National Drugs Strategy Team and discussed the potential implications for Dr. A. Superintendent D3 had been aware of the incident via a report dated 24 June 2004 which had issued from the Garda Liaison Officer in Holland.

- Mr. MHB 1 contacted Mr. D1, Chair of the Regional Drug Task Force on 26 June 2004. Mr. D1’s note of that conversation indicates that he was advised that DR. A was arrested “under certain suspicions” and Mr. D1 indicated that he was not aware from this contact by Mr. MHB 1 that this matter was related to any activities undertaken by Dr. A in connection with the RDTF. It is a matter of fact that the incident was not formally discussed at the RDTF.

- Mr. D2, Department of Justice Equality and Law Reform, indicated that he had been advised by telephone by Mr. MHB 1 that Dr. A had been arrested for public order type offences involving drunkenness but that there had been no reference
to an assault on a young person of a sexual nature or that there were any charges being pursued against Dr. A. Mr. D2 indicated that this was the only occasion when this matter was discussed with Mr. MHB 1 and that there was no discussion of this matter subsequently.

- It is a matter of fact that Mr. MHB 1 made no contact with Child Protection or Social Work staff within the Midland Health Board relating to the incident.

12.4.7. It cannot be established as a matter of fact that the following individuals were notified in the period 25-30 June 2004 of the involvement of Dr. A in an incident in Amsterdam.

- Alleged contacts made between Mr. MHB 1 and Ms. MHB 4, Assistant CEO. This is disputed by Ms. MHB 4. (At the conclusion of the Review Inquiry Mr. MHB 1 tabled telephone records which showed calls made to the numbers of various individuals including one made to Ms. MHB 4 at 18.09 on 25th June 2004 These records are attached as appendix II)

- Mr. MHB 1 claimed contact with Ms. D4, Director of the National Drug Strategy Team but Ms. D4 stated that she had no recollection of any such contact by Mr. MHB 1 and that she was not aware of the incident until July 2007. It is a matter of fact that the incident was not discussed at any meeting of the National Drug Strategy Team.
12.4.8. That on 30 June 2004 Mr. MHB 1 met with Dr. A and discussed the Amsterdam incident in detail and the effect of the incident on how the study was to be progressed. It is a matter of fact that the study continued. It is also a matter of fact that Mr. MHB 1 advised Dr. A that he had discussed the incident with his superiors within the Midland Health Board.

12.4.9. That on 1 July 2004 a lunch appointment took place between Mr. MHB 1 and Detective Sergeant GS 1 in a hotel in Moate, Co. Westmeath. It is a matter of fact that the Amsterdam incident was discussed. It is a matter of dispute as to whether in the course of the discussion, the ages of the young girls who made the complaint was raised.

12.4.10. It is a matter of fact that no formal notification was made to Mr. MHB 1 or any other Officer of the Health Board by Detective Sergeant GS 1 in respect of any Child Protection concerns relating to Dr. A. It is also a matter of fact that Detective Sergeant GS 1 did not formally or informally discuss the Amsterdam incident with any other Health Board personnel. It is also a matter of fact that no notification in accordance with the provisions of *Children First* was made by GS1 or any other member of An Garda Síochána to the Midland Health Board concerning the allegations against Dr. A.

12.4.11. That on a date in September 2004 Dr. A and Mr. MHB 1 discussed the most recent developments regarding the Amsterdam incident.

12.4.12. That on either 31 August 2004 or 4 October 2004, a discussion took place between Dr. A and Mr. MHB 1 relating to a forthcoming study trip to Canada relating to the drugs study. It is a matter of fact that the study visit to Canada went ahead in October 2004 and that, on the suggestion of Mr. Mr. MHB 1, a second female member of staff from the Midland Health Board accompanied Dr. A and Ms. MHB 5 on the study visit. It is a matter of fact that no recorded risk assessment was carried out prior to authorisation being given for that study visit.

12.4.13. That on 5 November 2004 a discussion took place between Dr. A and Mr. MHB 1 and it is accepted that the discussion included matters relating to the legal status of the allegations against Dr. A. Mr. MHB 1’s claim that he was advised by Dr. A that the case in Holland would not be proceeding is disputed by Dr. A. That on or around the same date a brief discussion took place between Mr. MHB 1 and Ms. MHB 4, the contents of which are disputed. Ms. MHB 4 denies that Mr. MHB 1 made any reference to possible legal proceedings against Dr. A.
and further asserts that this was the only occasion when Mr.
MHB 1 raised the issue with her.

12.4.14. It is a matter of fact that Mr. MHB 1 organised the launch
of the publication of the drugs study entitled *Darkness on the
Edge of Town* on 21 January 2005. It is a matter of fact that the
Minister of State, Addiction Services, launched the study. It is a
matter of fact that no discussion on the potential impact on the
launch event of a public disclosure of allegations against Dr. A
took place among the Health Service personnel who were aware
of either the detail of the Amsterdam incident or the generality
of the incident prior to the launch.

12.4.15. Between March and September 2005 it is a matter of fact
that Mr. MHB 1 entered into arrangements with Dr. A through
Dr. A’s private consultancy company to fund a number of
projects including one project on “Youth Resilience”. The funding
for that project amounted to circa €40,000 and it is a matter of
fact that this arrangement was arrived at without recourse to a
tendering process.

12.4.16. On 9 September 2005, the day that Dr. A was served
with a summons to appear in Court in Amsterdam, Dr. A’s
mobile telephone records show that a call was made to Mr. MHB
1’s mobile telephone number at 11:49 with a recorded duration
of 6 minutes 47 seconds. Both Dr. A and Mrs. A claim that Mr.
MHB 1 was advised of the summons and the pending trial in
Amsterdam. Mr. MHB 1 denies this. It is further claimed by Dr. A
that he advised Mr. MHB 1 by telephone on 6 October 2005 of
his conviction by the Amsterdam Courts. Dr. A produced a
telephone record which indicated that a call had been made to
Mr. MHB 1’s mobile telephone on that date at 12:11 and the
duration of the call was 39 seconds. Mr. MHB 1 denies that he
was ever advised of the conviction of Dr. A until the matter
became public knowledge in July 2007.

12.4.17. It is a matter of fact that other than the alleged
notification to Mr. MHB 1 by Dr. A on 6 October 2005, Dr. A’s
conviction was not notified to any other Officer of the HSE up to
the media disclosures in July 2007.
12.5. Documentation and Information from sources including An Garda Síochána and the Dutch Police in regard to any matters pertaining to Child Protection Issues touching on or concerning Dr. A

12.5.1. That GS 4, the Garda Liaison Officer, Irish Embassy, The Netherlands, provided a report to Garda Authorities on 24 June 2004 outlining the circumstances of the allegations against Dr. A describing the incident as “an alleged rape” and that the allegation had been made by three American females who were part of a tour of 70 American students and that the average age of the students was 17 years. This report was furnished to Superintendent D3 of the National Drugs Strategy Team.

12.5.2. That when referring to the ages of the young persons at the centre of the allegations, all subsequent Garda correspondence and reports indicate only an average age of the touring party/the young persons making the allegations, for example:

- Report by Detective Sergeant GS1, 4 August 2004
- Report from Inspector (former Detective Sergeant) GS1 17 July 2007
- Correspondence to the Review Inquiry from Assistant Commissioner, Crime and Security 15 October 2007

12.5.3. Detective Sergeant NL 1 however, of the Amsterdam Vice Squad, indicated to the Review Inquiry Team that...

“There has never been any doubt about the fact that the victims were young girls. In the conversations I had with Mr. GS1 and Mr. GS 4 the victims were always referred to as ‘girls’ and never as ‘women’.” and

“I seem to recall at any moment receiving a phone call from Mr. GS 4 (Garda Liaison Officer) or someone else from the Irish authorities who asked for the exact dates of birth of the victims and weather (sic) all three victims had actually filed a complaint or not. This memory is, I must say, rather vague at this time.”
12.5.4. That the Garda Authorities in Athlone have no record of any formal notification in accordance with the Children First Guidelines or any other note indicating notification to the Midland Health Board in the summer of 2004 of the alleged sexual assaults in Amsterdam. That the only record is a reference in a report from Detective Sergeant GS1 on 4 August 2004 “that he had met with and spoken briefly” to Mr. MHB 1, Regional Health Promotion Manager, Midland Health Board.

12.5.5. That An Garda Síochána, Athenry, served a summons on Dr. A on 9 September 2005 for a Court session in Amsterdam on 13 September 2005.

12.5.6. It is a matter of fact that the Children First guidelines apply to all young persons under 18 years of age. It is also a matter of fact that these guidelines are non statutory.

12.6. Documentation and Information from the Department of Justice, Equality, and Law Reform in regard to any matters pertaining to Child Protection Issues touching on or concerning Dr. A

12.6.1. That it is a matter of fact that the Central Authority for Mutual Assistance in Criminal Matters, Department of Justice, Equality and Law Reform, received correspondence from the Dutch Ministry of Justice on 27 July 2004. That correspondence contained the following information:

- That Dr. A “sexually harassed American girls, two of them being 18 years old and one of them being 16 years old” in Amsterdam in June 2004.

12.6.2. That it is stated by the Department of Justice Equality and Law Reform that the letter from the Dutch Authorities was furnished to the Garda Authorities on 3 August 2004 and the Office of the Director of Public Prosecutions on 8 September 2004. It is a matter of fact that there is no record of that correspondence being received within the Athlone Division, An Garda Síochána.

12.6.3. That it is stated by the Department of Justice, Equality and Law Reform that the letter was not furnished to the HSE, the Department of Health and Children, or to any State Agency
for third level education. It is further stated that details of Dr. A’s occupation were never furnished by the Dutch Authorities.

12.6.4. That it is stated by the Department of Justice, Equality and Law Reform that the Dutch Authorities were informed by the Department by letter dated 22 October 2004 that the Office of the DPP had concluded that any criminal proceedings arising from the matter would be more appropriately disposed of by the competent authorities in The Netherlands.

12.6.5. That it is a matter of fact that on 15 August 2005, the Dutch Authorities forwarded a request, under the European Convention on Mutual Legal Assistance, requesting that a summons be served on Dr. A for a Court session in Amsterdam on 13 September 2005.

12.6.6. That it is stated by the Department of Justice, Equality and Law Reform that it was not made aware of any detail of the conviction in September 2005 of Dr. A in Amsterdam.

12.7. Documentation and Information from Athlone Institute of Technology in regard to any matters pertaining to Child Protection Issues touching on or concerning Dr. A

12.7.1. That it is a matter of fact that Athlone Institute of Technology first learned of the incident in Amsterdam in 2004 and of Dr. A’s conviction in September 2005 on Tuesday 3rd July 2007 and that such information was disclosed by Dr. A following receipt of information that detail on those matters was in the possession of a section of the media. Dr. A states that he received legal advice that there was no requirement on him to pass information relating to his conviction on to any authorities.

