CONFIDENTIAL

Report of

Dr Kevin McCoy

on

Western Health Board Inquiry into Brothers of Charity Services in Galway

November 2007

PREFACE

In April 1999 the Western Health Board started an Inquiry into a number of allegations of past child abuse within the Holy Family School and Brothers of Charity Services in Galway. The Inquiry was established at the request of the Brothers of Charity and Terms of Reference were drawn up and agreed by both parties. The period covered by the Inquiry was 1965 to 1998.

The Inquiry Team comprised of a Chair and five professional staff together with one clerical officer to provide administrative support. The members of the Inquiry Team reported to the Chair who reported to the Regional Manager, Community Services, Western Health Board. By May 2001 all members of the Inquiry Team had returned to their substantive posts or had moved to other positions and the Chair of the Inquiry Team continued to work single handed.

The Inquiry Team interviewed 30 people. Twenty two were former pupils of the Holy Family School and two were relatives of former pupils; five were former residents of Kilcornan Centre, Clarenbridge and one was a user of after care services. Staff from both services were also interviewed. All interviews were completed by July 2000. From my review of the records, the Brothers of Charity Congregation and Services co-operated with the Inquiry.

The Chair of the Inquiry sought assistance with the completion of the report of the Inquiry and in May 2004 I was commissioned by the Western Health Board to assist with the analysis of information collected by the Inquiry Team. Editorial control of all material drafted remained with the Chair of the Inquiry. Part of this work was completed and agreed with the Chair in May 2005 and another part was under consideration by the Chair in December of 2005.

In September 2005, in accordance with the Health Service reforms, the responsibility for the Inquiry devolved to the Local Health Office Manager. At this time the compilation of

the report of the Inquiry was still being led by the Chair of the Inquiry. The Health Service Executive commenced a review of the Inquiry process and a Steering Group was established on 22 November 2005 with membership which included Health Service Executive staff, the Chair of the Inquiry and I. The purpose of the Steering Group was to support the Chair in the management of the Inquiry and the completion of the report.

The Chair of the Inquiry ceased working on the production of the report in late January 2006 for personal reasons. In April 2006 the Health Service Executive asked me to review all of the work completed by the Inquiry Team to date and produce a report based on the Inquiry Team's work.

The report which follows has been prepared following a review of documentation and the work carried out by the Chair and the Inquiry Team. This involved a detailed and careful review of a voluminous amount of documentation and records generated by the Inquiry. It was also necessary to seek appropriate legal advice in relation to the application of fair procedures and natural justice, particularly because of the non-statutory nature of the Inquiry.

The Inquiry was conducted in private and it should be noted that the evidence taken by the Inquiry was unsworn. On completion of this report, where possible, relevant extracts were furnished to appropriate parties to ensure natural justice was observed. All observations and responses have been considered in full and, where appropriate, are included in this Report. In regard to adults who were deceased by the time of the Inquiry, the allegations could not be put to them.

This report is not intended to nor does it make findings as to the culpability of any one individual or body. The situations that are noted are as recorded in the records and interview notes held by the Inquiry Team. This report is based on what is found in the records of the Inquiry and makes recommendations following same in Chapter 10.

It is clear from the records reviewed that both former and current service users and former and current staff have been frank and open in regard to their experiences. Without this openness it would not have been possible to produce any report. It should also be noted that I received full co-operation from the Health Service Executive.

The Inquiry commenced in April 1999 and many of the deficiencies or inadequacies identified in this report have been superceded by developments within the Brothers of Charity Services in recent years. It should be noted, with the passage of time, some of the recommendations contained in Chapter 10 may have already been implemented.

The report has been furnished to the Health Service Executive and it is a matter for that body to decide if the report is to be published.

Whilst this report is limited in its scope it is hoped that the implementation of the recommendations will ensure that the quality of services will be improved and that service users will be better safeguarded in the future.

Dr Kevin McCoy
Social Care Consultant
November 2007

INDEX

8. National and Regional Guidelines for Identification and Management of Child Abuse

CHAPTER 1

INTRODUCTION

1.1 Background Information

In 1998 the Garda Síochána and the Western Health Board brought a number of concerns to the attention of the Brothers of Charity Services. The concerns related to alleged past sexual and /or physical abuse of children within the Brothers of Charity Services, Co. Galway. The Brother of Charity Services were saddened and concerned that abuse may have occurred in their services in the past. They wished to ensure that anyone who may have been abused in their services was offered whatever help they required as a result. The Director of Services of the Brothers of Charity invited the Western Health Board to chair and co-ordinate an Independent Inquiry into abuse which may have occurred to some individuals who attended Holy Family School or any other Brothers of Charity Service in Galway.

The Western Health Board agreed to the proposal in early 1999 and as part of the agreement set up a Freefone Helpline which was manned for two weeks in February/March 1999 from 9.00am until 9.00pm. The Helpline was advertised nationally and locally.

The Inquiry Team was set up in March 1999 and the Terms of Reference listed below were agreed between the Brothers of Charity Services and the Western Health Board.

1.2 Terms of Reference

1. To investigate allegations of abuse of clients by adults which may have occurred in the Holy Family School and the Brothers of Charity Residential Services in County Galway between 1965 and 1998.
2. To put in place a process to investigate these allegations including responses from the Helpline and examinations of previous clients and present clients.

3. To assist any individual who wishes to make a complaint to the Garda Síochána.
4. To make any appropriate recommendations which may arise from the Inquiry. This would include examining policies and procedures in place in the Service.
5. Any records pertaining to any individual in the possession of the Brothers of Charity Services or the Western Health Board may be made available. Previous correspondence held by the above organisations may also be made available in relation to allegations in respect of former day or residential pupils of the Holy Family School and other Brothers of Charity Services in the Galway region. To assist in this process Mrs. Anne O'Connor in her capacity as Principal Social Worker, will act as liaison person in respect of the Brothers of Charity and Mr. Alex MacLean, Child Care Manager, in respect of the Western Health Board.
6. For the purposes of this investigation the members of the Inquiry Team will report to the Chair and the Chair of the Inquiry Team will submit a report every month to advise on progress and a final report at the conclusion to be submitted to the Regional Manager, Community Services, Western Health Board. The final report will be forwarded to Mr. P. McGinley, as a representative of the Brothers of Charity Services for follow-up action.
7. In the event of any serious occurrences being disclosed to the Inquiry Team in respect of children they will inform the Child Care Manager, Community Care, Galway, who will take appropriate action.
8. For interviewees requiring counselling, contact should be made with Mr. Jim Mansfield for appropriate referral.
9. Anyone named in a complaint by any person will be advised if practical.

At the outset the Inquiry Team obtained clarification that its work did not involve the Day Services provided by the Brothers of Charity in County Galway, nor did its work include investigation of allegations of past client- client abuse.

In addition, its work did not involve investigations of allegation/concerns relating to service-users of the Brothers of Charity in County Roscommon, nor in any Brothers of Charity Service in any location other than County Galway. Should any such concerns arise in the course of the Team's work, these were to be reported to the Regional Manager, Community Services of the Western Health Board.

The Team also obtained clarification that the reference in paragraph 2 of the Terms of Reference to the previous clients and present clients related to the children attending the Brothers of Charity Residential Services and the Holy Family School at that time, and to any previous allegations that had been dealt with insofar as might be germane to the allegations under investigation by the Team.

1.3 Nature of the Inquiry

The primary aim of the Inquiry was to follow up the initial complaints, and to investigate any allegations which might be made to the Inquiry during the course of its work. The role of the Inquiry did not extend to any disciplinary or employment issues in relation to any specific individual.

The Inquiry was non-statutory in nature and had no powers of subpoena. The Inquiry Team did not take any evidence under oath. Any assistance given to the Inquiry Team was provided on a voluntary basis. In addition, the Inquiry was clear in its view that, other than sharing relevant information with appropriate personnel in the Garda Síochána, the work of the Inquiry was independent of any parallel Garda investigations.

During the course of its work the Inquiry Team was at all times conscious of the balance necessary between the sometimes competing demands of possible child protection issues, parallel Garda investigations, and the personal, constitutional and employment rights of individuals. As part of its work, the Inquiry Team interviewed a number of individuals. Prior to undertaking interviews, the Inquiry Team developed the following Statement of Principles.

The Inquiry Team will:

have the safety and welfare of service users, past or present, as its priority;

respect the legal, constitutional and personal rights of each person in the course of its work;

treat with courtesy and respect, each individual whom it has contact with;

conduct its work in an objective, impartial and professional manner;

treat any information given to it with the appropriate level of confidentiality.

In addition, the Inquiry Team developed a set of Operational Protocols to underpin the work of the Inquiry. (See Chapter 2)

In order to support the work of the Inquiry Team when it was being established, the Brothers of Charity widely advertised the setting up of the Inquiry in the print media locally and nationally, and through interviews on local radio. They also communicated directly with clients and families to bring the establishment of the Inquiry to their attention.

Frequent announcements had previously been made in the national media by senior representatives of the Congregation encouraging persons who had suffered abuse in the Brothers of Charity Services to come forward and to report to the Gardai.

The complainants represented around 4% of the total of about 500 pupils who attended the school over the period. The complaints of four of the complainants related to Kilcornan which represented around 2% of the total number who attended over the period.

1.4 Helpline

As mentioned earlier a Helpline was established by the Western Health Board in February 1999 and operated from Monday, 22nd February, 1999 to Saturday, 6th March, 1999, from 9.00 a.m. to 9.00 p.m. The statistical data from the helpline is shown below

and as can be seen from the total of 96 calls, over one quarter wished to meet the Inquiry Team and/or An Gardai Siochana then or in the near future. This group, coupled with those who talked about abuse but did not give their name, indicate that over half of all callers said that they had experienced physical and/or sexual abuse. The incidents spanned the period of time from the late 1960s to 1999 and the allegations referred to a number of staff, both religious and lay. It is also important to note the number of silent calls to the Helpline. These amounted to one fifth of the total. The staff operating the Helpline empathised with the callers and the difficulty in speaking about what may have happened to them. The callers were assured of support and counselling and given a telephone number to contact.

There was a total of 96 recorded calls. It was possible for the Inquiry Team to deal with 25 of these calls as follows:

Agreed to intervention by Inquiry Team	16
Agreed to Garda Statement	4
Agreed to be re-contacted after considering options	5

There were 31 callers who gave information but refused to give personal identity.

Most callers described first hand experience of sexual abuse but expressed cynicism towards the Inquiry. Some agreed to reconsider and recontact the Inquiry again, but they did not. Some called several times to express the same view.

There were 40 calls which yielded little information/no information, as follows:

Silent calls	20
Hoax Calls	6
Congratulations	2
Related to other areas	4
Enquiries	8

1.5 Inquiry Team Members

The Inquiry Team which was set up in March 1999 was comprised of the following personnel who served on the team for varying periods of time:

Dr. Elizabeth Healy (Chair)
The Chair's work with the Inquiry ceased in January 2006 for personal reasons.

Ms. Dawn Glynn, Acting Senior Clinical Psychologist
Returned to her substantive post with effect from 28th August 2001.

Ms. Siobhan Burke, Clinical Psychologist
Returned to her substantive post with effect from 25th June, 2001.

Ms. Pat Melody-Dunne, Manager, Residential Centre
Availed of a Career Break with effect from 1st March, 2000.

Ms. Jill Osborne, Social Worker
Resigned from Inquiry Team with effect from 11th May, 1999.

Ms. Ann Wall, Social Worker
Membership agreed to 3lst August, 1999.

Clerical Support was provided by a range of temporary Clerical Officers.

In addition, Ms Mary Gordon, Psychologist assisted the Chair from June 2002 until December 2005.

I was brought in to assist the Inquiry in May 2004 and my work in relation to the Inquiry and this Report is described in the Preface.

1.6 Structure of Report

Chapter 2 describes the Methodology used by the Inquiry Team in dealing with the allegations received and considered by them as well as their general approach to the conduct of the Inquiry.

Chapter 3 gives a brief history of the Brothers of Charity, the development of the Congregation in Ireland and Galway, the development of services and their funding.

Chapter 4 sets out the Definitions used by the Inquiry Team in relation to Child Abuse and Neglect and Intellectual Disability.

Chapter 5 describes the complainants views of the services. The areas covered include:

- Coming into Residential Services and the Holy Family School;
- Premises;
- Consultation/Participation/Children's Rights;
- Complaints Procedures;
- Quality of Opportunity and General Care.

Chapter 6 describes the views of former and current staff and others who met with the Inquiry Team. The areas covered include:

- Physical Structures;
- Management, Staffing and Training;

- Admissions;
- Client Care;
- Challenging Behaviour;
- Personal Safety of Clients;
- Service Developments and Improvements.

Chapter 7 deals with the allegations received by the Inquiry Team.

Chapter 8 reviews the National and Regional Guidelines for Identification and Management of Child Abuse for the period covered by the Inquiry Team's work.

Chapter 9 refers to the Policies and Procedures in place within the Brothers of Charity for dealing with Child Protection. It also reviews how the Brothers of Charity dealt with a number of complaints and concerns that were identified by the Inquiry Team as relevant to its Terms of Reference.

Chapter 10 gives a commentary and makes recommendations for changes to the way in which certain matters should be dealt with in the future. The Chapter also reviews briefly a number of other reports which reflect on the quality of care and personal safety of service users and makes some recommendations on the future relationship between the Health Service Executive as the commissioner of services and the Brothers of Charity as service providers.

CHAPTER 2
METHODOLOGY

2.1 Development of Operational Guidelines/Protocols

The Inquiry Team's first priority was to establish a set of operational guidelines/protocols of the Inquiry Team in recognition of the particular issues involved, the complexity of the work being undertaken and the need to take account of the entitlements and rights of all concerned.

It was considered essential that this basic framework be laid down prior to the start of the interview process particularly as there were no guidelines in existence with regard to the proper conduct of such Inquiries.

These operational guidelines dealt with the following issues:

An overview of the tasks set out in the Terms of Reference;

A brief overview of the legislative framework relevant to its work;

Protocols relating to the various sets of interviews to be held;

Protocols for working with An Garda Siochana and the Western Health Board Child Protection Services;

Protocols for working with the Brothers of Charity;

Preliminary work on protocols regarding the review of children attending the Holy Family School;

Preliminary work on aspects of the review of protocols and procedures;

Information leaflets for potential interviewees.

The Inquiry Team identified three tasks relevant to its work. These were:

Task One. Investigation of allegations which involved interviews with those who had directly or indirectly requested to meet the Inquiry Team and other relevant individuals.

Task Two. A Review of safety of all children attending the Holy Family School, Galway and of children in Residential Services.

Task Three. An examination of policies and procedures in place in Holy Family School and Brothers of Charity Residential Services, Galway. It was perceived that as an integral part of Task 1 and Task 2, information relevant to Task 3 would be gathered from those interviewed.

2.2 Task One - Investigation of Allegations

In accordance with the Inquiry Team's Terms of Reference, the aim of this process was:

To provide an opportunity for the relevant past or current service-users and care givers to meet with the Inquiry Team;

To provide an opportunity for relevant parents/carers, service providers, past or current and others to meet with the Inquiry Team;

To provide an opportunity for those interviewed to describe their experiences of the relevant services;

To assess the credibility of any allegation/s that may be made;

To support any interviewee towards making contact with the Gardai where applicable;

To consider any wider protection issues that may arise and to take any appropriate action;

Where an individual requests counselling to refer the individual to the Regional Child Care Coordinator in line with the Terms of Reference;

To gain, insofar as possible, an insight into the culture and practices which prevailed within these services during the relevant period;

To utilise any such insights gained as appropriate within the Terms of Reference.

Chapter 7 deals with the allegations made and any responses received.

2.3 Task Two - Review of Safety of Children

This was to review the safety of all children attending the Holy Family School and the Woodlands Residential Services, Galway. The Inquiry Team was unable to undertake this task as it was not within its capacity and advised the Western Health Board (WHB) accordingly. The WHB subsequently established with the Inquiry Team that there was no known risk to children at the Holy Family School. The Residential Services for Children on the Woodlands campus was closed in 1984.

2.4 Task 3 - Review of Policies and Procedures

To review relevant policies and procedures and the relevant literature and to make any necessary recommendations in accordance with the Terms of Reference.
Chapters 8, 9 and 10 deal with guidelines, policies and procedures; handling of complaints and recommendations.

2.5 Protocols relating to interviews

The protocols developed in relation to interviews with adult service-users, current or past, included reference to the following aspects:

Definitions of abuse to be adopted and used by the Inquiry Team;

Factors which needed to be taken into account when interviewing adults with a possible intellectual disability;

The manner in which contact would be made with individuals who had contacted the Helpline or any other individual whose name had come to the attention of the Inquiry Team;

Pre-interview contact and planning;

Introductory meetings;

The location of interviews;

The generally appropriate number of interviews to be held with any one individual;

The conduct of the interviews;

The manner of recording interviews;

The manner of agreeing the transcript/recorded notes of any interviews with the interviewee;

Agreed actions to be taken in certain possible situations;

Criteria for assessment to be used should any allegations of abuse be made to the Inquiry Team in the course of its work.

2.6 Brothers of Charity Services in the Galway Region

In order to understand the context in which the alleged abuse occurred the Inquiry Team reviewed the development of services in the Galway Region. This is set out in Chapter 3.

2.7 Definitions/Review of Literature

A review of the literature was undertaken which included:

Definitions of Child Abuse;

Intellectual disability;

Factors that need to be taken into consideration when interviewing people with intellectual disability

The definitions are set out in Chapter 4.

Preparation of this Report

I reviewed the work of the Inquiry Team as described in this Chapter and has used this material in preparing this report.

CHAPTER 3
BROTHERS OF CHARITY SERVICES IN GALWAY

3.1 Background

The contents of this Chapter is based almost wholly on information provided by the Brothers of Charity.

The Brothers of Charity were founded in Belgium in 1807. The Congregation of the Brothers of Charity is an international religious voluntary body. It is now a worldwide organisation providing a variety of services, including services for people with intellectual disability, in more than 25 countries around the world. The central administration is based in Rome.

The Congregation in Ireland and Britain opened their first services in Ireland in 1883. These early services were for people who had mental health needs. In 1938 they started to develop services for people who had intellectual disability. The Religious Community Structure had few resources beyond the voluntary endeavours of the Brothers. Within St. Joseph's Province/Region over the years the number of religious communities has varied. Initially there was only one religious community in Galway, at Kilcornan, Clarinbridge established in 1950.

Up to the year 2000 this administrative region was known as St. Joseph's Province. The administrative responsibility for the Province/Region lay with the Provincial Superior, now the Regional Superior and his Council whose principal role is that of National Governance. These services are now organised into six regions - Clare, Galway, Limerick, Southern, South Eastern and Roscommon. The six regions of the Services in Ireland, though constitutionally linked to the Brothers of Charity Services National Organisation as part of a national corporate structure, are limited companies and each has its own Board of Directors, Chief Executive and management structure.

There is a distinction between the Brothers of Charity Congregation, which refers to the religious community of Brothers, and the Brothers of Charity Organisation or Services which refers to the intellectual disability services provided under the aegis of the Brothers of Charity.

3.2 History of Kilcornan

The religious community at Kilcornan (usually 6-9 Brothers) provided a residential service for people with intellectual disability, numbering over 100 residents by the late 1950s. The Brothers and the service users resided in the most cramped conditions in Kilcornan House, an old estate mansion. From the end of the 1950s the brothers gradually restored/renovated the out buildings of the old estate to provide more space for leisure and other day activities. From the early 1960s it became possible to employ a very small number of lay people, never numbering more than 5, to help with maintenance and repair of buildings, with farming, gardening and concrete block making amongst other activities. For the first twenty years Kilcornan House operated to the traditional model of most religious congregations. From today's perspective this model had the hallmarks of unsuitable accommodation, extremely poor staff-to-resident ratio, and a serious problem of over-crowding.

Planning the Village Complex

There was gradual improvement in the 1970s and a major break through saw the establishment of the village complex at Kilcornan in 1975 which provided for 120 residents in thirteen bungalows. This was the first such development in Ireland. After the bungalows opened there was a high demand for places in the centre as it was seen as the most modern facility available and there were few other residential services in the West of Ireland. In the early years of Kilcornan the residents were generally more able individuals and there was an emphasis on training and sheltered employment.

Leisure Activities

Leisure pursuits were encouraged for all the residents. The extensive grounds in Kilcornan facilitated walking. There was a film once a week, basketball was very

popular and there were concerts for special occasions, especially Christmas. A purpose-built gym and swimming pool opened in 1975 which greatly added to the leisure opportunities. People in the local community used the swimming pool, and the gym was the venue for a particularly strong local badminton club which welcomed residents as members. Residents who were not in a position to go to their family homes for holiday periods went on holidays to other Brothers of Charity Services in areas such as Cork or Waterford.

Initiation of Community-Based Services

In order to progress the concept of normalisation, the move from living on campus to living in community was initiated with the establishment of a number of group homes and a local training centre in Galway City. In the early 1980s similar type community programmes for adults in South Connemara, Ballinasloe, Castlerea, Gort and Roscommon were opened.

The resultant vacancies created in Kilcornan by the moves to community programmes were filled by applicants from waiting lists who had higher degrees of disability, were more dependent and required more care and attention and in many cases had complex challenging behaviour. Many were admitted to Kilcornan from the former psychiatric hospital, St. Patrick's in Castlerea, Co. Roscommon. As the original residents became older their level of dependency increased, necessitating greater levels of care and higher staffing levels. In 1982, there were 135 residents, which was in excess of the original complement of 120 places which had been established for people of higher ability.