12.7.2. That it is a matter of fact that Dr. A tendered his resignation to Athlone Institute of Technology on Friday 6th July 2007.

12.7.3. That it is a matter of fact that Athlone IT engaged an information technology company to carry out a forensic examination of Dr. A’s personal computer in the college and that no matters of concern were discovered.
12.8. **Documentation and Information from Waterford Institute of Technology in regard to any matters pertaining to Child Protection Issues touching on or concerning Dr. A**

12.8.1. That Waterford Institute of Technology carried out an Internal Inquiry into concerns raised by a member of the academic staff about the teaching materials referred to in 12.2.2 above. That the Inquiry concluded with recommendations that the slides in question be returned to their original owner, an Accident and Emergency Consultant, and that the material should not be used in the future. It is also a matter of fact that the Internal WIT Inquiry was carried out in the absence of knowledge of concerns expressed by the South Eastern Health Board.

12.9. **The extent to which the actions by the Health Service Executive on receipt of either formal or informal information of alleged indecent or sexual impropriety on the part of Dr. A, were in accordance with established statutory provisions, guidelines, protocols, and duty of care principles relating to Child Protection**

*With regard to actions taken by the former South Eastern Health Board*

12.9.1. The first recorded concerns which came to the attention of the Health Services pertaining to child protection issues touching on or concerning Dr. A, surfaced from discussions in 1997 between an 18 year old female, who had recently been the subject of a Care Order, and a Psychotherapist employed by the South Eastern Health Board. Those discussions centred on the 18 year old female's report of being interviewed by a man whom she named as “Mr. A” on the prevalence and extent of prostitution in Waterford and further stated that Mr. A had bought her a pint of lager either prior to or during the interview. This information was passed on to the Social Work Department who in turn made contact with the Dochas Hostel which provided hostel and supported accommodation for young persons aged 14-18. Dochas confirmed that the 18 year old female had provided information that she had been invited to
meet her former foster parent in the Tower Hotel, Waterford, on 15 March 1997. The 18 year old female was not told in advance of the purpose of the meeting and was not advised that Dr. A would be in attendance. The foster parent was, at the time, a student of Dr. A’s.

12.9.2. Following the publication of Dr. A’s study “Prostitution in Waterford City” a meeting was held with the 18 year old female and Community Child Care and Social Worker staff on 29 January 1998 and a report of that meeting was issued to the Senior Social Worker. Arising from the contacts made, it was decided not to formally investigate the possible breaches of confidentiality by the foster carer as...
   a) the foster carer was no longer providing a service to Waterford Community Care
   b) the young person concerned was over 18 and had engaged in an interview with Dr. A

12.9.3. The second recorded concerns which came to the attention of the then South Eastern Health Board pertaining to child protection issues touching on or concerning Dr. A, were raised informally with officers of the SEHB in late 1998. These informal concerns related to the use of materials by Dr. A for teaching purposes within Waterford Institute of Technology. The materials used included medical slides of injuries to children which are consistent with sexual abuse. The Regional Coordinator Child Care Services wrote to Dr. A on 21 December 1998 and expressed concerns about the reported use of materials and advised that these concerns had been discussed with the Regional Child Care Training Officer and the Director of the Community Child Centre in Waterford Regional Hospital. Dr. A responded by stating that the materials had not been used in two years. On the basis of that response no further inquiries were made by the South Eastern Health Board on this matter.

12.9.4. With regard to the actions taken by the South Eastern Health Board in respect of the above matters, the following can be established...

(i) That the appropriate Health Board Officers followed up the informal reports about concerns relating to a female 18 year old who was recently the subject of a care order, in a timely and appropriate manner. Notwithstanding that the young person was now technically an adult and therefore outside of the scope of Child Care Services, the relevant officers discharged their duty of care to a vulnerable young adult and arrived at a reasoned position
as to the appropriate steps to be taken. At this remove there are no reasonable grounds for suggesting that the decision taken not to formally investigate this matter was inconsistent with duty of care obligations.

(ii) That the actions of the Regional Coordinator, Child Care Services in formally and directly communicating concerns to Dr. A relating to the reported use of inappropriate teaching materials, was timely and appropriate. However, given the nature of the concerns, it would have been appropriate to consider forwarding those concerns directly to the Employer given that the original informal report had emanated from a student in WIT. It follows that, as WIT had a duty of care to that student and to the wider student body and that the South Eastern Health Board had a duty of care to the wider community it would have been appropriate to establish ...

a) That the use of such materials had indeed ceased some two years previously as had been claimed by Dr. A

and

b) That WIT, possibly in consultation with the SEHB would provide appropriate counselling and support services to any students affected by the use of such materials.
With regard to actions taken by the HSE Local Health Office Galway

12.9.5. The steps taken by the HSE Local Health Office Galway as described in section 12.3 above, represents a model of best practice in discharging *Children First* and duty of care obligations with particular regard to...

- The background checks undertaken by officers of the WHB prior to the sanctioning Dr. A’s short term placement in Aras Geal
- The risk assessment carried out on in respect of the period of Dr. A’s placement in Aras Geal
- The steps taken to contact other children’s residential units and other child care service providers in the area as Dr. A was supervising students on placement in those services
- Contact with the A’s family and establishing the level of risk following direct contact by Social Work staff.

With regard to the steps taken by the former Midland Health Board/HSE Midland Area

12.9.6. The facts as set out in 12.4.6 above clearly indicate that Officers of the Midland Health Board had sufficient information in respect of the incident which occurred in Amsterdam in June 2004 to trigger the appropriate child protection measures as set out in section 8 of *Children First*. Although such information was not formally notified to the Midland Health Board by An Garda Síochána as is required under the notification provisions of *Children First*, at least three Officers of the Health Board were aware that an incident with females had taken place, at least two Officers were aware that the incident was of a sexual nature involving one or more young persons under 18 and therefore within the ambit of *Children First*. It should also be noted that the only contemporaneous note that appears to have been recorded at the time, which was not available to the Health Board, was an internal Garda report provided by Sergeant GS1 on 4 August 2004 which refers to allegations of rape and sexual
assault against students with an “average age of 17 years” and that he had “met with and spoken briefly to” Mr. MHB 1.

12.9.7. The fact that the June 2004 incident occurred in another jurisdiction did not release the Midland Health Board from any obligation to carry out an appropriate risk assessment around the alleged perpetrator. If there was any doubt in the minds of the Officers of the Midland Health Board on this, clarification could have been obtained from Child Care expertise within the Midland Health Board or through the Department of Health and Children.

12.9.8. The fact that the alleged perpetrator was Dr. A, who had been undertaking the study visit with the imprimatur of the Midland Health Board, arguably placed an additional duty of care on the Midland Health Board to ensure that it was aware of all relevant information and detail directly from the Dutch Authorities and to take appropriate steps to establish close liaison with other relevant agencies including An Garda Síochána and Athlone Institute of Technology. Discharge of the duty of care would also include making enquiries with other Health Service employers to establish their links with Dr. A and making enquiries with the Western Health Board, where Dr. A resided. It would be reasonable to assume that such enquiries would have revealed Dr. A’s recent attachment to the Aras Geal Young Person’s Residential Centre, managed by the Western Health Board. The facts as outlined in paragraph 12.4.6 above indicate that this did not occur. The only evidence of a risk assessment being considered was by Dr. MHB 2 who formed an initial view that a risk assessment might be appropriate and at the same time formed the view that as Dr. A had no access to children in his work position there seemed to be no risk in his employment. It is a fact that Dr. A’s recent placement in a children’s residential centre in Galway was not known to Dr. MHB 2 at the time. It is also a fact that it does not appear to have been considered as to whether Dr. A would have among his student cohort young persons under 18 years of age who would come within the ambit of Children First.

12.9.9. It is not possible to establish as a matter of fact whether Ms. MHB 4 was advised by Mr. MHB 1 of the detail of the Amsterdam incident in June/July 2004. There are no written records available of any meetings or notes of meetings on this matter. Accordingly, notwithstanding claims by Mr. MHB 1 that he verbally reported details of the Amsterdam incident to Ms. MHB 4 in the summer of 2004, and confirmed at the time to Dr.
MHB 2 that he had done so, there is no record or report which supports that contention. Given the seriousness of the issue, the failure to record any such matters is not consistent with best practice. Ms. MHB 4 denies that she was made aware at any time that young persons were involved in the incident with Dr A which, she claims, was not mentioned to her until late 2004. Ms. MHB 4 had senior management responsibility for child protection matters at the time although she asserted in her response, attached in appendix I, that the line management reporting relationship for the Director of Child Care lay with Dr. MHB 2. It should be noted however that at the time, the Director of Child Care post did not carry operational responsibilities for child protection.

12.9.10. There are no available minutes or reports of the meeting between Mr. MHB 1 and Sergeant GS1 on 1 July 2004. The apparent complete absence of any such records is not consistent with best practice.

12.9.11. The apparent decision made by Mr. MHB 1 to curtail Dr. A's involvement in the drugs study in the summer of 2004 is not recorded or minuted. In making such decision, if indeed such a decision was made, no contact was made with the other parties to the study, Athlone Institute of Technology, and the Regional Drugs Task Force.

12.9.12. There is no evidence that the decision to facilitate a planned study to Canada by Dr. A in October 2004 was authorised following consideration of the potential for further risk to young persons, or to the reputation of the Midland Health Board or the Regional Drugs Strategy Team. The decision to have Dr. A accompanied on the study visit by two female staff members of the Midland Health Board was not arrived at having regard to any evident risk assessment. If, as is claimed by Dr A, that this decision was arrived at on or about 31 August 2004, it suggests that such a decision was not influenced by an understanding that proceedings were not going ahead against Dr. A in respect of the June 2004 incident in Amsterdam. Accordingly, such a decision did not represent an appropriate discharge of the Midland Health Board’s duty of care.

12.9.13. Four Officers of the Midland Health Board were aware that there had been an incident involving Dr. A in Amsterdam in June 2004 in the course of a study visit and that there was a relationship between that study visit and the Midland Health Board. At the time of the launch of the study “Darkness on the Edge of Town” in January 2005, three serving Officers of the Board were aware of the incident with at least one Officer aware
that an underage female was one of the complainants against Dr. A. Notwithstanding this, no consideration appears to have been given to the potential consequences that the disclosure of this information would have for the launch of the study by the then Minister of State for Addiction Services. Given the potential risk to the reputation of the Midland Health Board in respect of child protection and drug strategy initiatives, and the full or partial knowledge of the incident shared by four Officers of the Midland Health Board at various times, it is difficult to comprehend how this issue did not merit, at the very least, substantive discussion at Senior Management level within the Midland Health Board either at the time of the disclosures or prior to the launch of the study.

12.9.14. Having regard to all of the facts available in respect of Dr. A’s behaviour in Amsterdam in June 2004, the absence of any recorded risk assessment in respect of Dr. A, and the absence of any recorded “closure” of the Amsterdam incident for the Midland Health Board, it is inconceivable that an Officer of the Health Board would continue to make decisions to fund various projects involving Dr. A, particularly where they would involve young persons. The fact that at least one of those arrangements, incomplete and apparently entitled the *Youth Resilience Project*, was with Dr. A in a private capacity, and secured outside of any evident tendering or procurement procedures, raises serious concerns and requires further separate inquiry through the HSE’s Internal Audit system.

*With regard to actions taken by the HSE at national level on receiving information regarding Dr. A’s conviction*

12.9.15. On Friday 13 July 2007 the National Director for Primary Care Continuing Care (PCCC) HSE issued queries to all HSE LHO Managers and Assistant National Directors to determine whether Dr. A had been employed in the HSE in any capacity. This was the same date that Dr. A’s conviction was publicised nationally and was the first information received by the HSE of the conviction. The actions taken by the HSE following receipt of this information were timely and appropriate.
13. **Comparative Child Protection and Vetting Measures in Other Jurisdictions**

13.1. **Introduction**

13.1.1. The snapshot of comparable jurisdictions outlined below, which was of limited value to the subject matter of the Review Inquiry, did outline broadly comparable statutory and non-statutory child protection measures which appear to be in a constant state of review and amendment. What is clear from the limited examination of other jurisdictions is that in every case, child protection measures are dependent on all relevant public officials assessing information, reports, and notifications relating to young persons in a child protection context and those officials taking responsibility for complying with the relevant measures.

13.1.2. As can be seen below, The Review Inquiry Team did find some marked differences from the Irish jurisdiction in respect of...

- Vetting procedures
- Mandatory reporting of suspicions of child abuse

and in the case of New Zealand...

- provision for prosecution in domestic courts of nationals who commit offences abroad concerning sexual conduct with children

In preparing amendments or revisions to existing child protection legislation, the Review Inquiry Team would be of the view that a more in depth analysis of the international measures by the Irish authorities would be required.
13.1.3. The following sections briefly outline child protection and vetting measures adopted in jurisdictions that share either common law or constitutional antecedents comparable to the Irish legal system.

13.1.4. The following information does not constitute a legal interpretation of child protection and vetting measures in the relevant jurisdictions.

13.2. Australia

13.2.1. Statutory Basis for Safeguarding Children

Currently all states and territories have state based legislation which forms the basis of child protection measures. These are supplemented by non legislative policies and practices. Although each jurisdiction has its own legislation, the processes used to protect children are broadly similar.

Children who are assessed to be in need of protection can come into contact with state and territory child protection and support services through a number of avenues. These include reports of concerns about a child made...

- By someone in the community
- By a professional mandated to report suspected abuse and neglect
- By an organisation who has contact with the family or child

Reports are assessed and classified as either a family support issue or a child protection notification.

13.2.2. Mandatory Reporting

Other than in Western Australia where upcoming reform will introduce mandatory reporting of suspected child abuse for key professionals, all other Australian states and territories have enacted legislation to mandate professionals providing services to young persons to notify reasonable suspicion that a child or young person has suffered sexual abuse or non accidental injury.

Although the legislation in each state covers all young people up to the age of 18, the responsibility for mandatory notification does not always extend to age 18. In New South Wales the mandatory reporting obligation does not extend to young people aged 16 and 17. Otherwise mandatory reporting in all states/territories (except Western Australia) occurs in relation to all children and young people up to age 18.
13.2.3. **Vetting Procedures**

Many Australian states and territories have introduced legislation that requires all specific child related occupations such as teachers or child care workers to be screened for criminal offences. Some states have extended the screening to findings of a disciplinary nature made by professional regulatory bodies. There are no national standards regarding police checks and clearances.

13.3. **Canada**

13.3.1. **Statutory Basis for Safeguarding Children**

Child protection legislation in Canada exists at both federal and provincial level. The principal federal body of legislation is the Child Protection Act May 2003 (currently under review). The Child Protection Act is supported by the Criminal Code of Canada, a federal statute, which regulates offences by individuals against the State, against property, and against other persons. The Criminal Code identifies a number of sexual offences against young persons other than sexual assault. The offence of “sexual exploitation” stipulates that it is an offence for a person in a position of trust or authority to...

- “touch either directly or indirectly, with the body or an object, a person between 14 years old but under 18 years of age for a sexual purpose”

or

- “invite counsel or incite a person between 14 years old and under 18 years of age to touch the body of another person, including the body of the person who has invited such touching”

As the age of consent for sexual intercourse in Canada is 14 years of age, there are separate sexual offences stipulated where children under 14 years of age are involved.
13.3.2. “Vulnerable Sector” screening checks are carried out by regional and provincial police forces utilising an automated criminal records retrievable system maintained by the Royal Canadian Mounted Police. The vulnerable section screening applies to governmental and non-governmental prospective employees and voluntary workers working with:

- Children
- Elderly
- Physically disabled
- Mentally disabled

The vulnerable sector screening check includes checks of, and may provide information concerning:

- Criminal record
- Pardoned sexual offences
- Findings of not guilty by reason of mental disorder
- Probation, prohibition and other judicial orders which are in effect
- Potentially relevant apprehensions under the Mental Health Act and
- Details of incidents that may assist an agency in making an informed decision, including investigations where either no charges were laid or there was no finding of guilt

13.4. **England and Wales**

13.4.1. **Safeguarding Children and Young People in the UK**

“The support and protection of children cannot be achieved by a single agency... Every Service has to play its part. All staff must have placed upon them the clear expectation that their primary responsibility is to the child and his or her family.”

*Lord Laming in the Victoria Climbie Inquiry Report, paras 17.92 and 17.93.*

13.4.2. **Statutory Basis for Safeguarding Children**

The Statutory basis for safeguarding children in the UK is contained in the Children Act 1989 and updated in Section 11 of the Children Act 2004 which places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children.
Schools and further education providers have an equivalent duty through the Education Act 2002, and must have regard to the statutory guidance, Safeguarding Children in Education, issued in September 2004.

The Safeguarding Vulnerable Groups Act 2006 lays the foundation for a new scheme which aims to help avoid harm, or risk of harm, to children and vulnerable adults. The scheme will aim to do this by preventing those who are deemed unsuitable to work with children and vulnerable adults from gaining access to them through their work. This will be done by:

- Providing employers with a more effective and streamlined vetting service for potential employees
- Barring unsuitable individuals from working, or seeking to work, with children and vulnerable adults at the earliest opportunity

The new scheme will be phased in from autumn 2008.

13.4.3. **Statutory and Non-Statutory Guidance**

Associated guidance issued to support the implementation of effective cross agency arrangements to safeguard children and young people includes;

*Working Together to Safeguard Children 2006*¹ -

This guidance sets out how individuals and organisations should work together to safeguard and promote the welfare of children. The guidance has been updated since the previous version which was published in 1999. The new version reflects developments in legislation, policy and practice.

The guidance is addressed to all practitioners and front-line managers who have particular responsibilities for safeguarding and promoting the welfare of children, and to senior and operational managers in organisations that are responsible for commissioning or providing services to children, young people, parents and carers.

It is also addressed to senior and operational managers in organisations that have a particular responsibility for safeguarding and promoting the welfare of children.

The guidance helpfully sets out a clear definition of sexual abuse:

*Sexual Abuse involves forcing or enticing a child or young person to take part in activities, including prostitution, whether or not the child is aware of what*
is happening. The activities may involve physical contact, including penetrative (e.g. rape, buggery or oral sex) or non-penetrative acts. They may include non-contact activities such as involving children in looking at, or in the production of, sexual on-line images, watching sexual activities, or encouraging children to behave in sexually inappropriate ways.

Chapter 12 – Managing individuals who pose a risk of harm to children

provides guidance and highlights a range of mechanisms that are available when managing individuals who present a risk or potential risk to children. Specifically this guidance addresses:

- Collaborative working between agencies to identify and manage such individuals.
- Multi Agency Public Protection Arrangements (MAPPA) – full MAPPA guidance is available at:
  
  www.probation.homeoffice.gov.uk/output/page30.asp

Statutory guidance on making arrangements under section 11 of the Children Act 2004 –

Section 11 of the Children Act 2004 places a statutory duty on key people and bodies to make arrangements to safeguard and promote the welfare of children. The statutory guidance on the duty, which was first issued in 2005, has been updated. The revised version was published in April 2007.

These arrangements require all agencies to have:

- Senior management commitment to the importance of safeguarding and promoting children's welfare
- A clear statement of the agency's responsibilities towards children, available for all staff
- A clear line of accountability within the organisation for work on safeguarding and promoting the welfare of children
- Service development that takes account of the need to safeguard and promote welfare, and is informed, where appropriate, by the views of children and families
- Training on safeguarding and promoting the welfare of children for all staff working with, or in contact with, children and families
- Safe recruitment procedures in place
- Effective inter-agency working to safeguard and promote the welfare of children

- Effective information sharing

The guidance on the duty to cooperate is part of an interlocking set of guidance on the Children Act 2004.

Central to all of the guidance is a clear message about the crucial importance of effective information sharing between key agencies to protect the public from those who harm.


13.4.4. **Vetting and Barring**

In the UK there was much criticism of the system designed to safeguard children from dangerous adults.

This system had not changed since the end of 2002 when the Criminal Records Bureau began operating. In order to assess whether a coach, official or employee is suitable to work with children, many sports organizations ask them to complete a CRB disclosure which gives the organization valuable information about their criminal record history.

There are also three separate lists of people who are barred from working with children or vulnerable adults. These lists (namely List 99, the Protection of Children Act List (POCA) and the Protection of Vulnerable Adults List (POVA)) operate under different legislation and with different criteria and procedures.

The Bichard Inquiry Report identified failures in this system, which included:

- inconsistent decisions being made by employers on the basis of CRB disclosure information

- CRB disclosure information is only valid on the day of issue;

- inconsistencies between List 99, the POCA list and the POVA list; and

- inconsistencies in police disclosure of information between police authorities.
The new Safeguarding Vulnerable Groups Act 2007 provides for a central vetting process built on the Criminal Records Bureau with a new independent statutory board, the Independent Barring Board. It will take decisions on including someone on the barred list where evidence suggests that they present a risk of harm to children or vulnerable adults. The new procedures will integrate the current List 99 and the POCA list and also provide for a new list of people barred from working with vulnerable adults to replace the POVA list.

The Act removes responsibility for barring decisions from ministers entirely and transfers this to the statutory body, which will administer the new system and take decisions about who should be barred. Other key elements of the new system will allow:

- barring decisions to be updated as soon as any new information becomes available and employers swiftly notified if an employee is then deemed unsuitable; and

- secure access by all employers including domestic employers such as parents contracting private coaches to make secure instant online checks of an applicant's status.