3.3 History of Woodlands, Renmore, Galway

In 1965 a second religious community, which consisted of 8-10 brothers, was established at Woodlands, Renmore. The Commission of Inquiry on Mental Handicap (1965) recommended the establishment of special schools for children with intellectual disability. These were funded by the Department of Education. This community of the Brothers of Charity opened the Holy Family Residential Special School in August 1965

in buildings that had been originally constructed as the Woodlands Sanatorium. The school was set up to provide special education for boys with mild mental handicap in the 8 to 18 age range. The Brothers of Charity were trustees of the school and the Bishop of Galway was its Patron.

As it was the only special school for children with a mild intellectual disability on the west coast, the school attracted pupils from the west, north west and south west of the country and many of the students lived long distances from their families and only returned home at holiday times. By 1968, eight teachers were employed. There was huge pressure for placement and the brothers attempted to support in excess of 100 residential pupils in all aspects of their lives outside of school hours. In addition, 30 day pupils attended the school.

The school was located in what had previously been a 7-ward unit within the former sanatorium. One hundred children were accommodated in three dormitory-style residential units attached to the school; forty (40) pupils lived in a second 7-ward unit; a further 30 pupils in the former nurses' home and 30 pupils in Renmore House (a medium sized period house on the grounds, part of which was also reserved as accommodation for the brothers).

A new purpose-built school was opened in 1969 for up to 200 pupils and the number of teachers increased. The school had modern facilities such as a gymnasium and heated swimming pool and provided opportunities for horticulture, woodwork and cookery. The goal was to give new opportunities to children who could benefit from training in manual skills, in addition to the more traditional forms of education. Later, staff with special skills in physical education, music and drama, and arts and crafts were employed.

The 7-ward unit vacated by the school was renovated to provide for 42 residential pupils. Renmore House was also vacated as a residence for children and the total number of residential pupils reached its maximum at 112. By the mid 1970s there were 198 residential and day pupils attending the school.

In the early years, because of the very limited staffing and in the absence of adequate resources to provide more appropriate 'waking cover', (i.e. staff who were awake and supervised the residents) a number of brothers, who otherwise carried out a full day's work, had their sleeping accommodation in units dispersed on the Woodlands campus to provide 'night cover' for the residential pupils residing in these units. In each of the residential locations one religious brother on his own supported each large group of residents with occasional help from other brothers. In the area providing for the youngest children, two female support workers were employed along with the brother in charge. From the early 1970s a number of young staff members were employed and most of these were funded to attend the Childcare Course in Kilkenny.

From the earliest days of the school pupils had access to a wide range of leisure activities. The school swimming pool was also used by the local community and sports groups. There was a large playing field where soccer was a popular sport. Indoors there was the well equipped gym, boxing ring and table tennis. There were regular films and the annual Christmas pantomime was a big event, with pupils engaged in rehearsals from early in the Christmas term. From the 1970s pupils became involved in competitive sporting activities such as soccer, running and swimming and regularly travelled to events in various parts of the country.

Community-based Residential Services

A significant new trend in the provision of residential accommodation was initiated in the early 1970s by the then Brother Superior with the development of the first 'group homes' for five to six children in standard housing in the community. The group home scheme in the community was rapidly expanded and by the end of the 1970s almost all of the residential pupils on the Woodlands site were relocated in group homes or they returned to live at home. In 1984, the residential services attached to the Holy Family School had closed.

3.4 Inclusion in Mainstream Schools

From the late 1970s the Brothers of Charity campaigned for the provision of local special educational services and for the mainstreaming of pupils in ordinary schools. With funding made available by the Department of Health, the Brothers of Charity Services allocated professionals in the fields of psychology, social work and psychiatry to these schools. This led to a dramatic reduction in the number of pupils attending the Holy Family School from the late 1970s. Today there are only 26 full-time pupils in the school. The success of the programme brought a parallel decline in the number of pupils referred for residential accommodation, and the residential provision was gradually wound down to the point where there are no pupils in residence now, either on the Woodlands site or in community based group homes.

3.5 Development of Multi-disciplinary Services

In the early years neither the communities in Kilcornan or Renmore had any professional support initially, other than the services of a local doctor. Through the efforts of a Brother Superior, by the late 1960s the brothers gradually began to build up a multi-disciplinary support team and trained care staff.

The first Psychologist was engaged by the Brothers of Charity at Woodlands in 1967. The services of a Paediatric Consultant and a visiting Psychiatrist were also obtained. The first Social Worker was engaged in 1970 and sessional speech therapy was provided by the statutory authorities. A Consultant Psychiatrist, a Paediatrician and a Speech and Language Therapist were directly employed by the Brothers of Charity Services from the early 1970s.

In the late 1970s an early intervention service was developed in response to the needs of young children with intellectual disability in Counties Galway and Roscommon. This included home-based interventions by multi-disciplinary professionals to support children

and their families. Child Development Centres for pre-school children were established and in addition, Child Education and Development Centres were established to support older children who could not be facilitated in ordinary schools. A range of respite supports were also made available to families.

3.6 Funding of the Service

Prior to the early 1970s funding for the Brothers of Charity services was on a capitation basis from the Local Authorities that referred clients to the Brothers of Charity Services. When the Health Boards were established, the Department of Health assumed direct responsibility for funding the voluntary bodies, including the Brothers of Charity. These bodies reported directly to the Department until 1999 when, by agreement reflected in a document entitled '*Enhancing the Partnership*', these voluntary bodies began to receive their funding from and began to report to the Health Boards. Under the Health Act, 2004 which came into operation on 1st January 2005, the Health Service Executive (HSE) is responsible for funding and commissioning the Brothers of Charity Services, County Galway, in respect of the provision of disability services provided on behalf of the Executive. The Brothers of Charity Services, Galway has a total capital revenue budget for 2007 amounting to €53 million of which the HSE funds €47.5 million.

3.7 Organisation/Staffing Structures in the Galway Services

In the early 1970s, at both Kilcornan and Woodlands, Renmore, Galway the Brothers in their lives as religious and in their capacity as the staff of the services reported to the Brother Superior. The Brother Superior began to establish a management team at Woodlands, representative of the multidisciplinary professionals, the day and residential services and the newly developing administration. Brother Superiors in posts at both Kilcornan and Woodlands from the mid-1970s promoted the further development of this trend, as the number of staff employed by the Brothers increased.

In the mid 1990s the Congregation embarked on a course of separating ownership from management. The historical structures were separated through the appointment of a lay Director of Services (now Chief Executive) in 1997.

The introduction of Directors of Services brought about a subtle change in the distinction between governance and management. The Director of Services continued to have a high degree of local autonomy in the day-to-day operations of his/her functional area. New governance policies and accountability structures had to be established which took the form of identifying the reserve functions of the Provincial Council, the issuing of specific directives and the establishment of systematic reporting structures.

In the ongoing review of structures and services, the Brothers of Charity Services identified a number of important developments which were required in order to achieve the vision of supporting people with intellectual disability to be valued citizens in their local community.

This led to the commitment to develop structures in each region that were needed to address this goal. Another factor that influenced the restructuring of the services was the change in the funding and accountability relationships with the statutory authorities.

The revised structures that evolved saw the further progression of a more participative management system led by the Director of Services (now Chief Executive) who had overall responsibility for the Services supported by a Management Team made up of service leaders/managers and department heads who shared the responsibility for the management and development of the Galway Services as a whole.

In addition, an Adult Service Users' Council was established in Galway. This is an advocacy forum where members, elected by the service users, meet and discuss any issue that concerns them. The Chief Executive and senior managers meet and consult with the Service Users' Council on a regular basis. This consultation process and the outcomes of these meetings inform service planning.

A Regional Council was formed to oversee the work of the Galway Services in 1999. The Regional Council had two elected service users, two elected parents of service users, two elected staff members, two members of the management team and was chaired by an independent, experienced Chairperson.

In 2007 the Brothers of Charity Services Galway was established as a Limited Company. A Board of Directors, which includes family members of service users and members of the local community with legal, financial and business backgrounds, was appointed for the Galway Services. The Board of Directors has the responsibility to provide the governance for the Services. The Regional Council was dissolved at the formation of the Board of Directors.

To ensure and support increased participation by service users, family members and staff in decision-making, the Services in Galway re-structured their services into three Sectors – Children's Services, East Galway Adult Services and West Galway Adult Services. This re-structuring provided the opportunity to ensure that decision-making in relation to the planning and delivery of services occurred as close as possible to the people receiving them, and the authority to proceed with budget decisions was devolved to each local programme area.

Each Sector has its own management team which co-ordinates the work, activities and budget of the services in the Sector. It is made up of the Sector Manager, Team Leaders/Managers and representatives of the multidisciplinary services and organisational services.

Since 1996 the Service has published an Annual Report which is launched each year at a public General Meeting.

3.8 Current Services

In 2005 the Brothers of Charity in Galway provided services to 995 people and their families, and had a staff complement of 744.5(WTE).

In 2006 the Brothers of Charity provided services to 1032 people and their families, and had a staff complement of 961. Further details can be found at: www.brothersofcharity.ie/galway/annual2006

CHAPTER 4

DEFINITIONS

4.1 Definitions of Child Abuse

Child abuse is a highly complex issue, which does not easily lend itself to definitions or measurement. Definitions of child abuse differ from place to place and also vary over time, and between professional groups: Definitions contained in the Western Health Board Child Protection Guidelines (June 1998) are used in this Report.

Many attempts have been made to define Child Abuse and efforts at reaching a comprehensive definition are continuing to evolve. The one that was used by the Western Health Board was, *"as harm to children by parents or carers (or others) either by direct acts or failure to provide proper care or both"*.

4.2 Forms of abuse

In practice this definition extends to five general areas of abuse:

- Emotional Abuse
- Sexual Abuse
- Physical Abuse
- Neglect
- Institutional Abuse

4.2.1 Emotional abuse

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

Persistent and/or severe emotional ill-treatment or rejection includes affection being withheld and being subject to derision and constant criticism. From the definition there must be a connection between the persistent and severe emotional ill-treatment and an effect on a child. Emotional abuse does not include normal life events, e.g. illness, bereavement and separation which can also upset a child.

4.2.2 Sexual abuse

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

"The involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to, and that violate the social taboos of family roles".

Sexual abuse covers a wide range of behaviours, for example, indecent exposure, incest, sexual intercourse, engaging with a child in fondling, masturbation or oral sex; making the child watch sexually explicit behaviour, watch or participate in the making of pornographic material.

4.2.3 Physical abuse

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

Any form of physical abuse where there is definite knowledge or a reasonable suspicion that the injury was inflicted or knowingly not prevented. Examples include hitting, shaking, squeezing, biting, burning, attempted suffocation, use of excessive force when handling a child and deliberate poisoning.

4.2.4 Neglect

Neglect is usually a passive form of abuse, involving omission rather than acts of commission.

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

This includes inadequate medical care, being left alone or inadequately supervised, being starved or kept without adequate comfort, such as heat. Neglect of a child may be due, in most instances to poverty, ignorance or parental incapacity, and is, as such, not wilful. However, there is a minority of abusive parents, whose abuse of their child is *"a result of a pathological need to impose their will".*

4.2.5 Institutional Abuse

"Any system, programme, policy, procedure or individual interaction with a child in placement that abuses, neglects or is detrimental to the child's well-being".

The abuse of children in residential care is a complex and multifaceted problem. Three distinct forms of institutional child abuse have been identified. The first is physical, emotional, sexual abuse or neglect by an individual staff member or foster parent. The other forms can only occur in an out-of-home setting.

The second form, programme abuse, occurs when programmes within institutions fall below accepted standards or rely on harsh or inhumane techniques to modify behaviour (e.g. over-medication to control children's behaviour or oppressive techniques used to teach children).

The third form, system abuse, is *"perpetrated not by any single person or programme, but by the immense and complicated child care system, stretched beyond its limits and incapable of guaranteeing safety to all children in care".*

4.3 Intellectual Disability

4.3.1 Specific Intellectual Disability

Specific intellectual disability is a term used to describe impairments in specific areas such as reading, writing, spelling and arithmetical notation, the primary cause of which is not attributable to assessed ability being below the average range, to defective sight or hearing, to emotional factors, or to a physical condition or to any extrinsic adverse circumstances.

4.3.2 General Intellectual Difficulty

Individuals with general intellectual difficulty have significantly below-average general intellectual functioning, associated with impairment in adaptive behaviour. This may be reflected in a slow rate of maturation, reduced learning capacity and inadequate social adjustment. Their limited intellectual ability may be manifest in delayed conceptual development, slow speech and language development, limited ability to abstract and generalise, limited attention span and poor retention ability. Some may display poor adaptive behaviour, inappropriate or immature personal behaviour, low self-esteem, emotional disturbance, general clumsiness and lack of co-ordination and of gross and fine motor skills. A minority may also have varying degrees of hearing or visual impairment.

In school, such individuals have general intellectual difficulties which prevent or hinder them from benefiting adequately from the education which is normally provided in ordinary classes for pupils of the same age. Insofar as an Intelligence Quotient may be used as an indicator of general learning difficulty such individuals would lie within the I.Q. range 50 to 70. Many people functioning at this level may maintain themselves independently or semi-independently in the community. (UNESCO publication: “Terminology of Special Education” 1983).

4.3.3 Moderate Intellectual Disability

In general, the individual with moderate intellectual disability is likely to display:

Significant delay in reaching developmental milestones;

Serious deficits in language development;

A severe degree of apathy rather than a curiosity in relation to his/her surroundings; and

As an adult, inability to live an independent life.

Individuals with moderate intellectual disability form a heterogeneous population. Many will have accompanying disabilities such as physical, hearing or visual impairment, autistic tendencies and emotional or communication disorders.

Individuals with moderate intellectual disability may have impaired development and learning ability in respect of language and communication, social and personal development, motor co-ordination, basic literacy and numeracy, mobility and leisure and aesthetic pursuits. The World Health Organisation defines a person with moderate learning difficulty as being within the I.Q. range 35–50, insofar as an Intelligence Quotation may be used as an indicator of intellectual disability.

The UNESCO publication "*Terminology of Special Education*" (1983) states "…*such persons usually can learn self-help, communication, social and simple occupational skills but only limited academic or vocational skills*."

4.3.4 Severe/Profound Intellectual Disability

In general, persons with severe/profound intellectual disability display:

Very significant delay in reaching developmental milestones;

Very serious deficits in language development;

A severe degree of apathy relative to environment;

Dependence on others to satisfy basic needs e.g. feeding; and

Inability to live without support and supervision at any stage of life.

Individuals with severe/profound intellectual disability form a most heterogeneous population. Most will have other disabilities such as physical impairment, hearing impairment, visual impairment, autistic tendency, emotional disturbance, challenging behaviour, epilepsy and little or no communication skills.

Individuals with severe or profound learning disabilities are likely to be severely impaired in their functioning in respect of a basic awareness and understanding of themselves, of the people around them and of the world they live in.

According to the World Health Organisation classification of intellectual disability, a person with severe intellectual disability is described as having an Intelligence Quotient in the range 20-35, insofar as Intelligence Quotient may be used as an indication of mental disability. A person with profound intellectual disability is described as having an Intelligence Quotient under 20.

According to the UNESCO document "*Terminology of Special Education*" (1983) individuals with severe intellectual disability "*require continuing and close supervision but may perform self-help and simple work tasks under supervision*". Of persons with profound intellectual disability, the same source states "*such persons require continuing and close supervision but some may be able to perform simple self-help tasks*: *(they)…often have other handicaps and require total life-support systems for maintenance*". Source: Report of the Special Education Review Committee Nov. 1993, Department of Education.

CHAPTER 5

COMPLAINANTS VIEWS OF SERVICES

5.1 Introduction

The analysis in this section is based on the records of interviews with 28 former or current service users and relatives of two service users who were unable to attend for interview. Twenty of the interviewees attended the Holy Family School, as did the two men who were represented by relatives. There was only one female interviewee who attended the Holy Family School. Five interviewees, two female and three male, attended the Kilcornan Centre. Brief profiles of the interviewees at the time of their interview are set out below. The interviews were conducted between June 1999 and July 2000.

The numbers of former service-users who attended for interview was a very small proportion of the total population of those who either attended Holy Family School, Kilcornan or other services during the period covered by the Inquiry's Terms of Reference. The views expressed by the interviewees cannot be, and have not been considered, to be representative of that population, or to give a definitive picture of the experiences of all those attending the Brothers of Charity services during this thirty-year period. Their comments have been detailed here to reflect their views and their reported experiences of their time at the school or in Kilcornan and other services.

Paragraphs 5.2 to 5.19 deal with Holy Family School and Paragraph 5.20 deals with the Kilcornan Centre

5.2 Coming into Residential Services and the Holy Family School

Over the time period covered by the Inquiry, approximately 500 pupils attended the Holy Family School. Twenty two (22) of these came forward for interview with the Inquiry Team (4%). Two (2) others were represented by a family member. This group included one female interviewee who had attended the school from the age of seven until her late teens. Among the 21 male interviewees 7 were admitted when they were under 10 years

of age; six when they were between 10 and 12 years of age; and seven when they were between 13 and 15 years of age; information was not available on the remaining person. The average length of stay for the 16 males for whom the information was available was 7.1 years with a range of 2 to 14 years.

Prior to admission to the school, three interviewees attended primary schools; four were in the care of the State and two attended other facilities for people with learning disabilities. There is no information regarding the previous history of the other 13 interviewees.

The earliest date of admission recorded among this group of interviewees was 1965 for three people. A further seven were admitted in the late 1960s; eight in the 1970s and two in the 1980s. Information on the date of admission was not available for two people. Information on the date of leaving the school was available for 16 former pupils. At the date of interview, two had left the school within the last ten years; eight had left between 11 and 20 years earlier and six had left between 21 and 30 years earlier. The period between leaving and interview ranged from 8 years to 30 years with an average of 19 years.

Among the 24 former pupils, 20 attended the school on a residential basis, two were day pupils and two had attended both as day and residential pupils. At the time of the interviews, eight people were using Brother of Charity adult services, either residential or day services or a combination of both.

A high proportion of interviewees were able to give an account of the background to their admission and a smaller number had some recollection of their actual reception at the school. As noted earlier, the age of children at admission varied considerably and for most this event had occurred more than 20 years earlier. Recollections were hazy for some of them but those former pupils who could recall the experience of their admission said that there was a brief introduction, usually by a brother, when they were shown around and the routine was explained to them. For some of those who were admitted

directly from home it was a disturbing experience as there had been little preparation for the move. Those who were admitted from other residential settings were more positive about their admission.

It is clear from these accounts that the former pupils of the Holy Family School who were interviewed were unaware of the regime into which they were going to be admitted. They were not given information about the school before admission nor at the time of their admission. Their introduction to the school appears to have been superficial, with no information being given to them about what to do when they were not happy about their care or involvement with staff and other pupils. Pupils who had parents present when being introduced to the school had an advantage in that these adults would have been able to ask questions about policies and procedures in the school on behalf of their children, although one interviewee indicated that parental involvement would not always guarantee safety. On the other hand, pupils who were transferring from other institutions, hospitals, industrial schools or even foster-care, appear to have had no one to represent their interests and make inquiries on their behalf and were, therefore, more likely from this perspective to be more isolated and more vulnerable. The age at admission varied considerably and many remarked on the emotional difficulties they faced on moving away from home to a residential school.

5.3 Premises – Woodlands/Holy Family School

As noted earlier, the interviewees had been admitted to the school over a period of three decades. Comments by interviewees on the premises is presented on the basis of the decades in which interviewees were admitted. Eight were admitted in the 1960s; eight in the 1970s and two in the 1980s.

The progression of one interviewee through the school helps to illustrate the changes that took place, from the time he entered the school in the late 1960's until he left, 11 years later. He said that when he first went to the school, he lived in the "Main House", where the brothers also lived. He recalled that the children's dormitory was upstairs, directly over the dining room and living room. The pupils had their own big dining room and

there was a playground. The dormitories at that time were big rooms with 10 to 14 beds in each. He recalled that there were high partitions between the beds and little bedside lockers beside them. If children wanted to have time on their own they could go to their bedrooms. He said that the toilets and showers were outside the dormitory and that the showers were open planned which he was uncomfortable with. He said he had to strip naked in front of other children and that 2-3 children would be in one shower.

He said that in the mid 1970s, the brothers started converting the buildings into smaller units and that the brothers were trying to make people independent. He said that the first unit was opened in Our Lady's and then the second one was built. He moved from the Main House to St Joseph's where he remained for approximately 3-5 years. He said that, initially, there were no units in St Joseph's, but before he was transferred from there it was converted into Units with 6-8 children to a unit. He said he recalled it being cold with high ceilings and big windows. There were no partitions between the beds but the children had their own lockers. Along with the sleeping accommodation, there was a dining room, a playroom/ TV room and a living-room. He made no reference to a kitchen and said that food was brought down from the main kitchen in the main house.

When he finished in St Joseph's, he transferred to Our Lady's where he stayed for just over a year. This had the same layout as St Joseph's but had different colours. He then went on to record that in the 1970s, the Brothers purchased Group Homes in the community and he moved from Our Lady's building to a Group Home in Renmore. He said that moving to the Group Home was like winning the lottery.

1960's

Interviewees who had attended the school in the 1960's recalled a lack of privacy in the sleeping accommodation and showers. Pupils could have a bath alone but there might have been 7 or 8 in the shower room.

1970's

Eight interviewees who were admitted to the school in the 1970s described the dormitories as accommodation for four to eight pupils. Bedside lockers were provided for personal belongings. Some interviewees said that they moved out into Group Homes, under the care of house parents during their time at Holy Family School and shared rooms with other residents.

1980's – 1990's

The changes that were taking place over time are reflected in the experience of one former pupil who was admitted to the school in 1980 and remained there until 1991. He said that he shared his house with fellow pupils and explained that he had his own bedroom, which he had been able to decorate himself with various posters.

5.4 Consultation/Participation/Children's Rights

None of the interviewees were consulted or had any discussion on the reasons for going into the school and none indicated that they received any information in oral or written form about the school facilities or the regime that was in place at the time of their admission (as described above). While in the school, the pupils were not involved in any form of decision–making regarding themselves. For example, there was no consultation on the choice of meals, these were determined by the staff.

One interviewee said that he felt that he would not have been listened to if he had some opinion to express. While on the other hand others said that they were listened to and they named three brothers and an unnamed teacher as staff in whom they could confide.

One interviewee felt that his confidentiality was respected and felt that if he spoke to one of the brothers they would keep it private. This, however, was a minority view as others said that there was no great privacy and one person said that his letters from home were opened by the brothers and some of the contents (money) removed for safe keeping.

5.5 Complaints Procedures

As mentioned earlier, none of the interviewees received any information prior to entering the school and according to their comments during interview, there was no Complaints Procedure introduced during their time in the school. There were no explicit mechanisms for dealing with concerns and for having these investigated and assessed. One interviewee was quite clear, in that he said that if you had a complaint, there was no one to turn to. Others described the informal mechanisms they used to have grievances and complaints resolved.

Some interviewees said that they told their parents of beating and floggings and that the parents came to the school to complain. They generally felt that this intervention did not make any difference.

With regard to relationships with the brothers, one interviewee said, that one had really no contact with them and that there was only one brother that had time for anyone. He said that this brother was more or less a person that made sure that people were all okay in the house and that they had no problems. He said that he would do this by having meetings with the people who were running the houses. He stated that if he had any complaints they would talk to this brother in private, and that he would sort it out.

5.6 Education

Overall, most interviewees were dissatisfied with the standard of education that they received at the school. They felt that it was not commensurate with their needs or abilities. Some even questioned their placement in the school. One said that he did not know what disability he had, another referred to the stigma associated with going to the school and another suggested that a high proportion of pupils were inappropriately placed. The curriculum that the students followed, as reported by the interviewees, was very basic, covering reading, writing and sums with some reporting subjects such as art, history and geography.

There were no reports of special help being given to pupils with learning difficulties, apart from the attendance of students from the Regional Technical College, who were available to help children who had difficulties with maths or reading. A number of interviewees reported a lack of interest on the part of some teachers. One of the interviewees said that he was good at reading, writing and spelling. He used to write stories and explained that one of the teachers encouraged him in his writing.

Some interviewees reported using typewriters, which had been supplied through charitable sources or by their parents. No other special equipment was mentioned. A number of interviewees referred to being given homework. Some of this appears to have been done in school as part of the school day while others referred to doing this in dormitories or house units, usually in their bedrooms on a bed or a table.

Some pupils attended horticulture, woodwork and painting classes at the Regional Technical College.

One interviewee stated that teachers kept getting nicer as he progressed through the school, which seemed to suggest a growing confidence in this group of staff. He later said that there were only two teachers, whom he named, that were good to pupils but that he had nothing against the rest of them.

Some interviewees alleged that they could have benefited more from education in the school if they had not been abused as it affected their concentration during school the following day.

5.7 Sexuality Education

Only one former pupil recalled that a psychologist gave a talk on sexuality but he did not remember any specific details from the talk. At least five of the former pupils said that they had received no sexuality education in the school, while another two people said that they learned about such matters elsewhere, one by sending for literature by post and the other did not specify the source.

5.8 Health Care

A number of former residents recalled that there was a General Practitioner who used to come and visit on a weekly basis and when they were ill. He prescribed medication for them, and if necessary, referred them to hospital. In addition, some people mentioned the presence of nurses in the school. They were described as attending three or four times a week or being attached to the school.

Some referred to being admitted to hospitals, general and psychiatric, for both in-patient and out-patient treatment. Others referred to being seen by a psychiatrist and psychologist who were staff members in the school. The psychologist was described by one interviewee as a lovely person who made everyone feel at ease. The boys felt they could turn to this person, who tried to involve the boys more in decision-making. For example, when moves to the community were happening, this person would explain these to the boys.

5.9 Diet

There were conflicting comments on the food which was provided from a central kitchen. It appeared to be reasonably plentiful, but of varying quality at some times. Some pupils said they were given no say in what food/meals were provided and received no training in food preparation or opportunities to shop for the basic ingredients of their meals. There were a number of reports of boys refusing to eat their meals.

5.10 Self Help

It was clear from the interviews, that former pupils did not receive any systematic help with the development of social and life skills. One interviewee described daily life in the school as the same routine over and over. As part of the daily routine pupils would carry out various chores such as cleaning the dormitories, polishing corridors, washing dishes and chores associated with the preparation of meals. House parents would do all the shopping, cooking and washing of clothes. Training in the use of money was limited.

5.11 Leisure Activities

All interviewees reported on a wide range of leisure activities in the school. In the late 1960s, they had access to a swimming pool, playing fields, playground, boxing facilities, basketball, a gymnasium, played soccer and table tennis. They also had access to indoor games and television as well as regular showings of films. There were rabbits and budgies kept by the brothers and at least one pupil was able to keep a dog and have pigeons. There was opportunity for external activities through attendance at the local youth club where they played table tennis, soccer and attended “hops”. There was access to horse riding and a range of other external activities such as outings to various parts of the country.

Pupils were allowed into town once a fortnight or so. They would go into town in groups of 8 to 10, but each pupil would have a person looking after them. Some of the people who looked after pupils were volunteers from the outside community. In the 1970s, there was the opportunity to engage in running and this provided opportunities to travel to places in Ireland, Belfield and Antrim, and to America. During this decade, a club was set up in the school. This was known as ‘The Hut’ and was the venue for discos at the weekends to which people from Mervue and Renmore used to come.

5.12 Celebrations

Few interviewees had any recollection of the celebration of birthdays and other occasions such as Christmas and Easter, partly because they went home for the holiday periods. However, one interviewee did recall that on birthdays boys would receive birthday cake and birthday cards from a named brother and a couple of lads from the school. There was reference to Christmas plays and concerts being organized.

5.13 Multi-disciplinary Support

None of the interviewees indicated that a multi-disciplinary approach to their care was available. Initially, the main care providers in the school were brothers and there were not

many other staff involved in the provision of specialist activities to meet the needs of the pupils.

One interviewee said that he had been referred to a speech therapist, and others reported being referred to general and psychiatric hospitals. Another interviewee said that there were plenty of social workers and psychologists in the main building next to the gate and pupils were accompanied by a brother or senior teacher when they went to see them.

Some interviewees expressed the view that their time in the school improved with the employment of lay staff in the residential units and a named brother was credited with changing the structure and style of the residential section.

5.14 Key Workers

There was no mention of residents having a key worker but some interviewees said that some brothers gave them a good sense of caring. As house-parents were appointed, they seemed to have fulfilled at least to some extent the role of key worker. Some house-parents appear to have fulfilled the role of being in loco parentis extremely well and this was clearly valued by the residents, in that they returned to visit their house parents after leaving the school. Some interviewees spoke highly of a named untrained house parent, who they described as gifted. Others said that they would talk to a social worker.

5.15 Group Meetings/Individual Support

There was no indication of group meetings to provide mutual support for residents. One interviewee said that if he felt upset, he could talk to one of the teachers.

5.16 Opportunities to meet other people outside of the services

Several interviewees indicated that they had opportunities to go on visits outside of the school, although these were usually in the company of staff from the school. Some referred to holidays spent in Dunmore East and Belmont Park in Waterford staying for 1-2 weeks at a time. Others said that they would go to different places such as Limerick and

Ennis with the Boxing Club. Membership of the Boxing Club also enabled pupils to have visits from friends from outside the school.

Two interviewees mentioned that they were able to go home to their families, one at weekends and one at the Easter, Summer and Christmas holidays. Some interviewees said that they received visits from their families in the school and were able to meet in private in what one former pupil described as a warm, cosy room.

5.17 Privacy

The main areas where privacy was an issue with former residents were the dormitories and showers. All described living in dormitories with other residents, usually with six beds in each, although one former resident mentioned a dormitory for a much larger number.

Another source of complaint about lack of privacy was the reported opening of post addressed to pupils by the brothers. One interviewee said that if money was sent to him by his parents with a letter, it was removed by the brothers and this money was held in a sort of trust fund. There was a shop in the vicinity and if pupils were on good behaviour they would be given some money to spend.

5.18 Visits to staff members' homes

Some interviewees indicated that they visited family homes outside the school. They got to know staff members and their families who used to take them out to their homes at the weekends and holidays.

5.19 Sanctions

Nearly all of the interviewees described some form of punishment or sanctions which were administered by some individuals in various locations throughout the school, e.g.in classrooms, dining rooms, school yard, dormitories and other locations. From the descriptions given by the former pupils, there did not appear to be any consistency in the

severity or application of the sanctions. Punishment in the classroom was reported as being administered for lack of discipline on the part of the pupil or an inability to understand questions or learn the lesson being taught. Among the punishments mentioned were:

- Slapping on hand with cane or ruler
- Punched in face, stomach and down the back
- Hit on head with hand or ruler
- Pushed against wall with sufficient force to cause injury
- Being brought to front of class for slapping across hands
- Being made to stand on the same spot for several hours.
- Being made to go bed early for a week
- Having money confiscated
- Being forced to go into the boxing ring with children who were much stronger.

5.20 Kilcornan

Five interviewees attended the Kilcornan Centre, four on a residential basis and one as a day attendee. There were two females and three males. One female attended on a day basis and the other was resident. From the records of the Inquiry, the age at which the female interviewees started attending the centre and the duration of attendance is unknown.

Two of the males started attending at 14 and 15 years of age respectively. The earliest date of admission was in the late 1950's. Two of males attended for periods of 17 years but the length of attendance for the other is not known. Prior to their admission, two had been in the care of the State, one in another facility for people with intellectual disabilities and the placement of the remaining two was not known/recorded by the Inquiry.

At the time of the interviews (1999/2000), two of the interviewees had left the centre 24 years previously and the others had left 15, 13 and 11 years previously. At the time of

the Inquiry, four interviewees were using Brother of Charity Adult Services while the placement of the other was not known /recorded.

Some of the interviewees had a recollection of their admission to the centre and their experiences are reflected below. Several interviewees said that they had been collected from their former residential institution by a brother. They recalled being shown around on the first day and the routine was explained to them.

In 1952, when Kilcornan first opened, residents were housed in large dormitories in the main building and demand for places led to over-crowding. However, the Brothers of Charity responded to the recommendations of the Report of the Commission of Enquiry on Mental Handicap, 1965 and developed more suitable accommodation. Their ideas were also informed by developments outside Ireland, particularly Scandinavia where people village complexes were being established for people with intellectual disabilities.

Many of the first residents transferred directly from Lota in Cork and were therefore familiar with institutional living. Dormitories were in a large building. One interviewee said he shared a dormitory with seven boys, while another said his dormitory was very big and held 20-30 people. Presses (cupboards) were provided for personal belongings.

Kilcornan is situated some 16 kilometres from Galway City and is over a kilometre from the main road, thus isolating the campus from the local community and making access to public transport and community facilities more difficult. The former residents interviewed described a wide range of leisure activities which were available to residents, thus giving plenty of opportunities to engage in enjoyable pursuits.

One interviewee who was admitted to Kilcornan in the early 1950's, shortly after it opened, said that when he went to Kilcornan Centre he was not really happy and stated that it was very rough. He lived in the big building and shared a large 7-bed dormitory with other boys. He said that they had presses for their personal possessions. Initially, there was no school in Kilcornan Centre but later a school was established and he learned

to read and write. Another early resident said he shared a dormitory with about 20 to 30 other people.

One interviewee who had left Kilcornan many years ago and had returned to live there stated that Kilcornan is now very good. He said that he now had his own bedroom in a bungalow containing a bed, T.V. and a locker for his personal belongings. He stated that meals are sent down to the bungalow from the main kitchen in Kilcornan.

The interviewees had attended the centre over a period of five decades and, as might be expected over such a long time-frame, the nature of leisure pursuits and activities changed. One former resident who was admitted in the early 1950's, reported playing football and hurling and going for walks at weekends. He also said that one of the brothers bought a record player and he learned ballroom dancing in the centre. Another mentioned playing children's games such as 'hide and seek' and 'cowboys and indians' and the showing of films at weekends. At holiday periods, residents who did not go home were taken out to the cinema by a brother. Belmont Park in Waterford was a holiday destination for at least some of the residents.

CHAPTER 6

VIEWS OF STAFF AND OTHERS WHO MET WITH THE INQUIRY

6.1 Introduction

Forty seven people, thirty-four of whom were employed by the Brothers of Charity Services at the time of their interview were interviewed by the Inquiry Team. These included people from a range of disciplines:- nurses, medical practitioners, psychologists, social workers, teachers, administrators, house parents, occupational therapists, brothers, and care workers. The period of employment or association with the services ranged from two to over 30 years. The 47 interviewees represented a very small sample of staff who were employed in the services over the 30 year time period covered by the Inquiry. An official with the Department of Education and Science, a Child Protection Officer of the Western Health Board and a former chaplain were also interviewed. The interviews were conducted between January 2000 and February 2001.

6.2 Management, Staffing and Training

6.2.1 General Management

Initially, the brothers were responsible for the overall and day to day management of the services and the school. Over time, due to the expansion of services and the appointment of more lay professional staff and later the reduction in the number of brothers in the service, management posts were created and filled by lay people. The positive developments included:

- The recruitment of Administrative Directors in the Organisation.
- Appointment of female staff to the service.
- Appointment of clinical and lay professionals to the service.

Many people spoke very highly about a Brother Superior's management of the service and his vision for improving facilities and developing programmes of care to facilitate independence of service users to enable them to live in the community where possible.

Interviewees expressed positive views regarding the appointment of a lay Director of Services.

6.2.2 Recruitment policy

As noted above, over time the number of brothers gradually decreased and lay staff replaced them. Since 1974, a more multi-disciplinary approach to staffing has been adopted, thus allowing the input of people with different professional backgrounds. These developments have probably enriched the opportunities of the clients.

The majority of those interviewed have been employed in Brothers of Charity Services for a long period; five for over 30 years, twenty-four for over 20 years and nine for over ten years. A small number have had less than 10 years service with the organisation. Some have been promoted through various grades in their profession while some other still occupy the same grade as when they were first appointed.

In the early days teachers were not required to have any specialised training or experience in teaching children with intellectual disability. Some were supported to undertake courses relevant to their roles as teachers of children with intellectual disability.

The majority of nurses had acquired experience in other settings before appointment but not necessarily in the field of intellectual disability. Specialisation in intellectual disability did not seem to be a requirement for appointment.

6.2.3 Reporting relationships

Generally staff seemed satisfied with their reporting relationships. Frontline staff reported directly to their managers but could go to the person above the line manager if necessary. Frontline brothers reported to line managers in the same way as lay staff.

6.2.4 Supervision of staff

Generally professional staff indicated that they were satisfied with the level of supervision they received from senior colleagues. The Inquiry was told that more recently Senior Social Workers have become involved in the supervision of basic grade social workers.

6.2.5 Staffing levels and duty rotas

When brothers carried the main work load of caring for service users they had much longer working hours than lay staff and the service was highly dependent on their commitment and goodwill. This is evidenced by the fact that when it was necessary to replace one brother, 2.5 lay staff had to be recruited. Some interviewees said that in the past staffing levels in some parts of the organisation were inadequate probably reflecting the lack of resources available to the service. Staffing levels seemed to be a continuous problem, particularly in the evening and weekends. There is a fine balance to be struck in promoting independence and ensuring client safety. Inadequate staffing presents particular problems in residential services which deal with clients who exhibit challenging behaviour. Staffing levels in residences at night and weekends were generally perceived as inadequate and some house parents were on duty for long periods during these times. However, teacher to pupil ratios in the Holy Family School seemed to be very satisfactory and staffing levels are now further enhanced by the presence of classroom assistants.

6.2.6 Training policy

After the setting up of the services at Woodlands and Kilcornan, staff were supported to undertake further training. Teaching staff were supported to acquire specialist training in intellectual disability, while other care and professional staff were supported to do a variety of courses. Paid study leave as well as financial support was granted. In the past staff seemed to initiate requests for further training and generally selected courses which catered for a personal interest.

Since the establishment in the early 1990s of the Training and Development Department and appointment of a Director of Training and Development, training was organised on a more systematic basis and related more to service needs. The idea of staff appraisal where the individual's training need is identified together with the needs of the service was a welcome development which led to a more coherent training strategy which targeted needs. The organisation allocated a substantial budget for training.

In general, staff indicated that relief cover could be provided during absence for training. However, staff with responsibility for finding relief staff commented that it was often very difficult to do this. Nursing staff seemed to have the most difficulty in availing of training for this reason. When staffing levels are being determined account needs to be taken of the need for in-service training for all staff.

6.2.7 Training in Child and Client Protection

Among interviewees there was a general awareness of child protection policies and training has been undertaken by most staff in this area. It was acknowledged that training needs to be systematic and updated regularly and that people in roles such as designated person or deputy designated person need to have training focused on the responsibilities of the role.

6.3 Physical Structures

6.3.1 Woodlands

Interviewees reported that in Woodlands children were initially housed in large dormitories but in 1974 a policy was initiated first to reduce the size of the units and subsequently to move residents to live in houses in the community under the care of house parents. This was a very important initiative in helping clients integrate into the wider community and prepare for more independent living. This initiative also indicated a willingness on behalf of the Brothers of Charity to adopt new philosophies, and the vision and resolve to take on the enormous challenges that this change in philosophy

demanded. Interviewees commented positively on the policy of moving residents from the Woodlands campus to houses in the community to enable them to integrate with the wider community. Many of the interviewees applauded the foresight and initiative of the Brothers in adopting this policy.

The new school building, which was opened in 1969, provided accommodation for a wide curriculum including woodwork and cookery. Leisure facilities such as a swimming pool and gym provided excellent opportunities on site and a wide range of other sports was available. These developments provided facilities for children to develop skills and talents in non academic subjects.

At the time of the interviews with staff, Renmore House (formerly the Brothers' residence) was still home to a number of adults, mainly elderly. Some staff expressed concern at the suitability of this building for this purpose. The Inquiry was aware that the Brothers of Charity were in the process of purchasing/ building two adjoining houses in the community away from the Woodlands complex, after rejecting an original plan to build anew within the campus. This was a welcome development, and recognised that community-based facilities are far preferable to what would have be in effect a new, smaller institution, and are more appropriate to the needs and rights of people with a intellectual disability.

Staff expressed concern about service users sharing of rooms with individuals who present with challenging behaviour, but indicated that there was a plan to provide single rooms as resources become available.

6.3.2 Kilcornan

Interviewees said that in Kilcornan in the 1960s facilities were very limited and service users were housed in the main house in dormitories catering for 50-60 people on the upper floors. In the 1970s, bungalows were developed but pressure to admit new residents meant that the intention to move all residents from the main house to bungalows could not be achieved. Staff suggested that there were not enough resources outside the

Brothers of Charity Services to cater for the needs of the general population of people with intellectual disability. It coincided with the time when there were cutbacks in the health service due to financial constraints. The influx of new residents led to a higher proportion of dependent clients than had formerly been the case. This led to pressure on staff resources as well as affecting the programme to move residents into bungalow accommodation.

The village development reflected best practice at the time. The policy to move less dependent clients into the community reflected the policy which was advocated following the report of the Commission on Mental Handicap, 1965 and demonstrated that the Brothers were open to new ideas concerning best practice.

Some concern was expressed about the continuing necessity of clients sharing bedrooms but the Inquiry Team were told that the aim was to provide single bedrooms for all clients as soon as resources became available.

6.4 Admissions Policy and Criteria

6.4.1 Woodlands/Holy Family School

Interviewees said that admissions criteria had been developed more formally over time. Some children who were classified as 'slow learners' were placed in Holy Family School. This practice may have been due to main stream schools lacking resources to cater for children with particular learning difficulties at that time. Some children who were in State care were also admitted. It is not clear if this was because they had an intellectual disability or if they had delayed development because of previous institutional deprivation. Societal values at the time also had a significant role to play in this.

In the past, children were accepted from a very wide catchment area, but due to a policy of localisation of services strongly promoted by the Brothers of Charity, this practice had declined significantly by 1980. Children seeking admission have always been required to have a full psychological assessment to identify learning abilities and difficulties before

admission. There is now a formal admissions policy to all services. A multi-disciplinary admissions committee considers all applications, taking account of reports from psychologists, social workers and medical practitioners. Proposed transfers of clients within the services are also considered by a multi-disciplinary committee before decisions are taken. Currently admission is limited to children from County Galway.

6.4.2 Kilcornan Centre, Clarinbridge

Since the late 1970s an admissions committee dealt with admissions to Kilcornan and transfers between bungalows became more formalised with more specific criteria in place. The multi-disciplinary admissions committee considers applications, taking account of reports from psychologists, social workers and medical practitioners. Proposed transfers of clients within the services are also considered by a multi-disciplinary committee before decisions are taken. Prior to the establishment of the committee, admissions and transfer procedures were less clear and frontline staff were not always consulted when internal transfers of clients were made.

The profile of clients resident in Kilcornan has changed over time and this has had an impact on staffing levels as the current population have more profound intellectual disability and are more physically dependent. Challenging behaviour of some clients adds to the difficulties experienced by staff.

6.5 Client Care

6.5.1 Woodlands

Care plans and reviews

There was no indication in the early days of the school that multi-disciplinary care plans were developed for each child and systematically reviewed. Due to the very small number of multi-disciplinary support personnel available, the initial assessment was principally seen as validating the right to a service. As the number of multi-disciplinary

personnel increased, there was a greater emphasis on the development of an integrated plan for the education and overall development of each pupil.

Consultation with service users
The Inquiry was informed that a Service Users Council is a forum for clients to express their views on the services provided to them. There were also Self Advocacy groups which met frequently. The Inquiry was told that new developments at national level in the area of Advocacy Services were due to be rolled out over the following few years. Currently the Brothers of Charity are at an advanced stage in this process and a very active and independent Advocacy movement is in place locally and nationally.