The new centralized vetting and barring system introduced by the Act will mean that all those who are working or applying to work in roles that bring them into contact with children or vulnerable adults will be able to apply for a Vetting and Barring Disclosure. The Bill creates several offences, the most significant of which are:

a) an individual commits an offence if he applies for a position working with children when he is barred from doing so; this will hopefully prevent, for instance, a coach who has been barred through an application in one sport attempting to start coaching in another sport; and

b) a provider of a regulated activity, which includes the instruction of children, commits an offence if they knowingly permit a barred individual from working with children or vulnerable adults or where they have not ensured an individual has been vetted,

New sanctions of up to five years in prison and up to £5000 fines will be applied to ensure the use of the system and compliance.
13.5. New Zealand

13.5.1. Statutory Basis for Safeguarding Children

The Statutory basis for safeguarding young persons in New Zealand is provided principally under the Children, Young Persons and their Families Act [1989] and the Care of Children Act [2004]. Existing child protection measures apply to children and young persons 16 years of age and under. Consideration is being given in a published bill to expand this to 17 years of age and under. The New Zealand Crimes Act [1961] as amended in 1995 provides for prosecution in the New Zealand courts of New Zealand nationals who commit offences abroad concerning sexual conduct with children.

The New Zealand system currently provides for two intake pathways for notifications...

- Directly to a Care and Protection Coordinator
- Directly to a national call centre where a multi disciplinary team including police and social work staff make an initial assessment and decide whether the notification should be allocate to a social worker for investigation.

Both intake pathways provide for allocation and categorisation of notification from critical (same day action) to low priority (action within 28 days).

13.5.2. Mandatory Reporting

There has been an ongoing debate in New Zealand for at least the past 30 years on whether mandatory reporting of suspected child abuse should be introduced. The current system remains protocol rather than statutory based although a report issued by Justice MJ Brown in 2000 [Ministerial Review of Department of Child Youth and Family Services] concluded that...

“If voluntary reporting cannot be adequately depended on, mandatory reporting will become a necessity.”

13.5.3. Age of Consent

It is a criminal offence to engage in sexual activity with a child under 16. In the case of a person holding a position of trust, it an offence
to engage in sexual activity with a child in their care under 18 years of age.

13.5.4. **Vetting Procedures**

New Zealand police administer a vetting procedure for agencies seeking to employ staff to work with children, older people, and those with special needs. Two separate checks are available through the vetting procedures.

(i) the conviction record for the individual
(ii) other information held by the police relating to behaviour of a violent or sexual nature that may not have resulted in a conviction. In cases where such information exists, further investigations may be carried out and the application may be “red stamped”

The decision on suitability to employ rests with the employer. In guidance provided by New Zealand police, employers are advised to consider the following where vetting has resulted in a conviction being indicated or the application being “red stamped”...

- The nature of the offence and the relevance to the employment
- The length of time since the crime has been committed
- The age and maturity of the candidate now compared to when the crime was committed
- The pattern of crime
- The proximity of the person undergoing vetting to vulnerable persons

Where vetting applications are “red stamped” police may recommend that an individual does not have unsupervised access to children, young persons, or more vulnerable members of society.
14. **Recommendations**

14.1. **Introduction**

14.1.1. It is clear to the Review Inquiry Team that child protection processes, procedures, and protocols as set out in *Children First*, were available to the range of public officials with knowledge of the Amsterdam incident. It is the opinion of the Review inquiry Team that it can reasonably be stated that if such procedures had been followed by the public officials who were aware of the incident, timely and clear outcomes in a child protection context could have been achieved. Notwithstanding the view of the Review Inquiry Team that sufficiently clear child protection guidelines and protocols were available to the public officials with knowledge of the Amsterdam incident, the Review Inquiry Team has arrived at a number of recommendations to be considered by the relevant policy makers for legal and administrative improvements touching on or concerning child protection matters.

14.1.2. The following recommendations are made taking cognisance of the materials examined in the preparation of this Report and the circumstances that gave rise to the Review, which, in the opinion of the Review Team, have highlighted significant concerns with regard to matters touching on or pertaining to child protection issues.

14.2. **Placing Child Protection Measures on a Statutory Footing**

14.2.1. Article 19 of the UN Convention on the Rights of the Child provides that ...

> State parties shall take all appropriate, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse...

While the *Children First* guidelines constituted a significant development stage in realising the State’s obligations under the UNCRC, the lack of a statutory basis for child protection guidelines means that there are no specific actionable obligations on individuals to report child abuse or to comply with...
agency or inter agency risk assessment initiatives to discharge common law duty of care requirements.

14.2.2. The Review Inquiry Team notes the concluding observations of the UN Committee on the Rights of the Child, 2005, which recommended in 2006 that in light of Article 19 of the Convention, that the Irish State would...

a) continue reviewing the Children First guidelines and consider their establishment on a statutory basis

b) ensure that all reported cases of abuse and neglect are adequately investigated and prosecuted and that victims of abuse and neglect have access to counselling and assistance with physical recovery and social reintegration

c) develop a comprehensive child abuse prevention strategy including developing adequate responses to abuse, neglect, and domestic violence; facilitating local, national, and regional coordination and conducting sensitisation, awareness raising and educational activities; and

d) ensure that an evaluation of all employees and volunteers working with children is undertaken prior to recruitment, and that adequate support and training is provided for the duration of their employment.

14.2.3. The Review Inquiry Team notes the publication in February 2007 by the Government of a Constitutional amendment on Children’s Rights to “reflect the desire of the Irish People to establish robust safeguards for the rights and liberties of all children and that enshrine the very highest possible standard for the protection of children.”

The Government stated that the Constitutional amendment will empower the Oireachtas to make legislative change in four key areas, one of which relates to the Child Care Act 1991.

14.2.4. The Review Inquiry Team notes that both the Ferns Report [October 2005] and the Report of the Joint Oireachtas Committee on Child Protection [November 2006] identify the importance of allowing for the collective exchange of information between agencies concerning the risk of sexual abuse of children. The Findings of this Review Inquiry suggest that State Agencies outside of An Garda Síochána and the HSE were informed of a child protection issue relating to Dr. A in
Amsterdam in 2004, but did not process a notification in accordance with Children First guidelines. Accordingly, it is recommended that legislative effect be given to placing a statutory obligation on all State Agencies to comply with Children First. In the context of further Constitutional and legal reform, it is also recommended that a statutory obligation be placed on State Agencies to participate in an enhanced inter-agency approach to dealing with receipt of notifications or information relating to child abuse and the communication of such information to the HSE.

14.2.5. The Children First guidelines are stated as being directed at Health Board personnel, An Garda Síochána, other public agencies, community and voluntary organisations, and private citizens. On the basis of the Findings of Fact outlined elsewhere in this Report, and the State’s commitments under the UN Convention on the Rights of the Child, there are reasonable grounds for suggesting that clear delineated child protection responsibilities require to be set out for each Government Department and Agency with due regard to notification and inter-agency co-operation at national, regional and local level. Such a measure should be accompanied by an ongoing programme of appropriate training in each Department or Agency.

14.2.6. The Review Inquiry Team recommends that the introduction of statutory guidelines should include an independent quality assurance system of monitoring progress toward achieving the core objectives of child protection guidelines including preventative and protective measures.

14.2.7. While the Review Inquiry Team recognises that putting child protection guidelines on a statutory footing gives rise to complex confidentiality and legal issues, it is recommended that progress on this matter would be prioritised by the HSE in its interactions with Government in the context of the amendments of or additions to existing Child Care legislation to provide “Legal authority for the collection and exchange of information relating to the risk or actual occurrence of child sexual abuse” – (Governments wording on Constitutional Amendment on Children 19 February 2007). The Review Inquiry Team recognises that such Constitutional reform is ultimately a matter for Government and the Irish electorate.
14.3. **Vetting of New and Existing Staff**

14.3.1. Immediately prior to the revelations which gave rise to this Review Inquiry, the HSE issued a circular on 26 June 2007 regarding Garda vetting of HSE employees. This circular specified that the HSE would initiate Garda vetting of all new employees and sets out the consequences for employees of not declaring convictions. A further circular was issued in September 2007 by the HSE’s Garda Liaison Vetting Office, entitled “A Guide to the Garda Vetting Process for Employment Purposes”. The HSE circulars clearly identified Garda vetting as an important component of recruitment and HR practice, in addition to interviewing, reference checking, and other pre-employment screening which are the responsibility of each employer. The circular sets out detailed procedures to be adopted by Health Service Employers in respect of recruiting new staff including:

- A 21 step process to be followed in processing applications for Garda Vetting
- Guidance to applicants on obtaining police clearance from jurisdictions where they have resided for more than six months
- Guidance on dealing with unsatisfactory Garda Vetting Reports including advice on undertaking Risk Assessments of such candidates
- Pro-forma Statutory and Non Statutory Declarations to be completed by candidates confirming that there is nothing in relation to their conduct, character or personal background of any nature that would adversely affect the position of trust in which they would be placed

14.3.2. In this jurisdiction, Garda vetting has been centralised in a single unit based in Thurles, Co. Tipperary. In addition to providing a well regarded vetting service to the HSE, the Unit’s remit now extends to the educational sector, to many State funded voluntary bodies and recently to sports and community workers and volunteers. Garda vetting has been extended to all criminal prosecutions within the State irrespective of whether such prosecutions have been withdrawn, have been successful, are pending, or have been completed. Previously the central Garda Vetting Unit had the facility to contact the British Authorities to carry out checks on prospective employees, this service became unavailable from Britain but discussions have
been underway to re-establish that service. The Review Inquiry Team also understands that a further initiative is underway on the part of An Garda Síochána to develop reciprocal vetting arrangements through the European Union among fellow European Union jurisdictions. The initiative to develop reciprocal vetting arrangements with other EU countries is strongly endorsed by the Review Inquiry Team. Cross Border developments are also underway to ensure that background checks by the Pre Employment Consultancy Service (PECS) in Northern Ireland are available to organisations in the Republic of Ireland. Unlike the vetting procedure in the Republic of Ireland, the PECS check includes evidence of cautions, bind-overs, pending cases, reprimands, and final warnings relating to young persons and vulnerable adults. “Soft” information (such as concerns or allegations) may also be included in the PECS listings. The Review Inquiry Team recognises that the availability of “soft” information through PECS and through other international systems is permissible in the context of the legal and Constitutional position as it applies in those jurisdictions.