Education and life skills
Life skills training was provided by house parents through clients being required to do some basic household chores. Clients also spent time in workshops undertaking subcontract work, as well as activities such as part as arts, crafts and aerobics. There were also opportunities to go shopping, go to films, and on trips. Swimming, bowling and sporting activities were also available. The Inquiry Team were informed that with the improvements in staff to client ratios over the years, there have been very significant developments in this area and person centred programmes have increasingly become the norm.

6.5.2 Kilcornan

From the information provided to the Inquiry, although a range of activities and day programmes were provided for clients, it was not clear if each individual's needs were assessed and if a care plan was developed. There was a view expressed that some staff had become set in their ways and were not as open as they might be to new ideas. Some seemed to have a real fear of change as it might affect the clients with whom they had worked over an extended period.

Challenging Behaviour

The challenging behaviour of some clients was a big issue in the general management of service users in Kilcornan. Some psychology staff had developed a special interest in this issue and had developed an extensive knowledge base. A Challenging Behaviour Team was established to monitor challenging behaviour and develop strategies for its management. Quite extensive training in challenging behaviour had been provided for staff and a procedure for the management of incidents had been developed. However, some interviewees still did not seem to have a clear understanding of why they had to make written records relating to the management of challenging behaviour in individual cases. The purpose of collecting the data required by the Challenging Behaviour Team seemed not to be fully understood.

6.5.3 Personal Safety in Kilcornan/Woodland

Vulnerability of service users

Many interviewees seemed to appreciate that those children and adults with an intellectual disability were more vulnerable to abuse than other sections of the population. Some people mentioned that some service users were uninhibited in showing their affection even to strangers. They also pointed out that the risks to staff should not be ignored or minimised. However, clients who exhibit challenging behaviour and/or are considered to pose a risk to staff or others, are themselves at greater risk of possible exploitation and abuse, because their reputation and history can successfully provide a screen, behind which, abuse can more freely be perpetrated.

6.5.4 Complaints procedure

In common with the general population there was a lack of awareness amongst staff of the issue of sexual abuse until the topic gained media attention in the late 1980s. When it became apparent that some service users had been sexual abused, staff were genuinely shocked.

Prior to the introduction of the formal policy and procedures for dealing with complaints most staff said they would have talked to their line manager about concerns but not all were confident that their concerns would have been acted upon. Some people reported that case conferences would be set up to discuss concerns about particular service users. Some interviewees stated that when they reported concerns to management staff they were not recorded and acted upon.

In the past there does not appear to have been a formal complaints system for service users to express dissatisfaction about the quality, lack of, or refusal of, a service that the person complaining is entitled to use. Clients are now made aware of the complaints procedure through the self advocacy groups.

It was clear from the responses of interviewees that some informal reporting mechanisms were in place within the organisation. Some staff felt that it was better to inform line managers about concerns and allegations and leave it to them to decide whether to refer the matter on to the Designated Person. This approach could lead to a range of decisions not operating to a single procedure and may place clients and staff at risk. It may also undermine the position of the Designated Person. Discussions with staff also revealed a lack of clear understanding of the differences in the roles of the Designated Person and the Delegate. Some people were unaware that allegations against brothers were dealt with by the Delegate who was appointed by the Brothers of Charity Congregation under the provisons of the Church Guidance issued in 1996. (The roles of the Delegate and Designated Person are outlined in **Appendix A**).

Some interviewees said that in previous years families were not always informed about concerns, complaints or allegations which had been expressed by service users. The Inquiry was told that current procedures address this issue and place a responsibility on senior staff to inform families of any issues.

Comments by staff at interview highlighted the need for expertise in dealing with complaints or concerns expressed by service users with intellectual difficulties. They also

highlighted the need for a joint inter-agency approach to assessing complaints, thereby utilising all the experience and skill of all staff in the different agencies involved in dealing with these matters. In the case of vunerable adults, the Inquiry Team understood that there was some doubt if the report of the initial investigative interview conducted by the staff of the Brothers of Charity would be seen by the Health Board as one of their responsibilities, alongside of their responsibilities in respect of children.

Despite guidance on this matter it would appear that some staff were reluctant to formally submit a concern/allegation in writing. Some interviewees said that they preferred to report orally to a line manager or another professional and expected them to record and process the incident, and make the decision regarding informing the Designated Person.

6.6 Guidelines in relation to Sexuality & Relationships

Some staff referred to difficulties in relation to matters around informed consent in the context of clients with an intellectual disability. Lack of clarity and absence of a framework for the development and assessment of service users' ability to give informed consent increased service-users' levels of risk, and created confusion and uncertainty for staff. Clear, agreed, useable Guidelines in this area, widely disseminated to service-users, parents/carers and staff, are a vital cog in the client/child protection wheel.

Interviewees suggested that service users also need training to differentiate between appropriate and inappropriate behaviour of staff and other service users. They also said that there should be ongoing awareness training for service users to help them keep safe and reduce the risk of possible abusive behaviour of others toward them.

6.7 Records

No clear consensus emerged on how records were kept. Files were maintained at different locations for different purposes. It was not clear how these files were ultimately collated into a formal record. Neither were staff entirely clear as to where particular types of information were to be kept. Some information seemed to be recorded in personal files

while information relating to allegations of abuse or concerns was recorded in the privileged file. Some said that a note would be made in the day book. It was not clear from the responses of several interviewees whether or not a record of an allegation of abuse would be made in the personal file of service users.

Interviewees were unclear about what information was contained on personnel files about allegations or concerns. It was recognised that there have been moves to improve record keeping but as one interviewee stated there were still weaknesses in the system that needed to be addressed.

6.8 Service Developments and Improvements

Interviewees were asked how they had seen services develop over their career with the Brothers of Charity Services and were asked to identify positive and negative aspects as well as identifying any gaps.

Among the positive aspects identified were:

- Appointment of female staff
- Appointment of clinical and lay staff
- Increased awareness of quality of life issues
- Greater awareness of need for advocacy
- Awareness of need for clients to be listened to
- Vast majority of staff are deeply committed to and fond of clients
- Clients are treated with respect
- Staff attempt to provide a homely environment and enjoyable activites
- There are more policies and procedures. Things are now done on a more formal basis
- The policy to integrate service users into the community

However, among the negative aspects expressed were:

- Some reluctance to accept change and new initiatives
- Some lack of vision and direction
- Major problem with staffing numbers
- Major problem with bungalow accommodation
- Lack of initiative in development of Day Activity Programme to meet client needs
- Lack of fora where staff can express views, ideas, participate in planning
- Need for positive leadership
- Lack of fora where clients can express views, ideas, participate in planning.

One member of staff reflected the general view that the service was evolving, however, it was cumbersome and not as user friendly for clients or for staff as it should be.

Finally, another member of staff when asked about the factors which can affect the introduction of change, responded that one factor was resources but there were important cultural factors. The staff member gave an example from Kilcornan where a plan had been developed in consultation with staff over a period of time to divide Kilcornan into four teams. This plan had taken far too long to be agreed due to the fact that the culture was one which only marginally supported change. The staff member stated that the plan was finally to go ahead after a number of failed attempts.

CHAPTER 7

ALLEGATIONS

7.1 Introduction

The Terms of Reference of the Inquiry specified the time period under investigation as 1965 – 1998. The Inquiry Team received allegations of abuse relating to the time period 1965 – 1993.

Twenty one (21) complainants made allegations of abuse to the Inquiry Team that fell within the Inquiry Team's Terms of Reference (See Table 1)

The complainants made twenty seven (27) allegations of sexual abuse against sixteen (16) individuals and six (6) allegations of physical abuse against three (3) individuals, which are dealt with in this Report.

All of the persons against whom allegations were made were male.

Two of the complainants were female and the remaining complainants (19) were male service users or former service users.

The majority said that they did not report the alleged abuse at the time it was alleged to have happened as they felt there was no one who would listen.

Nine other individuals met with the Inquiry Team, seven former service users and two relatives of former service users. Six of these did not come within the Terms of Reference and one withdrew the allegation. All appropriate referrals to An Garda Siochana and the Western Health Board were made.

7.2 Profile of Complainants

In this Chapter each of the complainants has been ascribed a number e.g. Complainant 1 – Complainant 21, to preserve their anonymity. The persons, against whom allegations

have been made, have been allocated a letter and are thus referred to as Adult A – Adult R. This chapter describes the allegations made and any responses received from relevant parties, but makes no findings as to the veracity of the allegations. Seventeen (17) of the complainants were adult males who were confirmed to have attended the Holy Family School and the associated Residential Services in the past. Their allegations related to the time period they attended this service.

Four (4) complainants made allegations of abuse relating to the Kilcornan Centre. Allegations made by two male complainants relate to when they were in late adolescence/early adulthood. Allegations made by two female complainants related to when they were adults. At the time of the Inquiry, four complainants presented with intellectual disabilities and were attending Brothers of Charity Services.

In the course of interviews with complainants, accounts were given of witnessing incidents of physical or sexual abuse of fellow pupils by named Brothers and by lay staff members. The Inquiry Team tried to contact these people and three made allegations to the Inquiry.

All complainants were offered counselling and all their complaints were referred to An Garda Siochana and the Western Health Board in accordance with the Protocols established by the Inquiry.

TABLE 1

COMPLAINANT	**INDIVIDUALS AGAINST WHOM EACH COMPLAINANT MADE ALLEGATIONS**		
Allegations relating to Holy Family School/Residential Services		Number of Adults	Year(s) of allegations
Complainant 1	Adult A	1	Pre – 1970
Complainant 2	Adult A	1	Pre – 1970
Complainant 3	Adult A, Adult B & Adult L (deceased)	3	1965-1975
Complainant 4	Adult A	1	Pre – 1970
Complainant 5	Adult A	1	Pre – 1970
Complainant 6	Adult A, Adult C, Adult E, Adult H, Adult B, & Adult L (deceased)	6	1969-1980s
Complainant 7	Adult A & Adult M (deceased)	2	Pre 1980s
Complainant 8	Adult B, Adult Q	2	Pre 1975
Complainant 9	Adult B, Adult L,(deceased) & Adult P (deceased)	3	Pre 1980
Complainant 10	Adult D	1	Mid 1980
Complainant 11	Adult F	1	Pre 1980
Complainant 12	Adult F	2	Pre 1980
Complainant 13	Adult A	2	Pre 1970

Complainant 14	Adult O (deceased)	1	
Complainant 15	Adult R	1	
Complainant 16	Adult G & Adult N	1	Mid 1970s
Complainant 21	Adult D	1	
Allegations relating to Kilcornan			
Complainant 17	Adult I (deceased)	1	Pre 1970s
Complainant 18	Adult K (deceased)	1	1978-1993
Complainant 19	Adult K (deceased)	1	1978-1993
Complainant 20	Adult J (deceased)	1	Pre 1970s

7.3 Profile of Adults against whom allegations were made

Complaints were made to the Inquiry Team in relation to eighteen (18) adult males. Six (6) adults had allegations made against them by two or more complainants. The remaining twelve (12) adults were the subject of allegations by one complainant only.

All of the adults were former staff or former service users of the Brothers of Charity.

7.3.1 Brothers

Allegations of abuse were made against eleven (11) adults who were current or former members of the Brothers of Charity Congregation. At the time the Inquiry Team were conducting interviews, February 1999 to July 2000, six (6) of these brothers were deceased; two (2) had left the Brothers of Charity Congregation; one (1) brother was serving a prison sentence for sexual offences against former pupils of the Holy Family

School and the remaining two (2) brothers no longer worked in the Galway Services but were still members of the Brothers of Charity Congregation. They were no longer involved in direct work with service users.

7.3.2 Lay Staff

Allegations of abuse were made against four (4) lay staff. All four (4) Adults had left the service and two of these were deceased.

7.3.3 Others

Three (3) remaining Adults were former service users of Holy Family School who continued to visit Brothers of Charity Services. They were adults at the time the abuse was alleged to have occurred.

7.4 Allegations of Inter-Client Sexual Abuse

In addition to allegations against staff members and other adults, a number of complainants made allegations of sexual abuse against other service-users. Investigation of these was not within the Inquiry Team's Terms of Reference.

7.5 Process of informing people who had allegations made against them

Allegations made against eighteen (18) adults are described in this chapter. The Inquiry Team was able to inform eight (8) adults of the allegations made against them and gave them an opportunity to respond. All of these related to Holy Family School and/or the associated Residential Services. One adult did not reply to the letter and the remainder replied through their solicitors. All denied the allegations.

The Inquiry Team received allegations against ten (10) individuals who could not be informed of the allegations made against them because they were either deceased, not locatable or were the subject of a Garda investigation.

All of the allegations against then deceased individuals related to sexual abuse alleged to have occurred between 1965 and 1987. The allegations against five (5) of the adults

related to the time period they worked in Woodlands Centre. The allegations against the other three (3) adults related to Kilcornan Centre. Allegations ranged from single incidents to multiple incidents occurring over time.

Allegations of physical abuse were made by one (1) male complainant against an adult who could not be located. This involved a number of alleged incidents.

There was an allegation of sexual abuse against an adult which the Inquiry Team did not put to him as there was an ongoing Gardai investigation at the time when the Inquiry Team were conducting their interviews.

7.6 Allegations and Responses

This section is organised according to each Adult against whom allegations were made. Where allegations of both physical and sexual abuse were made against an Adult, the allegations of sexual abuse are dealt with first followed by the allegations of physical abuse.

7.6.1 Adult A

It was confirmed that Adult A worked in the Woodlands campus during the time each of the complainants attended the Holy Family School.

Nine complainants made allegations against Adult A to the Inquiry Team.

Two complainants allegations did not appear to relate to Adult A and are not referred to below.

7.6.1.1 Complainant 1

It was confirmed that Complainant 1 was a residential pupil at the Holy Family School during the time Adult A worked there. He alleged that when he was about 14 years old he was abused on a weekly basis for a period of about one year. He said that the alleged abuse progressed from fondling of his genitals to anal penetration and took place in a dormitory in a residence at Woodlands Campus. He gave a detailed description of some of the alleged incidents of abuse to the Inquiry. The complainant described how he developed preventative measures to stop the alleged abuse by tying sheets tightly around himself at night.

Complainant 1 told the Inquiry that he reported the alleged abuse to two brothers at the time but he was unclear as to the identity of these brothers. The Inquiry Team was unsuccessful in locating the two brothers who Complainant 1 claimed he reported the alleged abuse to as they had left the Order many years ago and their whereabouts were unknown.

He stated that he had trouble sleeping after the alleged abuse and that he would be tired the following day and would have had difficulty concentrating.

The complainant gave an account of what he regarded as the long term effects of the alleged abuse on him. These included depression, feeling suicidal in the past and recurring nightmares regarding the abuse.

The complainant expressed concerns that two other pupils may have been sexually abused by Adult A. One of these former pupils, Complainant 7, whom he named, subsequently made an allegation of sexual abuse against Adult A to the Inquiry Team. Complainant 1 could not remember the name of the other pupil.

In 1998 Complainant 1 made allegations of sexual abuse against Adult A to the Brothers of Charity. He also made a statement to the Gardai.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.1.2 Complainant 2

It was confirmed that Complainant 2 attended the Holy Family School as a residential pupil during the time Adult A worked there. He stated to the Inquiry that the alleged abuse started six months after he started in the Holy Family School when he was about 13-14 years old and continued for a period of six months on a frequent but irregular basis. He stated that it always occurred in his bedroom in the residences of Holy Family School in the Woodlands Campus.

He stated that prior to the alleged abuse Adult A was always friendly towards him and behaved in a playful way. He alleged the abuse involved Adult A fondling his penis and that Adult A fondled his own penis to the point of ejaculation. The complainant told the Inquiry that on the day following the first occasion of alleged abuse, Adult A called him aside and referred to another boy who had been sent to an industrial school. He interpreted this as an implicit threat not to disclose the alleged abuse. The complainant stated that in order to avoid the alleged abuse he climbed out of the window at night time and said that the alleged abuse stopped after that.

The complainant speculated about the possibility of other pupils being abused. He named two former pupils Complainants 5 & 7 who also made allegations of abuse against Adult A to the Inquiry Team. The complainant stated that he did not disclose the alleged abuse until he told his wife later on in his life. He said that it was his perception at the Holy Family School that no one would have been believed him if he had informed them of the alleged abuse. He gave details to the Inquiry Team of what he considered to be the long term effects of the alleged abuse on his life, including experiencing nightmares.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.1.3 Complainant 3

It was confirmed that Complainant 3 attended the Holy Family School during the time Adult A worked there. He started at the school when he was 8 years old and left when he was 15 years of age. The complainant alleged to the Inquiry that he was sexually abused by Adult A in the office of the Holy Family School. He stated that the alleged abuse consisted of Adult A masturbating the complainant and the involvement of the complainant in the masturbation of Adult A. The complainant gave the Inquiry a detailed description of what he alleged took place in the school office. The complainant was unsure of the exact period of the alleged abuse but said it stopped when Adult A left the school. He explained that he did not disclose the alleged abuse during the period of its occurrence, but disclosed it for the first time when he was an adult. When recalling the details, the complainant was upset and tearful. He reported having flashbacks to the alleged abuse.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.1.4 Complainant 4

It was confirmed that Complainant 4 attended the Holy Family School on a residential basis during the time Adult A worked there. He alleged that he was abused by Adult A in

the dormitory at night time on a weekly basis when he was approximately 12 to 14 years old. The complainant alleged that Adult A came to the dormitory at night time and would put his hand inside the sheets, fondle his genitals and masturbate him. The complainant also alleged that on a number of occasions Adult A kissed him and fondled his genitals in the school office.

The complainant stated that he felt degraded by the alleged abuse and stated that he suffered from depression. He stated that he did not disclose the alleged abuse to anybody at the time as he did not know who he could have told.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.1.5 Complainant 5

It was confirmed that Complainant 5 attended the Holy Family School on a residential basis during the time Adult A worked there. He alleged that Adult A abused him about twice weekly for two years in his bed in the residential accommodation. He said that the alleged abuse started when he was about 13 years of age and consisted of intimate kissing and masturbation. Regarding his thoughts and feelings at the time of the first alleged incident, the complainant stated said that he was very frightened and could not tell anyone. He said that he had discussed his allegations with a counsellor and his general practitioner in the past. Referring to the long term effects of the alleged abuse he stated that he was unable to hold down a relationship and had suffered from depression and alcohol problems which he attributed to the alleged abuse when he was a pupil at Holy Family School.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.1.6 Complainant 6

It was confirmed that Complainant 6 attended the Holy Family School as a residential pupil during the time Adult A worked there. He started at the school when he was 7 years of age and resided on the Woodlands campus. He moved to a Brothers of Charity home in the community. The complainant alleged that Adult A had assaulted him in a dormitory on two or three occasions over a two week period when he was between 8 to 9 years old. The complainant stated that after the alleged abuse stopped he noticed that Adult A was no longer in the school. He explained that he did not tell anyone of the abuse at the time due to fear. In 1997 he made the initial disclosure of the alleged abuse to a social worker. This social worker contacted the Western Health Board who arranged for this complainant to be interviewed by their staff when he repeated the allegations. The Health Board notified the Inquiry of the complainant's allegations. The complainant had a history of anxiety, depression and other medical problems which he attributed to the abuse.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.1.7 Complainant 7

It was confirmed that Complainant 7 attended the Holy Family School during the time Adult A worked there. The complainant alleged that he was abused by Adult A in his bed in a dormitory on the Woodlands campus on at least four occasions over a two month period when he was aged about 15 to 16. He alleged that Adult A fondled his genitals. He said that the abuse stopped after he hit Adult A with a shoe. The complainant stated that he informed his class teacher and the Brother Superior of the alleged abuse and he believed this resulted in Adult A's removal from the school.

Regarding the effects of the alleged abuse on him he reported concentration and behavioural difficulties in school and also stated that he had no one to talk to about the alleged abuse. He now found it hard to trust people.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

The complainant made a statement to the Gardai in 2000.

7.6.1.8 Characteristic Features of Complainants' Accounts

In the course of interviews, complainants made reference to a number of characteristics regarding Adult A and the pattern of his alleged offending behaviour. There were many similarities in their accounts of the pattern of abuse. These are drawn together and commented on below.

a. Location of the Alleged Abuse

The two locations referred to by complainants were the dormitory after 11.00 pm at night time or Adult A's office during school or study time. One complainant referred to Adult A not having any particular routine regarding which room he went to at night to abuse pupils.

b. Engagement Phase

Complainants referred to Adult A getting friendly with and getting to know a young person prior to the onset of the abuse. Others referred to being Adult A's favourite, being given permission to make tea during school hours, being brought away on trips and being taken to restaurants. One complainant commented that Adult A would make things easier in the school for him.

c. Complainants Understanding of the Alleged Abuse at the time

A number of complainants spoke of their lack of understanding of the alleged abuse at the time. One complainant referred to the abuse seeming normal to him, as Adult A did not force himself on him. Another complainant commented that he knew nothing about sex and that Adult A told him that some day he would have to do it for himself

(masturbation). A third complainant reported that he understood at the time that what Adult A was doing to him was wrong but commented that it was his belief that other pupils did not realise it was wrong. A fourth complainant spoke of his realisation at the time that what Adult A was doing was not normal and of the fact that he went along with it because as a 13 years old he felt powerless to do anything about it.

d. Manner of Alleged Abuse

Complainants commented on the manner in which Adult A approached and interacted with them during the abuse. From comments made by some complainants, Adult A's approach to them seemed to the Inquiry Team to be characterised by reassurance and sociable conversation.

e. Strategies to avoid abuse

Some complainants gave an account of strategies they developed to avoid being abused by Adult A. One complainant related that he started to climb out his bedroom window at night and leave the school campus for a few hours and stated that the alleged abuse stopped as a result. Another complainant referred to tying his sheet tightly around his body so that Adult A could not have access to him. For others, the abuse ended when they left the school or when Adult A left.

f. Awareness by complainants of abuse by Adult A of other pupils

Complainants referred to having an awareness of other pupils being abused by Adult A but stated that there was no discussion between pupils of Adult A's alleged abusive behaviour. One complainant said that he witnessed Adult A going to the beds of other pupils and starting to abuse them. Two complainants were named by other complainants as possibly having been sexually abused by Adult A.

g. Disclosure of Alleged Abuse

The majority of complainants reported that they did not disclose the abuse at the time of its occurrence. Two people commented that they could not talk because of fear and they

felt ashamed to say anything. Complainants spoke of their perception that they would not have been believed if they told and of having nobody to turn to.

Some complainants commented on being told by Adult A not to tell anyone about the abuse. One complainant told the Inquiry of what he perceived as an implicit threat of being sent to an industrial school if he disclosed the abuse.

Only two of the complainants gave an account of reporting it at the time to staff members. The Inquiry Team was able to locate and received a written response from one former lay staff member. This individual reported becoming aware of abuse by Adult A of pupils during the time he worked in the school and reported his concerns. He did not indicate how he became aware of the abuse. As indicated earlier, the Inquiry Team was unable to locate the two brothers who Complainant 1 claimed he reported the alleged abuse to as they had left the Order and their whereabouts were unknown.

7.6.1.10 Response by Adult A

In November 2000, through his solicitor, Adult A was informed in writing of the allegations made against him. He was offered an opportunity to respond to the allegations either through a meeting with the Inquiry Team, or in writing.

Adult A, throught his solicitor in 2007, stated that there was correspondence between his solicitor and the Chair of the Inquiry throughout 2000 and early 2001 regarding this issue. His solicitor requested in April 2001 clarification on certain issues about the Report, in particular to enable his solicitor to advise Adult A as to legal ramifications if he responded to the allegations. In April 2001 Adult A's solicitor received correspondence from the Chair stating that the Inquiry would not be in a position to interview Adult A, but he could respond in writing. Adult A, through his solicitor, stated that given the letter from the Chair in April 2001 and his own poor health at that time, he felt unable to assist the Inquiry. This was communicated to the Inquiry by way of letter dated in May 2001.

By letter dated October 2007 Adult A's solicitor advised that Adult A was charged with a number of sexual offences. His solicitor stated that Adult A admitted his guilt to charges of indecent assault at the earliest opportunity give to him by the Court and had expressed his remorse openly to the Court and victims present in Court.
His solicitor indicated that Adult A stated categorically, that whilst inexcusable, the only abuse committed by Adult A were acts of indecent assault. Adult A denied the allegations made by Complainant 6 in their entirety.

7.6.1.11 Information from Other Sources

Adult A's Conviction for Sexual Offences

On 1/11/2000, twenty sample counts of indecent assault in relation to ten different complainants were made against Adult A and he pleaded guilty to same.

The Inquiry Team received confirmation from the Brothers of Charity Services that Adult A was convicted of sexually abusing five complainants who made allegations against Adult A to the Inquiry Team.

7.6.2 Adult B

Four complainants made allegations of physical abuse against Adult B. Each of the complainants was confirmed to have attended the Holy Family School on a residential basis during the time period when Adult B worked there.

In accordance with the protocol of the Inquiry Team Adult B was informed of the allegations which had been made against him. Adult B responded to each of the allegations. Adult B's responses are outlined following the account of each complainant.

7.6.2.1 Complainant 8

The complainant alleged that Adult B had subjected him to physical abuse on a number of occasions and referred to three incidents. He said that during some of the incidents another adult, Adult Q, was present. (Adult Q is no longer associated with the Brothers of Charity Congregation and could not be located.)

Complainant 8 alleged that he was beaten with a scallop (a stick) by Adult B in the linen room and said that he was put on the ground and beaten on the buttocks wearing only his underpants. The complainant alleged that on another occasion he was held down in a chair in the linen room by another pupil while Adult B hit him across both hands with a long belt. He said that he was made sit on a chair with his hands held behind his back and that he was hit from the back by Adult B across the palms of his hands. The complainant alleged that on a third occasion he was flogged by Adult B and an old wound on his hand was re-opened and which required medical attention.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response by Adult B

Adult B responded that these allegations were totally untrue and stated that these incidents never happened. He told the Inquiry that he may have slapped a pupil in the linen room but he did not bring pupils to the linen room specifically for that purpose.

Adult B also expressed the opinion that there were many contradictions in the complainant's account.

Adult B, through his solicitors, by letter dated October 2007 stated that the allegations that a wound on Complainant 8's hand was re-opened requiring medical attention was utterly untruthful, and that no child in his care ever required medical attention as a result of being chastised by him.

7.6.2.2 Complainant 9

The complainant alleged that Adult B had physically abused him on two occasions while he was a pupil at the Holy Family School. The complainant stated that the first incident occurred when he was approximately 12-13 years of age while he was a resident pupil at the Holy Family School. He stated that following a fight with some other boys he had run away from the school, and had been brought back by a brother whom he named. He alleged that when he returned to school he was brought down to the linen room by Adult B who lashed him with a plank of wood which formed part of a shelf. He stated that after the alleged beating Adult B told him to get dressed and go to bed, which he did. He stated that after the incident he cried himself to sleep. The complainant stated that he did not report the incident at the time because Adult B was an authority figure and there was no-one else he could turn to.

The complainant alleged that a second incident occurred when he was approximately 13-14 years old. He stated that he was accused of drinking the altar wine and Adult B poked him with a snooker cue to try to get him to admit it. When he would not, he alleged that Adult B broke the snooker cue across his back.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult B

Adult B refuted both allegations and stated that if this complainant had been punished in the way he alleged he would have had marks on his body which would have been observed during, for example, swimming lessons. He remarked that snooker cues were very strong and that much force would be required to break one.

7.6.2.3 Complainant 3

Complainant 3 alleged that when he was a pupil at Holy Family School he was thrashed by Adult B in the kitchen after breaking a cup and spilling his cocoa. He told the Inquiry that Adult B walloped him with his fists.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult B

Adult B stated that he had no recollection of the alleged incident and explained that if someone did something accidentally he would not chastise them.

7.6.2.4 Complainant 6

Complainant 6 alleged that on one occasion when he refused to kick a ball Adult B hit him on the stomach and face and gave him a kick in the backside.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult B

Adult B denied the allegation and stated that he had no recollection of the complainant. Adult B referred to forms of discipline used in Holy Family School when he was a staff member. He stated that if a child broke a rule they would be spoken to. He also stated that he had used corporal punishment, but that this was only where there was a grave misdemeanor. Adult B clarified that by grave misdemeanor he was referring to where a pupil assaulted another pupil or used physical violence towards another child.

He stated that the corporal punishment he used was within Department of Education Guidelines as related to him by the then Brother Superior, who is now deceased. Adult B indicated that his understanding of the Department of Education Guidelines was that you could slap a child with reasonable force, but not causing any mark or damage to the child. Adult B also stated that other staff would have used similar discipline methods. He further stated that he had never been informed that corporal punishment was not consistent with the ethos of the Brothers of Charity Congregation.

Adult B stated that he slapped pupils with his hand across their bottom or the back of their shoulder on occasions. He clarified that the children's clothing would have been on at all times. He stated that the slaps were within Department of Education Guidelines. Regarding whether he would have hit a child on any other part of their body, other than bottom, back or shoulders, Adult B stated that he did not recall this, but that if he had hit a child across the face there would have been no force used that would have caused an injury. Adult B also referred to slapping a child on the legs. Adult B acknowledged he had slapped two of the complainants on occasion but stated he could not recall hitting the third.

Adult B, through his solicitors, by letter dated October 2007 advised that it is extremely difficult, if not impossible, to defend himself against allegations of physical abuse at some 35-40 years remove.

7.6.3 Adult C

Adult C was a member of staff during the time the complainant who made allegations against him attended the school. Complainant 6 made allegations of physical and sexual abuse against Adult C to the Inquiry. It was confirmed that the complainant attended the Holy Family School during the time Adult C worked on the campus.

Allegation of sexual abuse

Complainant 6 made allegations of sexual abuse including masturbation and anal penetration against Adult C and outlined five specific incidents. He alleged four of these incidents occurred in the dormitory of a residential unit at Holy Family School and said the fifth occurred in Adult C's bedroom. He said that the alleged abuse happened when he was between 7 and 10 years old.

The complainant stated that he did not disclose the abuse to anyone at the time because he felt it was pointless. He said that he thought he would not be listened to and feared being punished. The complainant made the first disclosure of the alleged abuse to a social worker in 1997 who informed the Western Health Board of the allegations.

The complainant described the effects of the alleged abuse which included his inability to sleep and loss of appetite. He stated that he continues to get flashbacks and attends his G.P. for a number of physical symptoms, which he attributed to the abuse.

Response of Adult C

In December 2000, the Inquiry Team contacted Adult C in writing through his solicitor. The allegations made by the complainant were presented to him in writing and he was invited to respond. Adult C's solicitor responded in writing and said that Adult C totally and completely denied any allegations of impropriety that had been made against him.

Allegation of physical abuse

Complainant 6 described three incidents of alleged physical abuse by Adult C. He said that in the first alleged incident Adult C had picked him up and threw him across a room

injuring his head and right knee. He stated that later Adult C took him to the local hospital. In his second allegation of physical abuse against Adult C, the complainant stated that Adult C tried to force him to eat rice by wedging a spoon in his mouth. He also stated that another person, whose name he could not recall, was holding his leg.

The complainant also alleged that on another occasion, Adult C hit him on the head with a large bunch of keys.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult C

Adult C's solicitor responded in writing and said that Adult C totally and completely denied any allegations of impropriety that had been made against him.

7.6.4 Adult D

7.6.4.1 Complainant 10

Complainant 10 made allegations of sexual abuse against Adult D who had been employed at the Holy Family School during the time he had attended the school.

Complainant 10 made three allegations of sexual abuse involving fondling of his genital area on the outside of his clothing by Adult D. He alleged that two of the incidents occurred in Holy Family School and the third occurred in Adult D's house. This complainant stated that he was approximately 15 years old at the time.

First alleged incident

The complainant alleged that when he was approximately 15 years of age he was in a room in Holy Family School with three other pupils and Adult D. The complainant explained that Adult D would ask the pupils to stay behind after class to help with some activities. The complainant alleged that Adult D would engage in a 'slagging' match with the group of pupils and then started fondling a boy (whom he named) on the outside of his trousers. The complainant alleged that Adult D would then encourage pupils to touch other boys (whom he named) on the outside of their trousers in a fun like way, making it look like a game. The complainant alleged that Adult D came over to him and touched his penis on the outside of his trousers.

Second alleged incident

The complainant described a second occasion where he alleged that Adult D touched him in a sexually inappropriate way in the school. He said that Adult D came up behind him and put his hands between his legs and touched his penis giving him an awful fright.

Third alleged incident

The complainant alleged that on one occasion when he had been absent from school he called up to the school and met Adult D. He alleged that Adult D explained to him that he

had to collect something at his house and that they drove there in Adult D's car. The complainant alleged that Adult D brought him out to his house, poured him a glass of 'coke' in the kitchen and sat down beside him and touched his penis again on the outside of his clothing. The complainant alleged that he just went numb and froze. Regarding the impact of the alleged abuse on his life the complainant referred to a difficulty in putting the abuse behind him.

The Inquiry Team offered two of the former service users named by Complainant 10 the opportunity to meet with the Inquiry Team. The offers were declined.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult D

The Inquiry Team informed Adult D in writing of the allegations made against him by the complainant. Adult D responded in writing denying all the allegations.

Adult D, through his solicitors, by letter dated October 2007, denied involvement in any abuse of Complainant 10 or Complainant 21 (as referred to below) or any other persons during his employment at the Holy Family School and the Brothers of Charity Services in Galway.

7.6.4.2 Complainant 21

It was confirmed that the complainant attended the Holy Family School as a residential pupil during the time Adult D was employed in the school. The complainant started at the school when he was about nine years of age.

The complainant made two allegations of sexual abuse against Adult D. One of these involved fondling of his genital area which he alleged occurred in Holy Family School. The second alleged incident involved buggery which he alleged occurred in Adult D's home. He stated that the alleged abuse occurred when he was 10 or 11 years old.

At the outset of his interview the complainant spoke of how he first got to know Adult D. He said that he would bring the complainant and another boy (whom he named) into town in the evenings after school and that he would buy both of them clothes. The complainant added that he and the other pupil (the same pupil referred to above) went to Adult D's house at weekends and in the evenings for either a few hours or the whole day. The complainant alleged that on occasions Adult D asked him to come up to the house on his own, which he did.

First Alleged Incident
In describing the first alleged incident, the complainant explained that he had been in the school after all the pupils had gone home and he went to use the lavatory, which was close by. He alleged that Adult D came into the lavatory, stood beside him and fondled his penis and then pulled up the complainant's zip.

Second Alleged Incident
The complainant alleged that a second incident of sexual abuse occurred at Adult D's house. He explained that one Saturday he visited Adult D who was alone in his house. He alleged that Adult D performed sexual acts including buggery on him.

The complainant spoke of the impact the alleged abuse had on him stating he felt it had ruined his life.

The complainant made a statement to the Gardai.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult D

The Inquiry Team informed Adult D of the allegations made against him by the complainant. Adult D responded in writing denying all the allegations.

Adult D, through his solicitors, by letter dated October 2007 denied involvement in any abuse of Complainant 10, Complainant 21 or any other persons during his employment at the Holy Family School and the Brothers of Charity Services in Galway.

7.6.5 Adult E

Complainant 6 made an allegation of sexual abuse against Adult E.

It was confirmed that Complainant 6 attended the Holy Family School during the period that Adult E worked at the school.

The complainant alleged that on one occasion Adult E attempted to put his hand on the complainant's penis during an activity at the school. The complainant said he told Adult E to clear off and also threatened him. He said that Adult E jumped and took his hand away. The complainant told the Inquiry that he was surprised by Adult E's behaviour and stated that he did not have any other concerns about Adult E.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult E

The Inquiry Team wrote to Adult E via his solicitor, offering him an opportunity to respond to the allegation made by the complainant against him. Adult E's solicitor replied in April 2001 stating that his client completely and totally denied any of the complaints made against him.

In September 2007 Adult E reiterated through his solicitor in the most forceful of terms that he completely denied any impropriety whatsoever in relation to this matter and continues to do so.

7.6.6 Adult F

Two Complainants, 11 & 12 made allegations of sexual abuse against Adult F to the Inquiry Team. Both individuals were confirmed to have attended Holy Family School on a residential basis during the time Adult F worked there.

7.6.6.1 Complainant 11

The complainant alleged that while he was a residential pupil in the Holy Family School, he was sexually abused on two occasions by Adult F. The alleged abuse involved fondling of his penis and anal penetration.

First alleged incident

The complainant alleged that Adult F first sexually abused him in his dormitory in the residential unit in the Holy Family School complex. He estimated that he was approximately 13 years of age when this incident occurred, that he had been in the school for some time before it happened, and that the incident took place at approximately 12:00 midnight.

The complainant alleged that he and the other four children who shared his dormitory were sound asleep in bed when Adult F climbed in the window. He alleged that Adult F put his hand under the sheets and started fondling his genitals. The complainant alleged that he had his pyjamas on during the incident and that Adult F had his clothes on.

The complainant alleged that he repeatedly told Adult F to leave him alone. The complainant alleged that he then heard the security guard's keys rattling and that Adult F said he would kill him if he told. The complainant alleged that when the security guard entered the room, he discovered Adult F in the wardrobe and that Adult F jumped out. He alleged that the security guard told him never to come back again. The complainant spoke of being frightened and scared during the incident. He alleged that he did not sleep that night because of the fear that Adult F would return. The complainant said that while his

recollection was unclear, he thought he reported the incident to a member of staff afterwards.

Second alleged incident

The complainant alleged that a second incident occurred on a mid-week day, in the evening time some time after the first incident. He alleged that he was on the football field and that there was no one about as it was late in the evening. He alleged that Adult F came over to him and dragged him into toilets where Adult F sexually assaulted him. The complainant gave the Inquiry a detailed description of the alleged incident. He said that he grabbed his clothes and ran away as fast as he could.

The complainant described being frightened during the incident and not knowing what was going on. He stated that when he returned to the unit he was frightened and out of breath, and did not sleep much on the night of the incident due to fear that Adult F would come back. He explained that he did not tell anybody about what happened because he thought that he would not be believed.

The complainant spoke about the effects on him. He started smoking and drinking heavily due to fear. He said that he often had nightmares. When discussing his education in the Holy Family School, he stated that he found it difficult to concentrate after the incidents of the alleged abuse.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.6.2 Complainant 12

The complainant alleged that when he was 15 years old, Adult F came into his bedroom in Holy Family School at 10 o'clock at night, while he was asleep. He stated that Adult F offered him a pack of cards if he (the complainant) would let him into the bed. At a later point the complainant alleged that Adult F had a knife which he took from his back pocket and left on the locker beside the complainant’s bed. The complainant stated that

Adult F got into the bed, pulled off the complainant's pyjamas and touched his genitals. He stated that Adult F's clothes were also off at the time. He explained that Adult F was pulling on his genitals. The complainant stated that he shouted for the brother who was head of the unit and Adult F hid in the wardrobe. He said that the brother came into the room and told Adult F to get out. The complainant showed his private parts and his legs to the brother, who was angry and said it should not have happened. The complainant described feeling frightened and shocked during the alleged incident.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult F

Adult F's solicitor wrote to the Inquiry Team on November 2000, stating that his client denied the allegations and declined to meet with the Inquiry Team.

Adult F was furnished with the above extract of this Report. In a letter dated October 2007, Adult F advised that he was charged and convicted in respect of one of the complainants. He advised that this happened when he was a young man and did not know anything about sex with men or women.

7.6.7 Adult G

Information from Brothers of Charity records and staff indicated that Adult G was employed at Woodlands for a short period.

Complainant 16 attended Holy Family School initially residing in the Woodlands complex and later moving to a Brothers of Charity group home in the community.

The complainant described two incidents of alleged anal penetration involving Adult G which he said occurred in a Brothers of Charity community house when he was 15 years of age.

The complainant alleged that the first incident occurred a few months after he moved to the community home. He reported being unsure of the time of year but noted that it was evening time because he recalled that it was dark. The complainant stated that he was in his bedroom alone one evening when Adult G, who was visiting the House Parent at the time, came into his room and closed the door.

He alleged that Adult G raped him. The complainant stated that the incident lasted for 10 to 15 minutes, and that during this time, Adult G said nothing and did not ask the complainant to do anything to him.

The complainant made a second allegation of sexual abuse against Adult G. He stated that he recalled that it was warm and bright and that it was early summer. He said that he was in his bedroom one day when Adult G entered the room. He said that when he saw Adult G he felt frightened. The complainant alleged that what occurred on the second occasion was similar to the first occasion. He stated that he went into the toilet after the incident and when he returned, Adult G was gone.

The complainant stated that he did not tell anybody about what he alleged happened with Adult G until he made a statement to the Gardai. He explained that he had not disclosed the alleged abuse prior to that as he was very young at the time of the alleged incidents;

knew nothing about the facts of life and was afraid that Adult G might have beaten him up. He described feeling frightened and embarrassed by the abuse. He stated that he had carried the alleged abuse with him for years and at that point, he wanted justice to be done.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult G

The Inquiry Team informed Adult G in writing of the allegations against him offering him an opportunity to respond. He declined, through his solicitor to meet with the Inquiry Team. In correspondence with the Inquiry Team Adult G's solicitor stated that his client categorically denied the allegations made by the complainant.

Adult G, through his solicitor, in November 2007, reaffirmed his denial of the allegations.

7.6.8 Adult H

One allegation of sexual abuse was made to the Inquiry Team against Adult H.

Complainant 6 stated that he knew Adult H from calling to visit his House Parent in the community home. The complainant who attended the Holy Family School alleged that the incident occurred in his community residential house.

The complainant explained that he was alone in his bedroom late one night, as his roommate had gone home for the weekend. He alleged that Adult H walked into his bedroom and made him engage in oral sex. The complainant said that he was shocked by what happened and explained that he did not tell anybody about the incident at the time because he was afraid of Adult H.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Response of Adult H

In February 2001, adult H was given details of the allegations made against him by this complainant, through a letter to his solicitor. In February 2001, Adult H responded to the allegation through his solicitor who informed the Inquiry Team in writing that his client completely denied the alleged incident as set out by the complainant. He stated that the incident described by the complainant did not occur.

7.6.9 Adult I (Deceased)

Adult I was based at Kilcornan over a period of 11 years several decades ago. One former resident of Kilcornan made allegations against him.

Complainant 17 resided there at the time when Adult I was based there.

The complainant made allegations of sexual abuse involving buggery and masturbation, against Adult I. He said that the alleged abuse took place in Adult I's bedroom when he (the complainant) was 18/19 years old. He stated that Adult I gave him money and told him not to tell anyone.

In 1997 he made the first disclosure of alleged sexual abuse to a social worker employed by the Brothers of Charity. This social worker referred him to the Inquiry Team. Adult I, against whom the allegation was made, has been dead for many years.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.10 Adult J (Deceased)

Adult J was based in Kilcornan for about 10 years several decades ago. Complainant 20 made an allegation of sexual abuse against him.

The complainant was resident in Kilcornan for many years having been admitted when he was 14 years old. At the time he met the Inquiry Team he was no longer resident at Kilcornan.