14.3.3. The Review Inquiry Team notes that Garda vetting is being progressively rolled out in respect of all new HSE staff and this initiative, in conjunction with the expansion of Garda vetting into the educational and voluntary sectors, has placed significant resource demands on the Unit. However with regard to existing staff who may not have been the subject of Garda vetting and who avail of a career break, or in the case of staff who have been vetted and who then leave the jurisdiction on a career break, such staff are not subject to further vetting on return to employment from their career break. Accordingly there is no existing protocol to establish whether a conviction has been recorded during the career break against such an individual if occurring outside of this jurisdiction. Existing Garda vetting, in the absence of an internationally recognised vetting database, would be unlikely to reveal such a conviction. It follows that it may be appropriate to consider placing a requirement on HSE staff who work directly with children or vulnerable adults and who avail of career breaks outside of the jurisdiction to furnish, as an interim measure, a police certificate from that jurisdiction prior to re-commencing employment in the HSE or in HSE funded agencies, pending the further development of reciprocal international vetting arrangements.

14.3.4. While recognising that in the vast majority of cases, existing staff fully discharge their duty of care and will voluntarily disclose any matter which may adversely affect their position of trust, the Review Inquiry Team recommends that existing HSE staff, or staff employed in HSE funded agencies,
working with young persons or vulnerable adults who have not been subjected to Garda clearance, should be required to be vetted as a matter of urgency. This requirement would also extend to any agency, locum or temporary staff working with those groups. It is further recommended that consideration be given to requiring that all HSE staff working in the child care or vulnerable adult services provide a statutory declaration on a periodic basis regarding anything in their personal background, conduct or character that would affect the nature of trust placed in them by virtue of their position and to provide consent to the HSE making any related inquiries into such matters. An alternative approach may be to institute periodic vetting of existing staff working in those areas. The Review Inquiry Team recognises that such a measure would impose a significant administrative burden on both the Garda Vetting Unit and the HSE Garda Vetting Liaison Office and also necessitate consultation by the HSE with An Garda Síochána, the Data Protection Commissioner and all other relevant parties.

14.3.5. The Review Inquiry Team recommends that the HSE would build on the progress made in putting the June and September 2007 Circulars into effect and formulate a policy direction in this area having regard to the measures recommended in this section and to have particular regard to adopting a parallel system of vetting in line with that applicable in Northern Ireland.

14.4. Testimonials and Endorsements of Teaching Practices

14.4.1. The Review Inquiry Team was concerned that in the course of its inquiries, material was tabled from 1997, 1998, and 1999 providing support for Dr. A’s use of teaching materials showing injuries to children consistent with sexual abuse. Those letters of support were issued on the headed paper of organisations funded by the State which provide services to vulnerable young persons. The Review Inquiry Team recognises that it is a matter of opinion as to the appropriateness of the educational material in question. However, the use of headed paper of the organisations in question suggests that those organisations strongly supported or validated the use of those materials. Although this is specifically a governance matter for those organisations, for future reference it is recommended to the HSE that it requires that protocols are in place for its own staff and for agencies funded by the HSE, that organisational approval is sought and obtained prior to letters of support being issued on the headed paper of the respective organisation.
14.5. **Internal Audit**

14.5.1. In light of the finding outlined in Section 12.9.14 above, the Review Inquiry Team recommends that all contracts and any informal arrangements entered into between the Midland Health Board, the HSE and Dr. A acting in a private capacity or, on behalf of a consultancy group, should be audited to determine the extent of such arrangements and their compliance with tendering and procurement policies and guidelines.

14.6. **Future Risk Assessments**

14.6.1. The Review Inquiry Team recommends that the HSE would make the findings of this Report available to any agency providing services to young persons or vulnerable adults where consideration is being given to engage Dr. A in employment or in consultancy work.
15. Acknowledgements

The Review Inquiry Team wishes to acknowledge the co-operation of individuals and organisations referred to in this Report. All of whom, without exception, provided their full co-operation.

Signed: __________________________  Date: __________________________
Conal Devine

______________________________  Date: __________________________
Eoin Rush
Appendix I

(i) Response by Dr. A to Draft Report

Dr A
Response to Draft Report 21/12/

Page 14
The matter of the child protection concerns and my use of slide educational materials raised in the unsolicited phone call from Dr. WIT 5 has been resolved by the most senior management in Waterford Institute of Technology by their witness to this Inquiry. They have also stated that there is no evidence that I ever made a request for any students to be filmed by a Technician there and that is because I never made such a request. This needs to be placed in the Preliminary Statement of Facts section. It should also be noted that the slide package was only ever used with adult populations.

Page 20.
It is noted that there was no tendering process in respect of the application for the study into heroin in the midlands. I followed established Athlone Institute of Technology policy on this and passed all relevant documentation through the Finance Office there. I also sent several drafts to Mr. MHB 1 for negotiation and, indeed, through my own line manager at the Athlone Institute of Technology.

Page 21
It is clear that there is a dispute between Mr. MHB 1 and Detective Sergeant GS1 around the ages of the victims. On my original call to Mr. MHB 1 from Amsterdam (see phone records supplied) I informed him of the ages. I also did this in my calls to Detective Sergeant GS1 from Amsterdam the 26th of June (see phone records supplied).

Page 22
For the sake of fairness and detail, the length of the calls made to Mr. MHB 1 from Amsterdam should be included (see phone records supplied).

Page 23
I note that Mr. MHB 1 claims he informed senior HSE staff. This is what he told me in my meeting with him in Tullamore (see my diary notes supplied). I was told that he was observing protocol and thus believed that I had done what was required of me.

Page 24
I informed Mr. MHB 1 that my Lawyer thought the case would not progress in Ireland but was unsure about Holland as per extensive documentation submitted.

Page 25
It is the norm for third-level lecturing staff to be involved in consulting work. I was assured that Mr. MHB 1 had authority to pass such project spend and all relevant documentation was forwarded to HSE Finance.

Page 25
Mr. Devine will note that I was only given three days notice of the impending trial in Holland. Nonetheless, I made arrangements to travel over. Also, it should be inserted that Mrs. A also was party to that phone call to Mr. MHB 1 of 6 minutes 47 seconds and that she has a clear recollection of informing Mr. MHB 1 of the trial.
Page 25
The phone call was indeed very brief just to note the trial outcome and to establish a face-to-face meeting with Mr. MHB 1 which took place later that month on the 26th of October.

Page 31:
I note that Mr. MHB 1 claims that he informed three senior HSE staff and later (6.1.13) that there was confusion as to what happens when an out of jurisdiction offence takes place. This was reiterated by my Lawyers who were, it transpires, also unclear as evidenced by the letter submitted by Mr. P.

Page 33
The Garda authorities in Athlone had been informed of the incident by Detective Sergeant GS1.

Page 33 (6.1.26).
Mr. MHB 1 asserts that he informed me to inform my employer. Under no circumstances did he tell me do so and I am categoric on this. It's a blatant untruth.

Page 34 (6.1.34)
Mr. MHB 1 suggests that he had “some concerns” about me. At all times, he informed me that he had no concerns and understood that it was a once off incident fuelled by stress and alcohol. I say that if did have concerns about me, why then did he give me more work following the incident in Holland.

Page 37
The first paragraph is confusing to read and does not have a logical flow.

Page 37 (6.2.9).
Mr. MHB 1 suggests not to confuse “a significant relationship’ with support. This is disingenuous. We had a very close personal relationship and I relied on him as a confidante.

Page 37 (6.2.10)
Mr. MHB 1 acknowledges that he told me he informed two senior people. This is correct and I understood that any necessary protocol would be observed. The fact that I did not hear anything back from the HSE resulted in me feeling that this was not a significant issue in terms of risk assessment.

Page 39 (6.2.14)
I note that Mr. MHB 1 states that Ms. MHB 5 and Ms. MHB 6 were made aware by him of the incident in Amsterdam. I was unaware that the two staff had been furnished with this information as stated in my interview.

Page 49 (6.6.11)
I note that Dr. MHB 2 was of the opinion that I did not present any significant risk as my post at Athlone Institute of Technology held no direct access to children. This is correct as I held a teaching/research post. I was never employed as a professional child care worker working directly with children and young people. In fact, latterly, I worked alone in the Centre for Child and Youth Care Learning and despite several requests for full-time and part-time AIT staff, I was accorded none in my period there from November 2003 to July 2007.

Page 52 (6.7.6)
It is incorrect that I “made a number of visits to Orphanages”. I made only one in the constant presence of a female Social Care Lecturer. Please correct this with a note.

Page 68
It is correct that I brought the matter of leaking the internal investigation to the attention of the WIT Director in a formal letter to him. Management were aware of the SEHB letter when I received it in December 1998. I understand that some WIT files are missing and, therefore, incomplete. WIT was aware of the correspondence.
Page 69 (8.1.5)
I note that WIT management record that there is no evidence to suggest that I ever asked a Technician to record students. I would like this inserted into the Preliminary Findings of Fact section due to the inaccurate reporting in the media over the summer of 2007 such as in the Irish Examiner.

Page 70
I would also like it inserted into the Preliminary Findings of Fact that there is no issue around supplying a reference for me in 2001 again due to the inaccurate media reporting over the summer of 2007.

Page 75 (8.2.12)
I would like it inserted into the Preliminary Findings of Fact that the three study visits abroad for the heroin misuse study were sanctioned in the original application to the HSE and passed by both the HSE and the Athlone IT.

Page 78 (9.1.14)
I note that Detective Sergeant GS1 also felt that Mr. MHB 1 was the most appropriate HSE Officer to report the incident to – as I did.

Page 78 (9.1.20)
****It is correct that I texted Detective Sergeant GS1 but I also made calls to him from my mobile phone in Amsterdam where we discussed the incident in some detail. I would like this inserted into the Preliminary Findings of Fact and the duration of the calls (see records supplied i.e. calls of 10 minutes 46 seconds duration and 5 minutes 22 seconds duration on June 26th).

Page 86 (10.1.8)
I think the paragraph reads a little confused and it needs greater clarity. It has been recognised already by WIT management that the Slides Materials were given to me by a colleague (and purchased through discretionary funds held by the College).

Page 87 (10.1.15)
This is correct but it was the Head of Department of Humanities in Athlone Institute of Technology who refused to allow Mrs. A to travel to Amsterdam and then Mr. MHB 1 suggested Detective Sergeant GS1. This should be noted as a matter of fact.

Page 90 (10.1.29)
It was not the Superintendent but Mr. MHB 1 who had spoken to senior people in Amsterdam. This needs to be corrected as a matter of fact.

Page 93 (10.2.6)
We have already clarified the sequence of events around the judgement – which Mr. Devine refers to later.

Page 134
The meeting was held on June 30th not July. Mr. MHB 1 did not inform me I should tell my employers. It is correct that I informed him I might well have to return to Holland to fact charges at some stage in the future.

Page 136
Mr. MHB 1 asserts that at no time did I make him aware of being formally charged or convicted. This is blatantly untrue. I informed him and my wife and I informed him on separate occasions as outlined in our evidence and notes.