The complainant told the Inquiry that Adult J touched him around the genital area but would not give any further details. He stated that he had given all the details in his statement to the Gardai and was not willing to repeat the information as he thought it would embarrass the interviewers. The complainant was not able to recall the exact year when the alleged abuse took place.

The complainant told one of his current support people about his allegation after he was informed about the Inquiry by a social worker. The support person reported the disclosure to the social worker and the Inquiry was informed of the allegation. Adult J, against whom the allegation was made, has been dead for many years.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.11 Adult K (Deceased)

Adult K worked in Kilcornan for approximately 20 years until he retired and continued to live there. He died before the Inquiry began its work. Two (2) female service users made allegations of sexual abuse against him which were alleged to have occurred when they were adults.

Complainant 18

Complainant 18 was a service user in Kilcornan during the period Adult K was based there. She alleged that on one occasion Adult K exposed his penis to her and attempted to sexually assault her. She was unable to remember the year of the alleged incident and stated she immediately reported the incident to a care worker whom she named and that this person had reported it to a manager whom she named to the Inquiry. At interview with the Inquiry Team this manager said that he had no recollection of receiving a report of the alleged incident. The Inquiry Team was unsuccessful in their attempts to locate the former care worker. There was no record of any report of the alleged incident in the Brothers of Charity files. In March 2000 the complainant disclosed the alleged incident to her social worker who referred her to the Inquiry Team.

Complainant 19

This Complainant resided at Kilcornan during the time Adult K lived there. During the course of three interviews the complainant made allegations of sexual abuse which she said occurred in Adult K's bedroom and in another location in Kilcornan.

Adult K, against whom the allegations were made, is deceased and the allegations could not be put to him.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.12 Adult L (Deceased)

Adult L was employed for many years at Woodlands. Three former residents who lived in Woodlands during the time Adult L was employed made allegations of sexual abuse against him.

Complainant 9

This complainant alleged to the Inquiry that when he was a teenager Adult L abused him on numerous occasions in the dormitory in Woodlands campus. The alleged abuse consisted of fondling the complainant's genitals while he was wearing his pyjamas. The complainant was unsure over what period of time this occurred.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Complainant 6

This complainant alleged that he was sexually abused by Adult L when he resided in Woodlands. He alleged that Adult L fondled his genitals and tried to masturbate him on two or three occasions.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Complainant 3

This complainant alleged that he was sexually abused by Adult L when he resided in Woodlands. He stated that the alleged abuse occurred in the toilets and dormitory. The abuse consisted of Adult L fondling the complainant's genitals and attempting to masturbate him. The complainant also alleged that Adult L got him (the complainant) to masturbate him.

None of the complainants disclosed the alleged abuse during the time they were pupils at the school.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Adult L, against whom the allegations were made, has been dead for many years.

7.6.13 Adult M (Deceased)

Complainant 7 was a residential pupil at the Holy Family School during the time Adult M worked there. He made an allegation of sexual abuse against Adult M to the Inquiry Team and stated that he was about thirteen years old at the time. The complainant said that he was fully dressed and standing up when Adult M put his hand down his trousers. He did not specify what part of his body Adult M's hand was touching or give any further details. The complainant related that he did not understand what was going on and did not report the incident to anyone at the time.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Adult M, against whom the allegations were made, has been dead for many years.

7.6.14 Adult N (Deceased)

Adult N was employed on the Woodlands campus for several years in the 1970-80s. Complainant 16 was a residential pupil in Woodlands during the time Adult N worked there.

The complainant alleged that he was sexually abused by Adult N on a number of occasions in Adult N's bedroom on the Woodlands campus. He alleged that Adult N fondled his genitals and attempted to masturbate him but that Adult N did not ask the complainant to do anything to him. He stated that he could not recall exactly when or how often it happened because it was so long ago, but that it occurred on a number of occasions and that he was approximately 12 years of age at the time. The complainant told the Inquiry that Adult N gave him money from time to time and speculated that he was given money to keep quiet. He stated that the alleged abuse occurred between four and seven times over several months.

The complainant explained to the Inquiry Team that he told nobody about what happened with Adult N until he spoke to the Gardai. He said that he found it embarrassing talking to the Gardai and the Inquiry Team about this. He said that embarrassment prevented him from disclosing the alleged abuse until he spoke to the Gardai and the Inquiry Team.

The complainant made a statement of complaint to the Gardai in which he made allegations of sexual abuse against Adult N.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Adult N, against whom the allegations were made, has been dead for many years.

7.6.15 Adult O (Deceased)

Complainant 14 was a residential pupil at Holy Family School during the time Adult O worked there.

The complainant alleged that he was sexually abused by Adult O almost every weekend over a two year period while he was a residential pupil at the Holy Family School. The complainant stated that he shared a bedroom with three other boys. He said that he dreaded weekends as the boys who shared his room went home and he was on his own. He alleged that Adult O sexually abused him in the bedroom at weekends. He stated the sexual abuse started with masturbation and progressed to anal intercourse over a period of time.

The complainant stated that he was about 14 years old when the alleged abuse started and was not sexually aware. He felt powerless to report the alleged abuse when it was happening stating that he did not feel anyone would believe him. The complainant stated that during the week the alleged abuser would give him favourable treatment such as extra pocket money and other treats. He stated that he was told to keep the alleged abusive behaviour a secret and felt under threat.

The complainant told the Inquiry Team about how watching a "Late Late Show" episode on child sexual abuse triggered his disclosure of his own abuse. He made the first disclosure to a member of his family and described a feeling of mixed emotions following the disclosure. He said that while he felt a sense of relief he was aware that he would be burdening his family. The complainant contacted the Helpline and was subsequently interviewed by the Inquiry Team. He reported flashbacks and nightmares regarding the alleged abuser. He said that the alleged abuse had a very negative effect on him throughout his life. He had found counselling helpful in coming to terms with the alleged abuse. The complainant made a statement to the Gardai.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Adult O, against whom the allegations were made, has been dead for many years.

7.6.16 Adult P (Deceased)

It was confirmed that Adult P worked on the Woodland campus for some time when Complainant 9 was a residential pupil at the Holy Family School.

Complainant 9 alleged that he had been sexually abused by Adult P when he was about 11/12 years old. He alleged that Adult P had put his hand down the complainant's pyjamas and fondled his penis.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

Adult P, against whom the allegations were made, has been dead for many years.

7.6.17 Adult Q (Unlocatable)

It was confirmed that Adult Q worked in the Woodlands campus for a short time when Complainant 8 was a residential pupil at Holy Family School.

Complainant 8 stated that Adult Q had been present and had witnessed Adult B administering physical punishment to him.

The Inquiry Team was unable to locate Adult Q in order to give him an opportunity to respond to the above allegations.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

7.6.18 Adult R

It was confirmed that Adult R was employed at the Holy Family School during the time Complainant 15 was a pupil there.

The complainant alleged that Adult R sexually abused him during the time he was a pupil at the school.

The allegation was the subject of a Gardai investigation at the time of the Inquiry's work.

The complaint was referred by the Inquiry to An Garda Siochana and the Western Health Board.

CHAPTER 8
NATIONAL AND REGIONAL GUIDELINES FOR THE IDENTIFICATION AND MANAGEMENT OF CHILD ABUSE

Awareness of abuse developed significantly over the period covered by the Inquiry Team's Terms of Reference, during which a series of procedural guidelines were published by central government to assist the identification and management of child abuse by Health Boards and other agencies. The Inquiry Team reviewed these in preparation for Task 3 of its activities i.e. to review relevant policies and procedures and the relevant literature and to make any necessary recommendations in accordance with the Terms of Reference.

These procedural guidelines are outlined below, categorised by the issuing government department.

8.1 Department of Health and Children

8.1.1 Memorandum on Non-Accidental Injury to Children (March 1977)

The first National Guidelines were published by the Department of Health in 1977 as the *"Memorandum on Non-Accidental Injury to Children"*, which was based on the recommendations made in the Report of the Committee on Non-Accidental Injury to Children, published in 1976. The aim of the Memorandum was *"to provide guidance for health agencies and health personnel on the identification, management and prevention"* of non-accidental injury. No definitions of child abuse were given (2.1).

The Guidelines in this Memorandum concentrated on the problem of actual, suspected or potential non-accidental physical injury to children. While many of the approaches and procedures suggested were seen to appropriate in cases of injury arising from emotional deprivation or neglect, it was considered that the evidence of such injury might not always be as clear cut. Because of this and the potential legal difficulties under existing legislation, it was considered necessary for procedures for intervention in such cases to be

dealt with separately. This matter was be further examined by the Department in consultation with the Task Force on Child Care Services. No mention was made of child sexual abuse (2.2).

Specific responsibility for the monitoring and co-ordination of Non-Accidental Injury was allocated to the Directors of Community Care and Medical Officer of Health within the Community Care Services of the Health Board.

The Memorandum gave a detailed checklist of indicators of physical abuse, and outlined actions to be taken by relevant personnel.

8.1.2 Guidelines on the Identification and Management of Non-Accidential Injury to Children (January 1980)

These Guidelines were concerned with the problem of actual, suspected or potential non-accidental physical injury to children.

8.1.3 Guidelines on Procedures for the Identification, Investigation and Management of Non-Accidental Injury to Children (February 1983)

In 1983, new Guidelines were published updating the 1977 memorandum. However, only passing reference was made to the issue of sexual abuse, the emphasis again being placed on physical abuse. (Injury resulting from sexual abuse was referred to as being included under the heading of "*confirmed or suspected non-accidental injury*"). The Guidelines stated clearly (page 13) that:

"The Gardai must be notified as quickly as possible where a breach of the law is indicated" (4.2).

In the Guidelines, reference was made to dealing with neglect:

"in all cases of serious injury or neglect, conferences to review the situations should be held from time to time (4.2)."

The Guidelines also stated:

"*Health Board staff should facilitate staff of other agencies in every way possible and should arrange for circulation of their guidelines to all agencies and bodies concerned, including schools, day care facilities for pre-school, mentally handicapped and physically handicapped children (and) children's residential homes. Boards should also notify them of the arrangements for contacting the DCC and other appropriate officers of the Board, where non-accidental injury to a child is suspected. Appendix C of these guidelines in the form of a short pamphlet should be issued to all hospitals every six months to coincide with the changes in Residential Medical Staff*".(7.1),

and further:

"*All staff dealing with the welfare of children have a responsibility in this area, and should develop a greater awareness of child abuse and of the circumstances of the families with which they are dealing*".(7.2)

However, the focus of the Guidelines and of the discussions and definitions of child abuse was directed at abuse occurring within families. No reference was made to any form of abuse by service-providers.

8.1.4 Guidelines on procedures for the Identification, Investigation and Management of Child Abuse (July 1987)

A revised set of guidelines were issued by the Department of Health in July 1987. For the first time, more specific reference was made to sexual abuse, identification and "*validation*" of which was stated to be "*fundamentally different*" and particular issues to be borne in mind in such cases were set out in a separate section. At the same time, the Guidelines stated that:

"*The procedures to be followed in dealing with child sexual abuse do not differ from the general Guidelines. However, the identification and validation of child sexual abuse is fundamentally different and a separate section (paragraph 6, pages 23-24) is included which sets out particular issues which must be borne in mind in such cases*".

No detailed definitions of abuse were given in these revised Guidelines, however, Appendix A of the Guidelines listed specific physical indicators of child sexual and physical abuse.

With regard to the action to be taken by personnel other than Health Board and/or medical personnel, paragraph 4.15 & 6.2.2 stated that such others (which included teachers, day care staff, and residential care staff, among others) should follow procedures as follows:

"*When the suspicion of a person other than health board personnel, G.P. or hospital/clinic personnel is aroused, he should notify the DCC/MOH immediately after consultation with his superiors. The DCC/MOH should then arrange with the appropriate member of his community care team to investigate further*". (4.15)

Paragraph 6.1 stated:

"*Sexual abuse of children, like other forms of abuse, has always existed. In recent years professional staff have realised that its prevalence is much greater then previously assumed. The number of cases being identified is increasing and this trend is likely to continue as professional staff become better able to recognise sexual abuse and as the public become more willing to report cases or to seek help*.

Any complaint of sexual abuse made by a child must be taken seriously. The complaint should be followed up by the initiation of the necessary investigation and validation process. Professional staff should take particular care to ensure that the initial verbal complaint by the child to them is preserved in writing.

Sexual abuse, as distinct from other forms of abuse, has particular features which require special attention and the following paragraphs seek to highlight these areas".

Paragraph 6.2.6 further stated that:

"*The welfare of the child must be of primary concern to all professional staff who become involved in investigating a case of alleged sexual abuse*".

The Guidelines clearly stated that "*the sexual abuse of a child is a crime*" and referred to both intra-familial and extra-familial abuse (6.2.7). Chapter 8 of the 1987 Guidelines laid strong emphasis on the need for Health Boards to circulate the Guidelines to staff in other agencies.

The Western Health Board accepted the Department's guidance as the basis for its policy for management of child abuse and in 1989 added two appendices to form the Board's policy on the subject.

8.1.5 Notification of Suspected Cases of Child Abuse between Health Boards and Gardai (April 1995)

In 1995, following specific recommendations in the Report of the Kilkenny Incest Investigation (1993), guidelines for notification of Suspected Cases of Child Abuse between Health Boards and Gardai were issued jointly by the Department of Health and the Garda Síochána.

The document amended the 1987 Guidelines of the Department of Health in relation to circumstances in which Health Boards and the Gardai were to notify cases of suspected abuse to each other and in relation to the consultation that should taken place between both agencies following a notification. In these Guidelines, definitions were given of physical abuse, sexual abuse, emotional abuse and neglect.

8.1.6 Putting Children First - Promoting and Protecting the Rights of Children (October 1997)

In 1997, the Department of Health outlined a number of initiatives, and arrangements for reporting of child abuse in this document. These proposed initiatives included:

The appointment of Child Care Managers in the Health Boards, with responsibility for coordinating inter-agency approaches to child protection within each community care area

The establishment of regional and Local Area Child Protection Committees to enhance inter-professional approaches to child protection

Multi-disciplinary training under the aegis of the Regional Child Protection Committee

Review of the 1987 Child Abuse Guidelines and 1995 Garda Síochána Health Board Guidelines to be undertaken by the Social Services Inspectorate (SSI)

Public Awareness Campaign to create an Increased Awareness of Child Abuse

The provision of support services by health boards for victim of abuse

The funding of voluntary agencies dealing with children to be conditional on procedures being in place to deal with allegations of child abuse

Helpline for victims of past abuse, operated by Health Boards

Evaluation of the impact of the above measures on the reporting of child abuse

Setting up of the Ombudsman for Children

In June 1998 the Western Health Board published 'Child Protection – Child Care Policies and Guidelines' which, while highlighting the need to differentiate between those children who need family support services and those children who are in need of care and protection, set out detailed advice on all aspects of child protection.

8.1.7 Children First-National Guidelines for the Protection and Welfare of Children (September 1999)

In 1999, and subsequent to the start of the Inquiry Team's work, this comprehensive document was published by the Department of Health and Children. The aims of these Guidelines are, in addition to assisting in the identification and reporting of child abuse, to clarify and promote mutual understanding among statutory and voluntary organisations in relation to child protection and to highlight the importance of consistency between policies and procedures across health boards and other statutory and voluntary organisations. They also emphasise yet again that the welfare of children is of paramount importance.

The National Guidelines are intended to provide a framework for inter-agency and multi-professional work practices and are directed at both Health Board personnel and voluntary organisations among others. The Guidelines are framed in the context of the Child Care Act 1991. Regional implementation groups were established subsequently to ensure consistency in the implementation of the Guidelines.

8.2 Department of Education Guidelines

8.2.1 Procedures for Dealing with Allegations or Suspicions of Child Abuse (1991/1992)

In November 1991 the Department of Education issued its first guidelines to the management authorities and principal teachers of National Schools with regard to the identification and notification of allegations, disclosures or suspicions of abuse within schools.

The Inquiry Team were informed that, prior to this date, cases that were brought to the attention of the Department were dealt with on a case-by-case basis. No formal guidance was available to schools or teachers on how to deal with cases of alleged abuse and that schools would have been expected to make contact with the local Health Board or Gardaí where such cases arose.

Since the Boards of Management of schools are the employers of the teachers within the school, the Department of Education informed the Inquiry Team that where an allegation related to a teacher, it would have been a matter for the Board of Management to take appropriate action.

Similar guidance was issued to the management authorities and principal teachers of Post Primary Schools in June 1992.

8.2.2 Procedures for Dealing with Allegations made to Officials of the Department of Education of Abuse of Children by Teaching and Other Staff of Schools. (1995)

In July 1995, the Department of Education issued a document entitled “Procedures for Dealing with Allegations made to Officials of the Department of Education of Abuse by Children by Teaching and Other Staff of Schools”.

- This document detailed the approach and actions to be taken by relevant staff within the Department of Education where an allegation of abuse, either

physical or sexual, was made. The procedures covered allegations of abuse of a child by:

- a member of staff of a school,
- people on contract to supply services to a school,
- people who have regular authorised access to schools, or
- other individuals.

The procedures also covered allegations of current abuse, as well as allegations in respect of abuse that may have occurred in the past and referred to allegations where the alleged abuser is or might be still involved with a school as a staff member.

In addition, the procedures referred to regular, monthly meetings between Principal Officers and the setting up of a register of notified cases, which would be monitored to ensure "that they are handled correctly".

Paragraph 3.8 states that allegations made to a School Inspector during school visits should be reported in writing to the relevant Principal Officer, even where the school states that the matter has been dealt with.

Paragraph 3.10 refers to situations where an allegation might be made against "either the person (in the school) to whom the Department would in the normal course make the Report, or a person closely related to him/her". In this situation "the Report should not be made to that person, but to a person higher in the reporting structure".

The Inquiry Team was informed that all schools should have adhered to these procedures from the time of receipt of the documentation.

As detailed above the 1991 Guidelines dealt with actions to be taken by a teacher in the event of an allegation of abuse being made against a staff member or against another pupil. The question of confidentiality and of the legal position regarding the notification of such a complaint by school personnel to the appropriate authorities was dealt with in some detail. (Section 8 a & 8 b).

In addition, Section 8 (d) deals briefly but clearly with the procedures in relation to informing the individual complained of.

The Department of Education and Science issued new guidance in 2001 for schools and the Youth Sector following the publication Children First in 1999.

8.2.3 Corporal Punishment 1946-1982

While corporal punishment was not abolished in Irish National Schools until 1982 there were Department of Education Guidelines regarding appropriate corporal punishment in existence for many years before this. As early as 1947, a Department of Education Circular, issued to Industrial Schools, indicated that corporal punishment in such Schools should only be administered as a last resort and "should be confined to slapping on the open palm with a light cane or strap".

In 1956 a Circular (Circular 17/56) was issued to Managers and Teachers of National Schools in relation to corporal punishment. This circular re-issued the then 'Rule 96' with a slight amendment. Rule 96 had made it clear that the only form of corporal punishment that was acceptable was "the use of a light cane, rod, or leather strap, which should be inflicted only on the open hand". The Circular re-stated that "The boxing of children's ears, the pulling of their hair or similar ill-treatment is absolutely forbidden and will be visited with severe penalties."

Further Rules for National Schools were published in 1965. In these Rules, a new Rule 130 replaced the previous Rule 96, stating that corporal punishment should be administered only in cases of serious misbehaviour, and not for "mere failure at lessons", and should only be administered by the Principal teacher or other member of the school staff authorised by the Manager for the purpose.

Circular 9/82 was issued in 1982 forbidding the use of corporal punishment with effect from the 1st February 1982.

8.3 Rules within the Brothers of Charity regarding Corporal Punishment

As far as the Inquiry Team could ascertain, no written guidelines were in place within the Brothers of Charity during the period relevant to the allegations which have been made to the Inquiry Team against a named brother. The Inquiry Team sought information from the Brothers of Charity Congregation and Services in relation to policies regarding corporal punishment during that period.

A senior representative of the Brothers of Charity stated that, during all of his time as a Brother of Charity, including his time as Provincial Superior, he was entirely of the understanding that the use of corporal punishment was seriously at variance with what the Brothers of Charity stood for. He informed the Inquiry Team that during his time at Woodlands he was not aware of corporal punishment ever having been sanctioned or used in any form in the residential services or the Holy Family School.

He also indicated that even if corporal punishment had ever been used in the school it would have necessarily ceased when it was abolished by the Department of Education.

CHAPTER 9

HANDLING OF ALLEGATIONS AND CONCERNS BY THE BROTHERS OF CHARITY

As part of its work the Inquiry Team was requested to make any appropriate recommendations which might arise from the Inquiry. This included examining policies and procedures in place within the service. (Point 4 Terms of Reference)

The Team did this by examining the manner in which the Brothers of Charity Services dealt with concerns/allegations of abuse and whether the guidelines in place at the time were followed. This was primarily done by reviewing files. The cases referred to in this chapter are examples of how some concerns/allegations were handled.

9.1 Policies and Procedures in Relation to Client Protection

Prior to 1993 there were no written formal policies or procedures in the Brothers of Charity Services or Congregation for handling complaints or allegations. This was not unusual in services of this kind at this time.

A member of the Congregation who was interviewed stated that the policy prior to 1993 was that if an allegation was brought to the attention of the Brother Superior it would be referred to an internal multi-disciplinary team, after which a Case Conference was implemented. The Case Conference would recommend what should be done and it would be up to the Director of Services to make sure that these recommendations were carried out. He was asked if there were any differences in procedures between an allegation against a lay staff and an allegation against a brother. He said that there was not necessarily a difference in procedure unless there was something characteristic about the allegation. He was also asked if allegations against brothers were recorded in the past and where they were recorded. He stated that any allegations that were recorded would probably have been recorded by the individual who was moving a brother from a service. He said that he presumed anything recorded would be kept in the local system.