Page 148
Is there any written communication to me stating that I should return the Slides to the original owner? I have no memory of such or documentation in my possession.
Preliminary Matters of Fact

12.2.1

I would ask that Mr. Devine omit the words ‘young person’ and insert the words ‘young adult’ as she was 18 at that time. I have already stated that it has not been my practice to purchase alcohol for any interviewees in over fifteen years direct research and her allegation in 1997 remains unsubstantiated. I most certainly believe that I did not but this lady a drink. It has neither been proved nor supported by a third party. If she was bought a drink, it may have been by her foster mother. I simply cannot remember some ten years later.

12.2.2

It is a matter of fact that the teaching slides were purchased out of discretionary funds held by Humanities management and were deemed as suitable by the entire academic course board as expressed in formal minutes recorded at a special meeting to discuss their course inclusion. It is not a matter of fact that the Slides first came to the attention of Waterford Institute of Technology only on November 24th 1999 in my letter to the Director. They had already been discussed informally at course board level and with Humanities management. I brought the letter to the attention of the appropriate line manager. This paragraph therefore should be altered for accuracy.

12.2.3

The brief of the report is to “look at matters of child protection touching on or concerning Dr. A”. Therefore, the last comment relating to “concerns in respect of professional boundaries” should be deleted as it does not pertain to child protection issues. The distinction here is quite important I believe.

12.3.4

The result of this was that no that no further action was deemed required. This should be included.

12.4.1

For balance, it should be reported that I submitted several drafts for Mr. MHB 1 and discussed these with relevant AIT management as outlined above. This is in line with established AIT protocol. As the paragraph is presented, it appears as if I omitted some procedure.

12.4.3

It should be included that this decision was made by the Athlone Institute of Humanities Head of Department and not Mr. MHB 1 as he had already sanctioned her involvement.

12.4.13

All that work was pre conviction. I have supplied an email sent to Mr. MHB 1 where I suggested that any private consulting work must be kept separate from AIT work for issues of clarity. Mr. MHB 1 agreed to this.
12.4.14

The second call referred to here of 39 seconds was only to set up a meeting in Tullamore where Mr. MHB 1 was informed of the specifics as outlined above. Anyone reading the report might infer that no significant conversation could take place in this short time.

12.4.15

It is reasonable for me to conclude that no further notification was required as I had notified a senior HSE Officer to whom I was directly reporting throughout.

12.6.3

I held an academic teaching and research post as outlined above.

12.6.6

Surely, the Dutch authorities should have informed the Irish authorities of the outcome of the case. Who, or which, was the proper authority to inform them?

12.7.1

****OK but for the sake of balance and fairness, it should be inserted that it is a matter of fact that I had specific advice, for which I paid, from eminent Lawyers in two jurisdictions i.e. that no further information had to be passed on by me to any authorities (I have supplied a letter to Mr. Devine stating this from my Dutch Lawyer, (named lawyer) and (named lawyer) agreed to the contents of my Garda statement in August 2007.

12.8.1

This is not correct on two counts and should be rephrased in light of the above. I have no memory of being asked to return the materials (neither does the Head of School of Humanities) and the College was aware of the letter from the SEHB.
Response to Draft Report by Ms. MHB 4

RE: HSE Enquiry

Dear ..., 

I refer to your letter of the 11th December 2007 and I thank you for forwarding me a copy of your draft Interim Report and upon which I make the following comments and observations insofar as the report affects me, before December 27th 2007 as per your request:

1. I made it quite clear in my interview with you and in my written responses to the notes of your interview with Mr. MHB 1 that I did not meet or discuss the incident with Mr. MHB 1 on the 28th June 2004 or at any time during that week as he has alleged. Since my interview with you I have been able to locate my diary records for that week and I enclose a copy of that record for your attention. It is clear from my diary records that I was on annual leave on the 28th June 2004 and so I could not have met Mr. MHB 1 on that day as he alleges. In addition my diary records confirm that at no stage during the week of the 28th June 2004 did I meet Mr. MHB 1. If I had met Mr. MHB 1 in his office as is alleged then any such meeting would have been entered in my diary. It is not and that is because no such meeting ever took place.

2. I wish to repeat what I have said previously to you and that is that Mr. MHB 1 mentioned this matter to me on one occasion only. He informed me at the end of a meeting in my office sometime towards the latter half of 2004 that Dr. A while on a trip abroad with others to Amsterdam, Holland had been involved in an incident in a hotel. According to Mr. MHB 1 Dr. A had “behaved badly” late at night in a hotel. I was told that the incident involved women. I was not given any other details. I advised Mr. MHB 1 to follow the matter up as appropriate and to keep me appraised of progress or any relevant issues. He did not make any further mention of the matter to me.

3. I refer to paragraph 5.5.26 of your report. This paragraph is ambiguous as it implies that I had knowledge on the 5th November 2004 that the case against Dr. A was not proceeding. This is absolutely untrue. The extent of my contact with Mr. MHB 1 in relation to this matter is set out above. Mr. MHB 1 did not inform me at any time that there was a Court case in Holland and he certainly did not ever mention to me that a case was not proceeding in Holland. This paragraph of your report therefore requires amending to reflect the foregoing.

4. I refer you to the summary of your interviews with Mr. MHB 1. I deny that I was contacted by Mr. MHB 1 as alleged in paragraph 6.1.1. In particular I deny that I met Mr. MHB 1 on the 28th June 2004 as is alleged in paragraph 6.1.21. My diary records confirm that I was on annual leave on that day. No such meeting took place and so each and every allegation made by Mr. MHB 1 in relation to that alleged meeting is wrong and I deny each and every one of them as if I had listed them here. As my diary records clearly corroborate my position I invite you to find as a fact that Mr. MHB 1’s allegation that he informed me of the incident on the 28th June 2004 or at any time during that week is without foundation and wrong.

5. I refer you to paragraph 6.1.22 of your report. Mr. MHB 1 appears to suggest that he may have discussed the question of informing Athlone Institute of Technology with me. He did not and any suggestion that he did is denied.
6. **Paragraph 6.1.26** suggests in the second sentence thereof that what Mr. MHB 1 alleges is a fact. I suggest that the second sentence of this paragraph be amended to state that he *alleges* he informed me and he *alleges* that I told him to go ahead with the meeting. Of course, I deny both allegations.

7. **Paragraph 6.1.29**: I deny that Mr. MHB 1 informed me either in November 2004 or at any time that the case in Holland was not going ahead. This is simply untrue. Similarly in **paragraph 6.1.34** I say that the reason Mr. MHB 1 cannot recall discussing the Canadian study trip with me is because so such discussion ever took place.

8. I refer to **paragraph 6.2.4** of your report. Mr. MHB 1 suggests that I was aware that this was a childcare issue and that I would be contacting the appropriate Childcare Manager. Mr. MHB 1 could not have believed that this was the case because I had never been made aware by him of the ages of the victims in Holland. I was simply told that the incident involved women, as set out in point 2 above.

9. I refer to **paragraph 6.2.5** and I say that it is completely untrue for Mr. MHB 1 to state that he turned to me for guidance on this issue. I deny this suggestion. Mr. MHB 1 never sought my guidance on this issue. Mr. MHB 1’s statement referred to in **paragraph 6.2.7** is without any foundation as I had not been made aware by him of the full details of the incident, merely what I have set out in point 2 above.

10. I refer you to **paragraph 6.4.4**. I wish to clarify that Mr. MHB 1 was the Interim RTDF Coordinator. I stated my interview with you that the Midland Health Board was a “post box” for funding, not Mr. MHB 1.

11. I refer to you **paragraph 6.4.9** which requires amending. I did not concur with Mr. MHB 1’s statement that he had spoken to me on two occasions about this matter. I refer you to the notes of the meeting which confirm, as I have stated herein, that the matter was mentioned to me once only by Mr. MHB 1 and that was at the end of a meeting in my office sometime towards the latter half of 2004.

12. I refer you to **paragraph 6.4.12** which is also incorrect. In my interview I did not make the confirmation that is set out in that paragraph. Firstly, I did not confirm that Mr. MHB 1 had spoken with me after he had spoken with Dr. A. I could not give such a confirmation because he did not tell me that he had spoken with Dr. A. Secondly, I did not say that I had spoken with Mr. MHB 1 in the latter part of November 2004. What I did say was that I had met him in the latter half of 2004. Thirdly, I did not confirm that Mr. MHB 1 informed me that no charges were being brought against Dr. A as no such information was given to me by Mr. MHB 1. I refer you to the notes of our interview and I invite you to make the necessary correction.

13. **Paragraph 6.4.19** has a typographical error.

14. I refer to **paragraph 6.6.9** and I say as a point of information that the Director of Childcare reported directly to Dr. MHB 2.

15. I refer you to **paragraph 12.4.6** and in particular the third bullet point thereof. At the outset of this paragraph you indicate that the matters that follow thereafter are established as a matter of fact. I say that it cannot be established as a fact that the contacts alleged by Mr. MHB 1 to have been made with me actually occurred. I suggest that the clear evidence is that his recollection is wrong and this paragraph should be amended to state “*alleged contacts...*.”
16. I refer you to paragraph 12.4.11 and I say that the evidence does not support the conclusions which you have drawn in this paragraph. I have consistently stated that Mr. MHB 1 did not inform me that the case against Dr. A would not be proceeding. I did not acknowledge any such contact as you have found. I respectfully suggest that the evidence does not support such a conclusion. Furthermore I did not separately acknowledge that on another occasion Mr. MHB 1 had made a passing comment. I refer you again to the record of my interview with you. In the circumstances, I suggest that this paragraph be amended to read as follows:

“That on 5th November 2004 a discussion took place between Dr. A and Mr. MHB 1 and it is accepted that the discussion included matters relating to the legal status of the allegations against Dr. A. Mr. MHB 1’s claim that he was advised by Dr. A that the case in Holland would not be proceeding is disputed by Dr. A. The only contact Mr. MHB 1 had with Ms. MHB 4 was when he made a “passing comment” in the latter part of 2004 about Dr. A behaving badly with women in Amsterdam. The ages of the females involved were not indicated to her.”

I respectfully suggest that the facts as presented warrant such a finding.

Yours sincerely,

Ms. MHB 4
Dear ... 

Many thanks for giving me the opportunity to respond to your draft report. I would like to make the following points:

1. My initial discussion with Mr. MHB 1 clearly set for context for what would be expected of any employee in the health services regardless of seniority. The discussion referred to possible contact with the child care service, risk assessment, and enquiries on my part about any possible access Dr A might have to children.

2. At the end of my initial discussion with Mr. MHB 1, I suggested, and we both agreed, that he should discuss the matter again, as we expected he would have much more information within a matter of days from further discussions with the Garda concerned. The initial details of the incident given to me were very sketchy and we had a very clear expectation that more details could be elicited through discussion with the Garda concerned.