He was asked if there was a policy of moving a brother in the context of an allegation being made against him. He said that the policy was that a brother would be moved out of the service system until it was established what if anything happened. Asked if a brother would ever be moved from one service system to another, he stated that this would not happen in his experience without some investigation taking place and stated that brothers would be moved out of direct contact with clients. If an allegation was validated, a brother would be moved permanently out of direct contact with clients. If an allegation was not validated the brother would be returned to post.

A former teacher in the Holy Family School said that there was no formal complaints procedure in place during his tenure. He thought teachers would not have been aware that children may have had complaints.

Another staff interviewee explained that, prior to the existence of the complaints procedure, a service-user would possibly have made a complaint to whoever they had a good relationship with.

When asked about the procedures which existed prior to the Designated Person System a staff member said that, prior to this procedure being introduced, professionals who received an allegation contacted the Director of Services.

Since 1993 the Brothers of Charity have developed three sets of guidelines for dealing with allegations and complaints of abuse. These are:

Guidelines for the Investigation and Management of Alleged Incidences of Non-Accidental Injury and Sexual Abuse (1993)

Guidelines and procedures for the Investigation and Management of Abuse Allegations (1996)

Brothers of Charity Congregation protocol for Responding Effectively to Complaints of Child Sexual Abuse (1997)

The three sets of guidelines are set out in **Appendix A.**

9.2 Handling of Allegations

This chapter deals with information received about a number of allegations/concerns, and other related matters, which give an indication as to how the Brothers of Charity Services and Congregation handled such situations over the 33 years covered by the Terms of Reference.

The detailing of the relevant information was undertaken by the Inquiry Team and included review of appropriate files and correspondence, together with staff interviews. The Inquiry Team identified a number of allegations/concerns which had been expressed relating to the Brothers of Charity Services and Congregation in the Galway area. Nine (9) of these cases are reviewed below. Seven cases fall within the period 1965-1993 during which, as already stated, there were no written policies/procedures. The remaining two cases fall within the period 1993-1996 and are reviewed in the context of adherence or otherwise to the formal written policies introduced from 1993 onwards.

Cases 1-7 fall within the time period 1965-1993.
Cases 8 and 9 fall within the time period 1993-1996.

1965-1993 Period

This is the period when no written procedures existed.

9.2.1 Case 1/Adult A

Initial Complaint (1969)

An official of the Department of Education and Science told the Inquiry that during a school visit in 1969 he spent part of the morning in one of the classrooms. The official said that the children had a lunch break of 1 - 1¼ hours when they were served a hot meal. He said that he was on his way to his lunch when a pupil came up to him in the school yard and said he wanted to talk to the official. The official said that he was surprised that this boy, who was an adolescent, knew his name and added that he was unsure whether the child had been in the class that he had visited that morning. The official said that the child made an allegation of sexual abuse to him against a brother, whom he named. He stated that he could not remember the boy's name or the precise language the child had used, but he recalled that the complainant was a residential pupil at the school. He said that the child's account to him left him in no doubt that there was substance to the allegation. He said that he recalled the child saying that sometimes the brother took him out in his car. He said that the boy told him that the brother touched his private parts. He said that he did not know from what the boy said, whether or not the brother asked the pupil to do anything to him.

The official said that he had cross-examined the child about what he had said and stated that this was to convince himself that it was not a silly prank or a ploy by the child to get at the brother. He said that in his opinion if a child with a intellectual disability invented a story, it would not be long before the flaws in his argument would become apparent. He said that after cross-examining the child, he was left in no doubt as to what this child was saying and that there was substance to the allegation.

Action Taken

The official stated that he was shocked by the allegation and reflected over it during lunch. He told the Inquiry that he telephoned his Line Manager in the Department of Education and Science for advice and was advised to talk to the School Manager locally. However, he decided to speak to one of the psychologists whom he trusted. He said that the psychologist was very taken aback by the allegation and was very concerned. The psychologist confirmed to the Inquiry that the official had discussed the allegation with him at the time and that he was also very shocked and surprised.

The official said he then informed the Brother Superior who had reacted with anxiety and surprise when he was informed of the allegation. He said that the Brother Superior undertook to investigate the matter. The official also telephoned the then Brother Provincial (who was based in Dublin) in accordance with the advice of his Line Manager in the Department of Education and Science. He then reported back to his Line Manager who told him to write down everything that had happened, and that he would make sure that the matter would be dealt with by the appropriate people in the Department, who needed to know. He made a written record of the incident and action he had taken. The official told the Inquiry Team, at the time of his interview, that he had recently searched in the Department of Education and Science for the file of the incident and the only record he found was his own written notes.

At interview with the Inquiry Team, a former brother, who had been the Provincial of the Brothers of Charity at the time the allegation was made, outlined from memory his involvement in the investigation. He stated that the records relating to the event are missing and informed the Inquiry that since 1969, (the time of the incident), that the Provincial headquarters of the Brothers of Charity (where the records would have been stored) has moved on three occasions. He stated that in 1969 he received an anonymous phone call to Provincial Headquarters in Dublin stating that the Gardai were going to call on a named brother at the Holy Family School. The interviewee's recollection is that he was told they would be calling the next day. He said that he took the matter seriously and stated that he went down to the Galway Service that evening and spoke with the Brother

Superior. He then sent for Adult A, who was to be interviewed by the Garda, and took him by car to Dublin. He said that he then oversaw his transfer to England, where he was placed to work in adult services. The Inquiry heard from others that Adult A spent some time in the Brothers of Charity premises in Waterford before his transfer to England.

Adult A, through his solicitors by letter dated October 2007, stated in response to the above paragraph that he was never told who had made the complaint or the details of the complaint. He further stated that on the same day that the complaint was made, he was sent to the Brothers of Charity Psychiatric Hospital at St. Patrick's, Belmont Park, Waterford.

He stated, through his solicitor, that he remained there for 2 years until April 1971 when he was transferred to Adult Services in Britain.

The former Provincial stated that his own concern was to get the man out of contact with children. He said that staff in the English Centre were unaware of the allegations against Adult A and stated that he had no clear recollection of the nature of the allegation. He stated that it was managed locally, and that there was a system in place for dealing with the incident. He said he was unsure as to the nature of the procedures that the Department of Education had in place at that time, but that the allegation was processed by them. The interviewee stated that he had no direct contact with anyone from the Department of Education in relation to the allegation. He stated that he dealt with the Manager of the school as did the Department of Education. He said he did not know what the investigation involved. He said that he did not know anything about the individual who made the allegation or how the allegation came to light.

Notification to Gardai

The Gardai informed the Inquiry Team that there was no Garda record from the late 1960's or early 1990's of any investigation into Adult A's activities.

Adult A's Conviction for Sexual Offences

On 1/11/2000, twenty sample counts of indecent assault were made against Adult A and he pleaded guilty to indecent assault in relation to ten different individuals.

As previously stated, the Inquiry Team received confirmation from the Brothers of Charity Services that Adult A was convicted of sexually abusing five complainants who made allegations against Adult A to the Inquiry Team.

9.2.2 Case 2/Adult K (deceased)

The management of this case predates the introduction of formal written procedures within the Brothers of Charity. However the final stages of the case overlap the period when the introduction of the designated person (1993) and delegate (1996) were under discussion. (These roles are described in **Appendix A**).

The case concerned allegations made to the Inquiry by Complainants 18 & 19 about Adult K who is deceased. Adult K was an elderly brother who had been resident in Kilcornan for many years.

Complainant 18 was interviewed by the Inquiry Team. She stated that she had informed a care worker and a manager following an incident of indecent exposure and an invitation to engage in sexual activity involving Adult K. A senior line manager who was interviewed by the Inquiry Team indicated that he understood that the incident occurred in 1978. He believes that the event was only incidentally brought to his attention some years later. His recollection is that when recounting the matter to him the experienced senior staff member who had handled the incident indicated that it had been handled satisfactorily. The senior brother manager in Kilcornan at the time of the alleged incident was deceased by the date on which the Inquiry Team began its work.

Complainant 18 also recalled a further incident of indecent exposure by Adult K when he was dancing with another service user at a social occasion where several members of staff were present. Complainant 18 drew the matter to the attention of a houseparent who removed the service user from the situation. The date of the incident is not recorded.

The Inquiry Team were informed of another allegation made by a service user in 1987 against Adult K. At interview with a senior brother/manager the Inquiry Team informed him that they had received information that a report was written on the incident and that a verbal report was made to him by a member of staff at a meeting between the two. The senior brother/manager stated that he recollected meeting with a senior member of the

bungalow staff at about that time but that he had not been informed of any allegation of sexual abuse. The meeting related to the fact that Adult K was causing a nuisance by hanging around the bungalows annoying female residents. He confirmed to the Inquiry Team that he supported the staff request that Adult K would not be allowed around the bungalows and followed up by addressing the matter with Adult K, as an elderly member of the religious community.

At interview some current and former staff stated that it was well known over a long period throughout Kilcornan that Adult K posed a risk to female service users and that management had been informed of his behaviour on many occasions. These staff stated that they were aware that he had to be watched in the presence of female service users and they had been told to watch out for him and not allow him near the bungalows. Two front line staff gave accounts of incidents of attempted sexual assult by Adult K where they personally intervened to protect services users and reported those incidents. They were told that senior management would look after it and thereafter, the situation would improve for a time.

When asked at interview about Adult K, a senior social worker referred to him as an elderly man who was not involved in the services. She became aware that some staff held the view that he was inclined to touch female residents inappropriately. She raised this matter with a senior manager pointing out that she thought that clients should not have to put up with this behaviour. A staff member who was one of the Senior Managers at the time indicated at interview with the Inquiry Team that he definitely had no recollection of a discussion or meeting with a senior social worker about Adult K.

In 1993 two members of staff reported to their line manager that they had observed a serious incident of attempted sexual assault by Adult K. By this stage the Brothers of Charity had introduced new written guidelines and appointed a Designated Person. The manager took immediate steps for the safety of the service user and instructed that the incident be recorded in the day/night book and the next day the two staff concerned sent a signed letter to the Designated Person.

The case was written up and a Case Conference was held. The manager concerned contacted the senior brother/manager who, in turn, contacted the Brother Provincial and Adult K was removed from Kilcornan to a retirement home two days after the incident had been reported. None of the incidents concerning Adult K were reported to Gardai or to the Health Board at the time.

9.2.3 Case 3/Adult T (deceased)

The Inquiry Team was made aware of three allegations which dated back to the late 1970's against a male member of the non-teaching staff at Holy Family School.

9.2.3.1 First allegation late 1970's

The first allegation against the lay worker was made by the mother of a child who was not a service user to a member of the management staff. She alleged that Adult T had made some sort of inappropriate approach to her child while she was using the swimming pool at Holy Family School.

A manager interviewed Adult T and he denied the allegations. The manager informed Adult T that if there was substance to the allegation or if there were further allegations, he would be dismissed from his post. The manager informed the alleged victim's mother of the action he had taken.

At the time the manager thought that there was not any substance to the allegation. This conclusion was based on two factors:

- the child's mother did not pursue the matter further after hearing back from the manager;
- The manager knew the accused was a family man and that at the time he thought it would be unlikely that anything would have happened.

The manager told the Inquiry Team that he did not recall reporting the allegation to the then Director of Services or making any record of the allegation. He did not think any other staff member was aware of the allegation.

The Director of Services was informed of this allegation only on the 4th October 2000, long after Adult T had left the service. The Director of Services told the Inquiry Team that there was nothing at all in Adult T's personnel file that connected him in any way

with any such allegation. The Designated Person was informed of this allegation in February 2001 by the Director of Services.

9.2.3.2 Second allegation early 1980's

In the early 1980's a female service user made an allegation to her house-parent that Adult T had abused her. She had been a pupil at the Holy Family School.

The house parent notified a second house parent who made a record in a diary. The second house parent notified a nurse who was visiting a sick child in the Group Home. The nurse stated to the Inquiry Team that she was in a Group Home visiting a child who was sick. During her visit the House Parent reported to her that one of the service-users had alleged that Adult T whom she named had taken her out to the country and brought her into a shed and took off her clothes. The nurse stated that she reported the alleged incident that evening to her Line Manager. Both the nurse and Line Manager then returned to the Group Home and interviewed the House Parent regarding the allegation. The nurse recalled that the Line Manager, either later on the evening the allegation was made, or the following evening asking her to accompany him when he travelled to Adult T's house. The nurse stated that the house parent kept a diary of the allegations for sometime after the allegation was made. The nurse did not have any further involvement in the handling of the allegation and did not make a written report. No record of this meeting was available. The Inquiry Team was informed that this information would not have been recorded on Adult T's file and there was no designated file at that time. The nurse related that Adult T continued to work in the Brothers of Charity Service.

Through a letter to the Inquiry Team from the Designated Person it was reported that the Line Manager whom the nurse named had no recollection of such a meeting or of interviewing the alleged victim.

Record of the allegation

One of the house parents made the following record in her diary which she retained. The Inquiry Team reviewed the entry which is signed and dated. The entry from the diary is reproduced exactly as it was recorded below.

"[name of alleged victim] alleged to house-parent that Adult T had sexually abused her in the school "every morning" when she used to arrive in early to school. More than one occasion.

He further sexually abused her at two other locations.

Another Houseparent on duty in both of these occasions.

The nurse [named] called on visit to another client.

Houseparent told the nurse about the service user's allegations.

Meeting subsequently held in Group Home... Nurse, House parent, and Line manager."

Another named service user told the house parent the same story as the first complainant about Adult T."

In early 2000 the Director of Services was informed that this diary was in existence. The Director of Services informed the Designated Person who notified the Inquiry.

In a letter to the Inquiry Team a social worker stated that she interviewed the complainant at the time the allegation was made and that this interview would have been recorded in the Group Home diary. The social worker stated that during the interview the service user made no specific allegation but only said that this man had been at her. The social worker stated that the service user did not elaborate in any way and made no other statements

that she could interpret as a formal complaint that could be investigated. The social worker stated that she personally informed the Brother Superior of the concern relating to the lay worker.

Reporting of allegation to management

The social worker's line manager informed the Inquiry Team that the social worker had informed her at the time of the allegation, and she in turn informed senior management.

The social worker's line manager stated to the Inquiry that subsequently the member of senior management to whom she reported the allegation interviewed Adult T about the allegation and then came back and informed her that Adult T had absolutely denied the allegation.

At interview the senior manager said that he had no recollection of being informed of this allegation in the early 1980's, and that had he been informed he would have linked it with the previous situation involving Adult T, who had been named in the complaint made in the late 1970's.

Adult T continued in his position until retirement.

Repetition of the allegation in the late 1990's

In the late 1990's the service user repeated the allegation during an interview with a psychologist. She said that she had reported the matter, but was unsure to whom. The service user said that Adult T, against whom she had made an allegation, continued to work at the school. She had no recollection of speaking to the Gardai about the matter at the time.

The psychologist notified the Designated Person in writing stating that the service user named Adult T as a person who had sexual contact with her. The psychologist also stated that she did not go into any great detail with the service user on these allegations as she

felt it was more appropriate in her counselling role to let her client talk with minimum interruption.

In February 2000 the Designated Person notified the Western Health Board of the allegation naming Adult T. The Gardai were notified by the Western Health Board in May 2000 after being prompted by the Inquiry Team to do so.

9.2.3.3 Third Allegation

The person who made this allegation declined to be interviewed by the Inquiry Team. This information is compiled from records reviewed and other interviews held by the Inquiry team. In June 1999 a service user made an allegation of sexual abuse against Adult T. On 8th June 1999 a social worker notified the Designated Person. About a week later the complainant was interviewed by the Gardai to whom she made a statement. Subsequently, the Gardai notified the Inquiry Team of the allegations.

9.2.4 Case 4/Adult R

Allegations in the late 1980's

In the late 1980's a female pupil at the Holy Family School made an allegation against Adult R to a student working in Brothers of Charity Services.

On the same day the student reported the allegation to a staff member who reported it to his Line Manager. The Line Manager interviewed the complainant. The allegation was repeated. A psychologist undertook a second interview with the complainant and the allegation was repeated again.

The next day a Senior Social Worker in the Brothers of Charity Services notified the complainant's social worker in the Western Health Board (WHB) who interviewed the complainant. The WHB social worker met the Chairman of the Board of Management of The Holy Family School. Two days later, the Chairman discussed possible action with the Western Health Board. A Psychiatrist undertook a further interview with the complainant to judge the veracity of the allegation. The complainant repeated the allegation again. Four days later, a Case Conference was held which was attended by Senior Brothers of Charity and Western Health Board personnel. The following issues were discussed:

protection of the complainant;

safety of other children;

where did responsibility for dealing with the allegation lie; and

informing the accused person of the allegation against him.

Over the next two days, the Chairman and a psychiatrist, who was employed by the Brothers of Charity, confronted Adult R against whom the allegation had been made. He admitted that he had seen the complainant alone in a room with the door closed. He gave guarantees that he would never see any child alone again with the door closed.

A decision was made that the pupil's family would not be told at that time. Four months after the initial complaint was made, a School Inspector, from the Department of Education met the complainant's social worker. On the next day, the School Inspector interviewed the complainant in the presence of her social worker, a Western Health Board employee. The complainant made the same allegation. One month later, the Department of Education announced that it would set up a Inquiry to deal with the allegation.

Approximately two months later, following a meeting between the Brothers of Charity and the Western Health Board regarding concerns expressed by a psychologist employed by the Brothers of Charity about current safety of the complainant, the Chairman of the Holy Family School put some arrangements in place so that the complainant would have no contact with Adult R. The Chairman also instructed Adult R not to have any contact with the complainant. The next day the complainant's social worker visited the school regarding safety of the complainant. The Director of Community Care, Western Health Board wrote to the Department of Education expressing concern about the delay in setting up the Inquiry and said that Adult R was still working in the school. Following a meeting of the Board of Management of the School held one month later, Adult R was suspended with pay.

Over a year after the allegations were first made, the Department of Education Inquiry was held and the complainant gave details of three alleged incidents of sexual abuse.

The Inquiry came to the conclusion that the allegations were not substantiated and this information was communicated to Adult R and the Board of Management of the school then wrote to Adult R advising him that he could resume duty and the Board stressed the adherence to certain good practice guidelines.

Allegation in early 1990's

A rumour concerning an alleged inappropriate interaction with a pupil came to the attention of the school nurse. The school nurse immediately consulted Adult R in his

formal role. Adult R told the school nurse that he was aware of the rumour which related to him. The school nurse reported the rumour to the Consultant Psychiatrist and they jointly informed the Chairperson of the School Board. The Chairperson of the School Board immediately informed the Head of Social Work/Designated Person. On the same day the Head of Social Work/Designated Person, accompanied by the school social worker, visited the pupil's home and met the pupil's mother and the pupil separately. The pupil and her mother said that there had not been any inappropriate interaction and that they were making no allegation whatsoever and that there was no complaint against any staff member. The parent told them that it was another named pupil who had been making the allegation. The next morning, the Head of Social Work/Designated Person and the school social worker met with the Chairperson of the School Board and the school nurse to formally report that they had received no allegation or complaint.

They also met the second pupil who confirmed that she had not been involved in any inappropriate interactions and that she was only 'messing' when she had said that to the first pupil. She made no complaint or allegation.

Further Allegations made in 1990's

A school social worker received information regarding allegations against Adult R concerning another pupil at the school. The social worker immediately informed the Chairperson of the Board and informed him that he would report the matter to the Designated Person/Head of Social Work, which he did the next day.

The following day, the school social worker and the Designated Person/Head of Social Work obtained details of an allegation that Adult R had sent for the pupil and that he had sexually abused her. They were told the alleged incident was interrupted by the appearance of another member of staff but it was alleged to have continued when that staff member left the room.

The Designated Person/Head of Social Work and the school social worker reported this allegation to the Chairperson of the School Board. The Chairperson of the School Board sent a registered letter to Adult R asking him to contact him as a matter of urgency. Adult

R telephoned the Chairperson of the Board and arranged to meet him five days later along with his Union representative and another member of the School Board. In that formal context Adult R was informed about the allegation and he responded that he denied it completely. He also asked for time to consider the allegation and the Chairperson of the Board agreed to reconvene the meeting three days later.

In the interim, the school social worker received a further allegation that Adult R had sexually assaulted another pupil. The school social worker reported this allegation to the Chairperson of the School Board.

The Chairperson of the School Board and the Designated Person/Head of Social Work met the Acting Director of Community Care of the Western Health Board and the Child Care Manager of the Western Health Board and informed them in detail of the allegations and Adult R's response. The Chairperson of the School Board also contacted the appropriate statutory bodies.

The Western Health Board staff met with each child and their parents and an appointment with a child psychiatrist was offered. The children were not re-interviewed due to prior Gardai interview and statement.

At a meeting of representatives of the Board of Management Holy Family School/Western Health Board/Brothers of Charity it was recommended that Adult R should not resume work until the investigation was completed and pending outcome of same. The Chairman informed the Board of Management of the recommendation and Adult R was suspended.

Adult R was charged on two counts in Galway Circuit Court and the case was referred to the Central Criminal Court. The State entered a Nolle Prosequi.

Discussions then took place between the Western Health Board, the Holy Family School Board, and the Brothers of Charity Services as to the steps to be taken arising from the court proceedings.

The Chairperson of the Board of Management of Holy Family School wrote to the Director of Community Care of the Western Health Board seeking a further meeting to discuss the way forward.

The Western Health Board/Brothers of Charity/Holy Family School Board held a meeting to discuss the situation vis a vis Child Protection and Employee Rights of Employment.

The Holy Family School Board of Management received advice that it should set up a sub-committee to re-hear the complaints made against Adult R from the Western Health Board. The Chairperson of the Holy Family School Board was concerned in regard to responsibilities of the school in this situation and asked about the Western Health Board's statutory responsibility and requested that the Western Health Board would:

- Carry out this investigation with Brothers of Charity Services and Holy Family School involvement, or

- Give clearance to the Board of Management to carry out this process.