3. I had assurances on two occasions that Mr. MHB 1 had met Ms Ms. MHB 4 to inform her of the matter. Mr. MHB 1 was a very Senior Manager in the system who had been invited, and the best of my knowledge as that time, had availed of awareness training on child protection issues, which would have clearly and comprehensively outlined the responsibility of everyone who had suspicions of child abuse. This awareness training, as far as I can now recall, consisted of a two day course, although shorter modules were available. The assurances I was given, concerning a meeting with Ms. MHB 4 having taken place in an office were very explicit and were given to me within 24 hours of the meeting with Ms. MHB 4. I was also given to understand that the incident had been documented. When Mr. MHB 1 reported to me after his meeting with Ms. MHB 4, I said that was fine as long as the child care people knew. I said to him that the importance of her knowing was that fact that she was the Senior Manager responsible for child care, not that she was responsible for drugs services.

4. I think that is it not unreasonable that a member of the top management team of the Health Board should ask one of his Senior Managers who has been informed of a serious incident by the gardai, and who was in a position to get more comprehensive knowledge of the context and details of the incident, to ensure that the child care staff in the Board were made of aware.

5. While I now accept that we have no record of my actions aimed at ensuring that child care staff should be informed, it is also fact that I did take action after his reported meeting with Ms. MHB 4 in advising my Senior Manager for Health Promotion to make sure that the child care staff were aware of the incident.

6. While the details initially reported to me by Mr. MHB 1 were very serious it seemed reasonable to allow a few days for Mr. MHB 1 to get more details from the Garda sergeant concerned. When Mr. MHB 1 reported to me that he had spoken to Ms. MHB 4 I expected that discussions with the specialist child care staff would follow.

I also had a 100% expectation that a formal notification would come from the Gardai to the child care staff in the MHB given that the Gardai already had first hand knowledge.
7. My initial knowledge was that three “girls” or “women” (I’m not sure what term was used) were involved, one underage. The exact details of the incident were unclear. My understanding was that Dr. A had been socialising with them earlier on in the evening; that apparently he and the Garda sergeant had gone to bed, but that Dr. A must have subsequently left his room to make contact with the girls. I would not therefore have been aware of all aspects of the incident. There was no suggestion at this time that Dr A had stripped himself, used physical violence or threatened violence or that he physically restrained any of the girls.

I note in the finding of fact 5.5.17 mention of “suspected sexual abuse against young girls”. Mr. MHB 1 clearly stated to me that one of them was underage.

Yours sincerely

Dr MHB 2
(iv) **Response to Draft Report by the Department of Justice, Equality and Law Reform**

Re: HSE Inquiry/Dr. A Draft Interim Report

Dear ....

I refer to your letter of 11 December 2007 in relation to the above. Thank you for providing me, on behalf of the Department of Justice, Equality and Law Reform, with the opportunity to provide written comments regarding the draft report. I have a number of comments to make which I hope will assist in clarifying the chronology of events:

4.14.1 The Central Authority (CA) for mutual legal assistance in criminal matters, based in the Department of Justice, Equality and Law Reform, had received information from the Dutch authorities on 27 July 2004 regarding the substance of the alleged offences committed by Dr. A. A copy of the letter from the Dutch authorities, containing this information, was sent to the Office of the Director of Public Prosecutions on 8 September 2004.

The request from the Dutch authorities to serve the summons on Dr. A is dated 15 August 2005. The request, together with the summons, were received by the CA, based in the Department of Justice, Equality and Law Reform, on 2 September 2005. The Mutual Assistance Section of the Garda Síochána, based in Garda Headquarters, was requested on 2 September 2005 to make arrangements to serve the summons on Dr. A.

12.6.2 A copy of the letter from the Dutch Ministry of Justice, received by the CA, based in the Department of Justice, Equality and Law Reform, on 27 July 2004, was forwarded to the Mutual Assistance Section of the Garda Síochána on 3 August 2004.

Yours sincerely,

_____________
Mr. J1
Assistant Secretary

(v) **Response to Draft Report by National Drugs Strategy Team**

Dear ..., 

Thank you for the report and for the opportunity to make observations on matters of fact in the draft - I have reviewed the notes on my interview with you and have one minor comment namely under 5.3.5 that ....she understood there was some discussion... as I had heard about that discussion from Mr. D2.

I would also like to take the opportunity to reiterate the point that a well developed, structured process is now in place in relation to considering and assessing all project proposals, including research, coming from Task Forces. All project proposals are developed with promoters in conjunction with the Task Force support staff, proposals are formally approved at a Task Force meeting and are then submitted to the Team for assessment and approval or otherwise.

Ms. D4, 
Director, National Drugs Strategy Team
Dear Mr. Devine,


...In relation to the preliminary findings of fact set out in the Interim Report, I wish to state the following:
I did not telephone Mr. NL 1 for the information as set out in item 12.5.3 (second quotation marks) of the interim report.

Yours faithfully,

GS 4
Garda Liaison Officer
Appendix II

Response to Draft Report by Mr. MHB 1, received on 17 and 22nd January 2008
(typed from original document)
Mr. CD
c/o Asst General Secretary
IMPACT

18.01.08

Re: Review Inquiry on any matter pertaining to Child Protection Issues
touching on or concerning Dr. A

Dear Mr. CD

In my response to the draft review inquiry document forwarded to you the week ending 20th January 2008, I omitted a number of points: I now wish to add this letter as an amendment to my response.

**Additional points of clarification**

1. Is it Dr. A’s position that he fully disclosed his role in the assault committed against the American Students in June 2004 either during his telephone conversation from Holland on the 26th of June or at any sequent meeting before his trial in 2005 with me?
2. At Dr. A’s trial in Holland in September 2005, did he plead guilty to the charges laid against him or was the evidence presented to the court and as a result Dr A was found guilty?
3. In the documentation forwarded by the Dutch Authorities to the Department of Justice, Equality and Law Reform to Dr. A’s title (Dr. or Mr)?
4. Was a copy of the report written by the Garda Liaison Officer based in Holland and forwarded to the Irish Embassy and Garda Authorities provided to the Review Inquiry? Did the Report refer to the age profile of the American Students and the nature of the assault?
5. Was a copy of the statement provided by Mr. MHB 1 in August 2007 forwarded to Dr. A prior to his interview with the Review Inquiry Team?
6. Is it the case that the Dutch Police referred to American Students as young girls when discussing the matter with members of An Garda Síochána?
It is my contention that depending on the response to the above questions a number of findings of facts can be made.

Finding of Facts:

1. The Review Inquiry Team finds as fact that MHB 1 did not report the allegations to Childcare. It is equally a point of fact that no other official either HSE or Garda referred the allegations to Childcare or at any later point checked to see if the allegations were referred.

2. It is a point of fact that Mr. MHB 2 clearly recalls that Ms. MHB 4 had been informed of the incident. The phone records now submitted to the Inquiry Team shows an out of hours call to Ms. MHB 4 on Friday 25th June 2004 in the midst's calls made to key individuals.

3. The phone records submitted to the Review Inquiry Team shows a call to Ms. D4 on the 28th of June of significant duration as outlined previously to the Review Inquiry Team. This call followed a call to Mr. D2, Department of Justice, Equality and Law Reform (Taskforce Liaison Officer). I believe that these are significant points of fact.

4. The Review Inquiry Team finds as fact that Tendering did not take place in relation to the ‘Resilience Study’. Under HSE procurement policy:
   - Formal tendering takes place for amounts over 50,000 euro
   - Amounts under 50,000 euro three quotes can be sought
   - In certain circumstances a contract can be awarded if certain conditions are met.

Dr. A contacted the current Area Manager following his conviction and he was advised the HSE did not wish to continue with his service.

5. In relation to the two other projects which were funded.
   (a) Project 1
   Project was approved for funding prior to the incident in Holland 2004. Funding was withheld following the incident in 2004. It was only after Dr A informed me that the Authorities were not proceeding with the case against him that I released the funding. The funding was not only provided for the publication but also included presentations by Dr. A and a Named Academic to HSE Health Promotion staff.

   (b) Traveller Study
   Dr. A applied for funding in respect of comparison study focusing on two indigenous communities. Dr. A submitted a detailed document on the work underway in Canada and was seeking funding for the Irish component of the Study. Traveller Health Research required the approval of the DoHC, and documents were submitted, the DoHC informed the HSE that their group was not currently active, and an outline of the study was brought to the Local Traveller Health Unit for consideration. The Unit decided that it was happy for the work to proceed. The work was supervised by the acting Health Promotion Officer of Traveller Health. The Project was launched jointly in Canada and Athlone Institute of Technology. The funding related to the cost pf
publishing the study and did not relate to the commissioning of research. I received updates from Dr. A and acting Health Promotion Officer, but had no active involvement in the work or launch.

Please not that I am trying to ascertain the person associated with mobile phone number 086 0868282316

Yours sincerely,
Mr. MHB 1
(typed from original document)

Mr. PS
Department of Community, Rural & Gaeltacht Affairs
43-49 Mespil Road
Dublin
07.11.04

Re: Funding Allocation to Midlands Regional Drugs Taskforce

Dear P,

As you are aware the Midland Health Board administered the funds of the Midlands Regional Drugs Taskforce. In 2004 the Health Board has received one payment from your Department in the amount of 12,500 euro.

On the basis of 50,000 euro available from the Department of Health and Children and an additional 50,000 for technical assistance from your Department in 2004, the Taskforce entered into a number of initiatives. On behalf of the Regional Drugs Taskforce, I now wish to draw down the remaining amount of the technical assistance allocation from your Department. I would be grateful if you can arrange for the sum of 37,000 to be transferred to the Midland Health Board to ensure that appropriate funding is in place for the Midland Health Board to pay vendors which the Taskforce has entered contractual arrangements with before 21st December 2004.

Yours sincerely,
Mr. MHB 1
Attached: Expenditure Account (table attached)
In relation to my interview on the 9th of November 2007, no text was forwarded to me prior to the circulation of the draft document – ‘Review Inquiry on any matter pertaining to Child Protection Issues touching on or concerning Dr. A.

It is my intention to provide any information to the review inquiry which is deemed relevant. With this in mind I requested my mobile phone records for June 2004 and October 2005.

The record shows: (record attached I)

I am aware that the record of a telephone conversation does not confirm the detail of the conversation but simply shows calls were made.

1. Regarding Evidence provided by Dr. A

I wish to state the following points in relation to the evidence provided by Dr. A

(a) At no time did I offer advice to Dr. A in relation to the level of severity pertaining to allegations associated with events in Holland.

(b) At no time did Dr. A confirm the ages of the American Students in the room of the Hotel nor did he provide detail in respect of the nature of the assault. He did confirm that he had been questioned in relation to assault allegations. If Dr. A had confirmed what took place in the hotel room as outlined in this Review Inquiry Document then the outcome of the meeting would have been significantly different.

(c) Dr. A was advised that the trip had be cancelled when in rang on Saturday 26th June 2004. Dr A informed me that he was going to visit some friends in Holland and would return in a number of days.

(d) At no time was I advised by Dr. A that consideration had been given to his case by the Department of Justice, Equality and Law Reform

(e) At no time was I advised by Dr A that he had engaged an Irish legal firm and equally I was not advised of the outcome of any discussion with this firm.

(f) Dr. A clearly advised me that the Authorities were not proceeding with a case against him. The only authorities that Dr. A ever spoke to me about were Dutch.

(g) At no time was I advised by Dr. A in respect of summons issued to him September 2005 or his subsequent conviction. I wish to state clearly that at no stage did Dr. A notify me of his conviction.

On page 118 of the Draft Review Inquiry Document it states ‘Mr. MHB 1 phones my Dutch Lawyer’. I wish to state at no time did I have a conversation with any person representing Dr. A in Holland.

I wish to state that I have other issues with evidence provided by Dr. A but
believe there have been covered in the interview process. I do reserve the right to provide additional clarification.

2. Regarding Evidence Provided by Ms. A

I wish to state the following points in relation to the evidence provided by Ms. A:

(a) I have never meet Ms A
(b) I have never discussed with Ms. A
   - the allegations pertaining to Dr A
   - the summons, trial or conviction of Dr A
(c) I have never discussed any work carried out by Dr A on behalf of the HSE with Ms A
(d) I have never knowingly participated in a three way phone call which involved Ms A and Dr A

I acted in a professional manner while dealing with the allegations pertaining to Dr A, at no time would I consider myself to be part of a ‘close circle of friends’ of the As.

I had not dealings with Ms A in relation to any matter which subsequently emerged from the events which took place in Holland (June 2004). Any position put forward by Ms. A is conjecture.

I can confirm that I made a phone call to Dr A on the 06/10/05 following a voice message left on my phone. I wish to state clearly no discussion took place in relation to the trial or conviction.

3. Regarding Evidence Provided by Ms. D4 – National Drugs Strategy

In relation to 7/3/4, Ms. D4 states that the ‘research proposal was not sent for comment or approval at national level’. A copy of the proposal was forwarded to the National Drugs Strategy Office and a request received from the National Drugs Strategy Office to forward the proposal to the National Advisory Committee on Drugs. The National Advisory Committee on Drugs responded to the outline with a number of suggestions. The suggestions were forwarded to Dr A for consideration.

In relation to 7.3.7 it remains my position that Ms. D4 was advised of the incident in Holland.

IN relation to 7.3.11 I enclosed a copy of a letter forward to Mr. PS, Department of Community, Rural and the Gaeltacht Affairs outlining the expenditure of the RDTF (Midlands). Funding was allocated by different Government Departments to the RDTF’s and this funding formed the core budget of the RDTF (Record attached 2)
Regarding Evidence Provided by Mr. D1, Chair of RDTF (Midlands) and Mr. D2, Principle Officer, Department of Justice, Equality and Law Reform (NDST Liaison Officer)

(a) No information was ever withheld from Mr. D1 or Mr. D2 in relation to the work of the Regional Drugs Taskforce. Any information requested by Mr. D1 or Mr. D2 was always forwarded. They had access to any document pertaining to the RDTF upon request.

(b) Both Mr. D1 and Mr. D2 were advised of the events which took place in Holland in June 2004 as relayed to be by Sgt. GS 1.

(c) If the incident which took place in Holland was not connected with the work of the RDTF, Mr. D1 would not have been advised. The main reason for advising him was the fact that the incident took place while Dr A was on RDTF business.

4. Regarding Evidence Provided by HSE Staff – Mr. MHB 2 Ms. MHB 4 and Ms. MHB 3

(a) It remains my position that Ms. MHB 4 was fully advised of the incident in Holland pertaining to Dr A in June 2004. It is also my position that I meet with Ms. MHB 4 prior to my meeting with both Sgt. GS 1 and Dr A in July 2004. In addition I acted on advice discussed with Ms. MHB 4.

(b) It is my position that Ms. MHB 3 was fully advised of the incident in Holland in June 2004. Ms. MHB 4 was briefed by me in the context that if this matter broke in the media that weekend she would have significant knowledge to deal with any enquiry.

(c) The evidence provided by Dr. MHB 2, I believe to be an accurate account of our conversations.

(d) Dr. MHB 2 clearly recalls that Ms. MHB 4 had been advised in June 2004. I would suggest that missing informing Dr. MHB 2 that Ms. MHB 4 was aware incident would have been very foolish on my behalf.

(e) Dr. MHB 2, Ms. MHB 3 and Ms. MHB 4 were all based in the same complex and their offices were less than 50 feet away from each other. Providing them with different information or misinforming them about the incident would not have been an option.

5. Regarding Meeting on 30th June 2004 with Dr. A

In my evidence to the Review Inquiry, I suggested that this meeting took place on or around the 6th of July. My leave sheet shows me on leave on the 30th of June 2004. A member of my family died on the 30th of May 2004, and the 30th of June was the months mind. It is my recollection that I was at home that morning. (record attached 3)
6. Regarding Athlone Institute of Technology

The media coverage associated with the news of Dr A's conviction, the Director of the Institute stated on RTE News that Dr. A was in Holland in a private capacity.

It is clear from the evidence provided to the Review Inquiry that:
(a) Contract for the research was with the Centre for Childhood and Youth Care Learning, Athlone Institute of Technology.
(b) AIT 4, Dr. A's line manager was aware of the visit. (page 107)
(c) AIT 4 approved final payment invoices in respect of the funding allocated to AIT (Record attached 4)

It is my position that as a point of fact that Athlone Institute of Technology had a clear role in respect of the research.

7. Regarding Darkness of the Edge of Town (Relates to 5.5)

It has been noted in the Review Inquiry Document that no tendering process was entered into in relation the Heroin Research. Applications are received by the HSE from external organisation in respect of research or initiatives. Such requests are dealt with through a submission and a grant agreement process. The procurement process does not apply. Currently there are a number of such projects ongoing within the HSE and a number related to research.

As a point of fact it is noted in the review document that HSE staff raised no concern regarding the launch of 'Darkness on the Edge of Town' in January 2005 in light of events which took place in Holland in June 2004. It is equally the case that members of the National Drugs Strategy Team aware of events in Holland in June 2004 raised no concerns.

In Dr. A's evidence he states he was very concerned in relation to the launch in light of events which had taken place in Holland in 2004.

(a) At no time did Dr. A express such concerns in the planning stage of the launch
(b) Dr. A made himself available to Regional/National print and revulsion media
(c) Dr. A challenge the media coverage, as is shown in the attached email (record attached 5)

8. Regarding Dr. A's alleged Notification 26th of October 2005

A number of questions emerge out of the alleged Notification which I require clarification:
(a) Should it be the case that Dr A advised me on the 9th of September of his pending trial immediately after being summoned, why after his conviction on the 26th of September
did he wait until the 6th of October. Was he not concerned that conviction would be picked up by the media.

(b) In relation to the alleged notification, why was Dr. A formally informing the HSE, he had allegedly been advised that there was no need to register?

(c) In relation to the alleged notification, given that Dr. A had now informed the HSE, what steps did he take to inform his principle employer (AIT)

(d) Assuming that Dr. A believed it was ‘the right thing to do’ in notifying the HSE, why when there were no emerging response did Dr. S not enquiry into what steps the HSE were taking.

(e) Assuming that Dr. A believed it was the ‘right thing to do’ in notifying the HSE, similarly given that Dr. A had a criminal conviction did he not register with An Garda Siochana? What change between 26th of October 2005 and 28th July 2007 when Dr. A registered his details with An Garda Siochana.

(f) If Dr A had informally or formally notified of his conviction, it is my position that:
- a meeting would have been arranged as a matter of urgency, and not left 20 days
- the meeting would not have simply been scheduled alongside another meeting and business as usual
- it would be highly unlikely that I would have been the person carrying out the interview given the nature of Dr. A’s alleged notification
- given the nature of Dr. A’s conviction all work would have stopped. It would have been irrelevant the severity of th conviction.

9. Regarding Additional Work Allocated to Dr A in 2005

This work was allocated to Dr. A on the grounds that he had informed me that there was no case pending against him.

I am happy to provide a context to the work, if this is required at this point.
Appendix III - Documentation Considered in the course of the Review not referred to in Section 11 of the Report

(i) Notification of Suspected Cases of Child Abuse between Health Boards and Gardaí, [Eastern Health Board - April 1995]


(iii) Children First, National Guidelines for the Protection and Welfare of Children [Department of Health and Children, May 2004]


(vi) “Beyond Borders” – Protecting Children on the Island of Ireland - Conference Report, 19 September 2002

(vii) “Screening and Police Checking” - Volunteering England Information Team

(viii) The Ferns Report, [October 2005]

(ix) Advice to the Minister on Implementation of Children First and Vetting, National Children’s Advisory Council, [December 2002]
“Children First on a Statutory Basis”, [Barnardos, 8 June 2006]

Translation of Judgement by the Dutch Courts in September 2005 in respect of the conviction of Dr. A

“Comprehensive Vetting System” [Barnardos, February 2007]

“Submission to the Review of Children First Guidelines by the Office of the Minister for Children” [Children’s Rights Alliance, 28 April 2006]


Review of the List 99 decision making process and policy implications, [England and Wales]

Bichard Inquiry, [British Home Office, 22/ 6/ 04]

Independent Safeguarding Authority, England and Wales, [Establishment Documents, 2006/ 07]

“Darkness on the Edge of Town”, [Centre for Child and Youth Care Learning, AIT, January 2005]

Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children [2006] HM Government

Statutory guidance on making arrangements to safeguard and promote the welfare of children under section 11 of the Children Act 2004 - Updated March 2007 DCSF
Appendix IV
Additional Item of Correspondence Received after the Conclusion of the Review Inquiry which is to be associated with the Final Report

7th February 2008

Mr. Conal Devine & Associates
3 Limekilns Lane
Balgriffin
Co. Dublin

Re: Draft Report

Dear Mr. Devine,

Thank you for your prompt reply to my correspondence dated the 5th February 2008 regarding the above and I note its contents.

In my original reading of the summary of the transcript of my evidence of 19th August 2007, Section 6.6.11 of the document, I interpreted the summary as indicating that it was I who had made the suggestion. On reading it again, I realise that it may mean that MHB1 made the suggestion. I would just like to add that on the first occasion that MHB1 mentioned that a study was being conducted by Dr. A, I made it clear to him that the MHB should not accept any study from Dr. A even if it meant getting into difficulties with him about funding. I would appreciate if you could confirm that this will be included in the final report.

Apologies for bringing the detail mentioned above to your attention at this late stage.

As requested in my letter of the 5th February 2008, I would appreciate if you would confirm that I may have an opportunity to review the final report before it is published.

Yours Sincerely

MHB2