Statements made to the Gardai were obtained by the Board of Management with the consent of the relevant individuals.

The Board of Management set up a sub-committee to make a formal recommendation to the Board of Management in respect of Adult R. The sub-committee advised the Board of Management to dismiss Adult R. The Board invited Adult R to make his case in front of the Board of Management.

Having been suspended for nearly four years Adult R resigned from his position.

9.2.5 Case 5/Adult U

The Inquiry Team were informed by a Senior Medical Officer employed by the Western Health Board of an allegation made in the early 1990's by a service user against a lay employee. The Senior Medical Officer informed the Inquiry that at the time the allegation had been made, a multi-disciplinary investigation of the allegation was undertaken, involving the Brothers of Charity and the Western Health Board.

The information in the following paragraphs was extracted from the Western Health Board files by the Inquiry Team as neither the complainant nor alleged offender was interviewed by the Inquiry Team.

During a joint interview with the Director of Children's Services and a social worker the complainant, who was 14 years old at the time, made the allegation against a male employee. The complainant alleged that during the previous summer Adult U had invited him out for a walk and sexually abused him. The complainant also alleged on two subsequent occasions the man had invited him to go for a walk.

The interviewers notified a senior social worker who then interviewed the complainant in the presence of the Director of Residential Services. During this interview the complainant repeated the allegation. The social worker informed the Administration Department and a Senior Social Worker in the Western Health Board. The Gardai were also informed of the allegation by the Brothers of Charity. Adult U was interviewed by Social Work staff and admitted two incidents. The families of the complainant and alleged offender were notified of the allegation. Adult U was dismissed from the service.

Paragraph 9.2.5 of the Report was furnished to Adult U for his comment. Adult U, through his solicitor, by letter dated October 2007, made no admission or acknowledgement in respect of the contents of this paragraph.

9.2.6 Case 6/Adult S (deceased)

In the late 1990's a former service user met with a member of Brothers of Charity staff and made allegations against Adult S. The staff member who received the allegation explained the Designated Person system to the complainant. During the conversation the complainant was adamant that the allegation should not be disclosed to anyone else. The staff member spoke to his line manager but did not disclose the name of the complainant or the person against whom the allegation had been made. The line manager advised that the staff member should meet the complainant again and encourage him to discuss the allegation with the Designated Person. The complainant refused to have the Designated Person present when he met the staff member again. The staff member who received the allegation was very stressed by the communication restrictions placed on him by the former service user. He was supported by his line manager who encouraged him to persuade the complainant to allow him to disclose details of the allegation to the Designated Person. The line manager also advised the staff member that he should seek help from a member of Brothers of Charity staff who had special expertise in professional ethical issues and that he should also seek legal advice.

The Designated Person was informed of the allegation against Adult S and immediately informed the Western Health Board and Gardai in writing.

9.2.7 Case 7/Adult V (unnamed)

In the mid 1970s Adult V who worked in Kilcornan was seen by front line staff using undue physical force in handling an unnamed service user. The incident was reported by the staff to the then Director of Services and the member of staff was suspended pending investigation of the incident. The case went before a Rights Commissioner. The outcome was that the member of staff was dismissed from the Brothers of Charity Services.

1993-1996 Period
This is the period when written procedures existed.

Cases 8-9

9.2.8 Case 8 Adult W

In the 1990's a member of the nursing staff reported to her line manager that she had witnessed a member of the staff using force to restrain a service user. The allegation was dealt with under the Disciplinary Procedures. Adult W was suspended and the complaint was investigated. The complaint was upheld. A final written warning was issued to the member of staff who was also demoted and transferred to another area where closer supervision was available. A training programme was also provided to Adult W.

9.2.9 Case 9/Adult X

A member of the care staff witnessed Adult X verbally abusing a client and reported the incident to a manager. The member of staff against whom the allegation was made was suspended while an investigation was undertaken. The complaint was upheld and a written warning was issued. The member of staff was demoted, and no longer selected for night duty and was put on two years probation.

The member of staff who reported the matter was well supported by management and transferred to another part of the service at her own request. Training was put in place for other staff working in this service.

CHAPTER 10
COMMENTARY AND RECOMMENDATIONS

Information Sources

The following commentary and recommendations are based on several sources of information. The first is a consideration of the views of the clients and staff who have been involved in the services over the period covered by the Inquiry and who came forward for interview or made written submissions. The second is the allegations which were made to the Inquiry Team and the examination of how the Brothers of Charity Services handled concerns and allegations that had come to their attention in the period covered by the Inquiry. The third is consideration of reports of other reviews which were conducted after the work of the Inquiry had been completed.

There were two reports commissioned by the Brothers of Charity Services. These are:

1. Challenging Behaviour Programme Evaluation Report: Brian McClean (2003).

2. Independent Assessment of Proposals for Future Services at the Brothers of Charity Services in Kilcornan, Clarinbridge, Co. Galway: 1066 Consultancy Ltd & Healthcare Consultancy Ltd (2006).

The third report listed below was commissioned by the HSE as part of the HSE's review of the Inquiry process and ongoing quality assurance arrangements in the services.

3. Review of current practices for the protection of service users within the Brothers of Charity Services, Galways, by Paul Murphy, Child Care Manager, Health Service Executive (West) and Breda Mulvihill, Disability Services Manager, Health Service Executive (West) 2006/2007.

Fourthly, current developments in services for people with an intellectual disability and in the protection of children and vulnerable adults have been taken into consideration.

I also received 29 reports, policy documents and assessments which were furnished by the Brothers of Charity Services and which are listed in **Appendix B**.

The Brothers of Charity also provided comments in regard to the recommendations contained in this Chapter. These comments, insofar as they directly relate to the Brothers of Charity, are contained in **Appendix C**.

As noted in the Preface, with the passage of time, some of the recommendations may have already been implemented. It should be noted also that some of these recommendations may have a broader application than the Brothers of Charity Services in Galway.

The following are my commentaries and recommendations arising from the Report:

10.1. Arrangements on Admission to Care/Services

Commentary

This review has shown that admission to care/services for clients with intellectual disability was difficult if not traumatic for many in the past. The experiences outlined by those interviewed by the Inquiry Team make sombre reading and are reflective of past regimes and practices. Now, there is a greater recognition of the rights of users and their families and the responsibilities on service providers to ensure that optimum care in the appropriate environment is provided for users of all services whether residential or day. This process can be assisted by the provision of appropriate information leaflets on the services available and service charters where applicable. Relevant induction programmes for clients and their families should also be arranged prior to admission to any service. A fundamental feature of the arrangements should be the completion of formal multi-disciplinary assessment of all clients prior to admission and the development of a care plan to meet the needs of each individual which is subject to regular review.

Recommendations

10.1.1 That all applicants for a service are assessed before being admitted to a service.

10.1.2 That the Brothers of Charity Services produce information leaflets or prospectuses on each of their services for potential users and their families to explain what the service has to offer and how it will be provided.

10.1.3 That prior to admission a care plan should be developed for each service user by a multi-disciplinary team in conjunction with the applicant and their family or carer.

10.1.4 That all care plans should specify a review date.

10.1.5 That each new service user and their families/carers should have an induction programme on admission.

10.2. Record Keeping

Commentary

The issue of appropriate record keeping arises time and again throughout this report. The Brother of Charity Services need to develop a comprehensive policy on the process of compiling and maintaining records. The establishment and maintenance of records is an essential and integral aspect of health and social care service provision. Staff should receive appropriate training on record keeping and the general principle should be that all significant details about service users are recorded and accessible to all relevant staff in a timely fashion.

Recommendations

10.2.1 That the Brothers of Charity Services in Galway should undertake a comprehensive review of how records are maintained both on paper and electronically to ensure that information can be easily accessible to those who require it.

10.2.2 That all significant details about service users are recorded and accessible to all relevant staff in a timely manner.

10.2.3 That a simple report form for recording concerns and allegations of abuse should be introduced for use by all staff.

10.2.4 That the development and implementation of the record keeping system is supported by a training programme.

10.2.5 That records in each service are audited annually by a senior manager.

10.3. Guidelines on Personal and Sexual Relationships for Service Users

Commentary
A focus of this Report has been on the alleged incidents of sexual and physical abuse of some clients of the services over the period under review 1965 – 1998. There is a need to develop clear guidelines on inter-personal and sexual relationships between clients in the services and such guidelines need to be developed taking into account the views of the clients themselves, their families and the staff caring for them.

Recommendations
10.3.1 That clear guidelines in relation to personal and sexual relationships should be developed for service users in conjunction with service users, their families and staff.

10.3.2 That these guidelines be widely disseminated to and understood by all service-users, parents/ carers and staff.

10.4. Protection of Vulnerable Adults

Commentary
The issues of child abuse and more recently abuse of older adults are now well recognized in our society and measures have been taken to address them. This Report has examined the situation around allegations of abuse made by some four residents at Kilcornan Services over the period of the review 1965 – 1998 and allegations by 17 individuals who were in residential accommodation while attending the Holy Family School during the review period.

Trust in Care, published in 2005, is the Policy for Heath Service Employers on Upholding the Dignity and Welfare of Patients/Clients and the Procedure for Managing Allegations of Abuse against Staff Members and has particular relevance to clients in residential services in the intellectual disability services. The policy is primarily concerned with these issues in the context of the employment relationship with staff. It is acknowledged, however, in the policy document that health care and social care agencies have a duty of care that goes beyond their duty as employers and the policy called for the simultaneous application of related policies such as Children First. In this regard it is noted that the Health Service Executive (West) produced a publication entitled Action on Adult Abuse Guidelines (2005). Furthermore, the HSE is in the process of developing a national policy on the protection of vunerable adults.

A recognized definition of a vulnerable adult is *"any person aged 18 or over who is or maybe in need of community care services by reason of mental or other disability, age or illness; and who is or maybe unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation*." It is clear that a policy on the protection of vulnerable adults would have particular relevance in the intellectual disability services both residential, day and community and the Brothers of Charity Services should ensure that

policies and procedures are introduced to their services as appropriate. The introduction of new policies should be accompanied by service specific guidelines and codes of conduct and awareness training for staff, clients and their families.

Recommendations

10.4.1 That a national policy on the protection of vunerable adults be developed and introduced by the HSE at the earliest opportunity.

10.4.2 That all staff should be made familiar with and should clearly understand the concept of vulnerability and the factors which increase children's/ adult clients' vulnerability.

10.4.3 That factors which influence the vulnerability of people with intellectual disability should be included in the staff training programmes.

10.4.4 That ongoing awareness training for service users is provided to help them keep safe and reduce the risk of possible abusive behaviour of others toward them. Such training should also be available for family members.

10.4.5 The Brothers of Charity Services should develop and implement a Code of Conduct for staff in all services especially, residential services, where service users are likely to be more vulnerable.

10.4.6 That the Brothers of Charity should ensure that policies and procedures are introduced to their services as appropriate.

10.5. Complaints and Allegations

Commentary

A primary focus of this Report has been the way in which complaints and allegations were handled by the services in the past. The arrangements were far from ideal. The Health Act 2004 has introduced specific procedures for dealing with complaints and the Health Service Executive has now established a Consumers Affairs Department and uniform arrangements for dealing with complaints are being introduced.

In terms of services provided by external agencies it is noted that the Health Service Executive is now developing a new Service Level Agreement which will include a specific section on the handling of complaints by such agencies. The new arrangements should provide for the development of a complaints procedure which is widely disseminated amongst staff, service users and their families. The monitoring of complaints and their outcomes should also be a regular feature of the system. A system of service user advocacy should also be available for those service users who do not have direct family involvement.

Recommendations

10.5.1 That each service should have a complaints procedure which is widely disseminated and understood by all staff, service users and their families and in a format that is user friendly.

10.5.2 The process of preliminary assessment of allegations should be reviewed, to define its purpose, clarify criteria, and give strict guidelines as to how it is to be carried out and who should be involved.

10.5.3 That the procedure provides for the organisation to monitor the implementation of reporting arrangements to the designated person.

10.5.4 That a senior manager should review, on an annual basis, the records of all complaints received and report any unusual patterns or occurrences to the national executive of the Brothers of Charity Services.

10.5.5 That the service should develop a policy to support staff who report abuse or concerns relating to other members of staff.

10.5.6 That a comprehensive system of client advocacy be introduced for all service users in Brothers of Charity Services.

10.5.7 That specific arrangements for investigation of complaints is included in a new Service Level Agreement between the Health Service Executive and the Brothers of Charity Services.

10.6. Challenging Behaviour

Commentary
The Brothers of Charity Services at Kilcornan currently provides residential services for clients, some of whom present with Challenging Behaviour. External evaluations of the service were conducted in 2003 and 2006 and concluded that all such service users should be transferred to purpose built facilities in the community. A number of recommendations to this effect are included later in paragraph 10.7 below.

Recommendations
10.6.1 That residents of the challenging behaviour services at Kilcornan be transferred to new purpose built facilities in the community.

10.6.2 That staff should have more specific advice and practical assistance in relation to individuals exhibiting challenging behaviour.

10.6.3 That the purpose of collecting the data required by the Challenging Behaviour Team should be clarified and explained to staff.

10.7. Service Developments

Commentary
It is generally accepted now that for all but a few people, health and social care should be provided in their own homes or in community settings alongside the rest of the population. This means that residential care, in campus/congregated settings should be kept to an absolute minimum of provision, and the dominant focus should be the development of comprehensive family support and tailored packages of services in order to maintain children and adults within their families and within the community.

Any alternative care provision should attempt to replicate the ‘normal’ experience which is to live within one’s family and extended community. It is accepted that in rare and exceptional situations some residential or alternative care provision/out of home placements may be

necessary for a very small number of persons with complex needs. However, any such special arrangement should only take place following a comprehensive multi-disciplinary assessment, which identifies the specific needs which required to be addressed and outlines the clear intervention plan, with regular reviews and associated timelines.

Such placements should be kept to a minimum duration and should be the subject of independent reviews. Particular measures should be taken to ensure the safety and quality of such placements.

It is evident from experience internationally that the quality of life for persons with intellectual disabilities in campus style settings can never equate to that of persons with intellectual disability who are cared for within families and communities. Modern thinking in relation to residential care emphasises that it is a setting for services rather than a service in itself, and historically it is evident that residential services, and indeed, any service which caters for vulnerable people in settings that are apart or separate from the community, run the risk of developing practices which even, unintentionally, are not in the best interests of service users. It is very important that the Health Service Executive ensures that as it progresses, the development of its community based services/primary care services that such services are linked very substantially to persons who are already in receipt of their main care within residential or indeed, community based settings.

Settings which tend to segregate people and break those linkages which are usual for most citizens must extend even more importantly to vulnerable people in any kind of segregated setting. Examples for these linkages are, the relationship between a General Practitioner and a patient, which is a direct one to one, or a Primary Care Team and a patient.

People with learning disabilities should be able to lead normal lives. To enable them to do so they need to:

- be included, better understood and supported in the communities in which they live;
- have information about their needs and the services available, so that they can take part, more fully, in decisions about them;
- be at the centre of decision making and have more control over their care;
- have the same opportunities as others to get a job, develop as individuals, spend time with families and friends, enjoy life and get the extra support to do this ; and
- be able to use local services wherever possible and special services if they need them.

Pursuing these objectives by putting in place appropriate services will allow people to live properly in the community and facilitate the closure of long stay institutions.

In order to achieve these objectives the Health Service Executive should introduce a system of Care Management to oversee the care of people with complex needs and those whose families are, for whatever reason, unable to maintain contact with them.

Care Management is:

- A process that includes assessing individuals needs and tailoring services to meet those needs;
- Focused on people with complex, or frequently or rapidly changing needs; and
- Undertaken by a range of professionally qualified staff in social work and health, with appropriate training, skills and experience.

The key principles in Care Management are:

- People who use services and their carers should be actively involved and enabled to participate;
- The needs and aspirations of people and their carers should be central;
- Care arrangements should be tailored to individual need;
- Care management should promote choice for people;
- Care management should facilitate access to all community care services across agencies and sectors;
- Care management is an integrated process leading to co-ordinated care.

It is recognised that there is a concern that, due to the very significant and multi-annual investment programme in the area of disability and the associated concentration on the development of new services for persons who are not in receipt of services to date, the attention would not be focused sufficiently on the needs of the 3000+ people with significant intellectual disability who reside in segregated/campus based settings throughout the country.

For this reason a fundamental review should be undertaken by the Health Service Executive in partnership with the providers of all such services. Based on that review the stakeholders, which include the Department of Health and Children, the Health Service Executive, the voluntary organisations and the religious congregations, should consider the development of a specific investment programme which would resource the transfer of the vast majority of such persons from campus style settings to community based settings.

Recommendations

10.7.1 That residential care, in campus/congregated settings should be kept to an absolute minimum of provision, and the dominant focus should be the development of comprehensive family support and tailored packages in order to maintain children and adults within their families and within the community.

10.7.2 In keeping with the general thrust of the 1066 Consultancy/Healthcare Report of 2006 the Brothers of Charity should plan an orderly but rapid transfer of all services off the Kilcornan site into appropriate community facilities located as part of natural residential communities.

10.7.3 That a fundamental review of campus style residential settings should be undertaken by the Health Service Executive in partnership with the providers of all such services. Based on that review the stakeholders, which include the Department of Health, the Health Service Executive, the voluntary organisations and the religious congregations, should consider the development of a specific investment programme which would resource the transfer of the vast majority of such persons from campus style settings to community based settings.

10.7.4 That the Health Service Executive introduce a system of Care Management to oversee the care of people with complex needs and those whose families are, for whatever reason, unable to maintain contact with them.

10.8. Holy Family School and Department of Education and Science

Commentary
A significant section of this Report has dealt with allegations from 17 former pupils of the Holy Family School. This represents approximately 4% of the pupil base over the period under review 1965-1998. It is recognised that all children are vulnerable but particular safeguards are required for children with intellectual disability. Schools of this nature should regularly review their child protection arrangements and the Department of Education and Science should also ensure that its guidance and policy documents on child protection are regularly reviewed and continue to update specific provisions for protection of children with intellectual disability both in specialist school services and in mainstream education.

Linked to this type of policy provision there should be regular updates of appropriate codes of conduct for teachers and all staff in such schools. Information on the school's policies and procedures should be made available in appropriate formats for pupils and their families and all staff. Staff should receive awareness training on a regular basis.

Recommendations
10.8.1 That the Board of Management of the Holy Family School should review the Child Protection arrangements in the school on an annual basis and have regard to any policies issued by the Department of Education and Science.

10.8.2 That the Holy Family School should provide awareness training on child protection for all staff on an annual basis.

10.8.3 That the Holy Family School should develop and implement a Code of Conduct for teachers and other personnel in the school to safeguard the children attending the school and have regard to any policies issued by the Department of Education and Science.

10.8.4 Information on the school's Child Protection Policies and Procedures should be made available to all pupils, parents and staff in formats suitable to different needs.

10.8.5 That the Department of Education and Science review its Child Protection Guidance to reflect the position of children with special needs especially those with intellectual disability.

10.9. Inter-agency working between the Health Service Executive and An Garda Síochána

Commentary
Good inter-professional and inter-agency working between the HSE and An Garda Siochana is the cornerstone of good child protection and was evident in the arrangements governing the Inquiry and its aftermath. The arrangements should be reviewed regularly at the highest level in both organisations to ensure that these key agencies develop policies and protocols on joint working, co-operation and training. This should apply equally to the protection of vulnerable adults. Such policy provisions should involve arrangements to avoid or reduce stress on children and vulnerable adults who make complaints or allegations while in receipt of care or services.

Recommendations

10.9.1 That the Health Service Executive and An Garda Síochána review their policy and procedures on inter-agency working in relation to children and vulnerable adults taking account of guidance and developments on child protection and vulnerable adults and developments in other jurisdictions.

10.9.2 That the Health Service Executive and An Garda Síochána take all necessary and appropriate steps and ensure that an approach is adopted which will avoid/reduce stress on children and vulnerable adults who make complaints or allegations.

10.10. Contractual Arrangements – Health Service Executive and Brothers of Charity Services

Commentary

The existing contract arrangements between the Health Service Executive and agencies providing services to persons with intellectual disability derive from "Enhancing the Partnership" (1996) which was an agreed process by which funding of such agencies was transferred from the Department of Health and Children to the then Health Boards.
Historically, the large voluntary/not for profit organisations, many of which have their roots in religious congregations, were the first organised services in modern times for persons with intellectual disability and the State's involvement was subsequent and supportive of the work of the congregations/organisations.

Consequently, it is understandable that in the 1990's when responsibility was transferring from the Department of Health and Children to the Health Boards, that there were clear concerns regarding the need to respect the autonomy of the agencies. The contracts emanating from "Enhancing the Partnership" emphasised the need to respect the operational autonomy and identity of the agencies and tended to define accountability, mainly in financial and quantum of service terms.

It is very evident to this author that the framework for managing the relationship between the Health Service Executive and service providers needs to be reviewed with a much stronger focus on a multi-dimensional accountability framework which, in particular, focuses on safety, standards and quality of service for service recipients. It is understood that such revised arrangements are contemplated in new contract discussions underway with the agencies and that any new contract will also provide for a comprehensive complaints process which will be subject to monitoring within the contract arrangements.

Recommendations

10.10.1 That the contract arrangements between the Health Service Executive and the Brothers of Charity Services be reviewed on the foot of a new Service Level Agreement which will have a much stronger focus on a multi-dimensional accountability framework with an emphasis on, safety, standards and quality of service for clients.

10.10.2 That the Annual Service Agreement between the Health Service Executive and the Brothers of Charity Services includes a monitoring template on complaints and allegations.

received in the service, assurances that investigations comply with agreed arrangements and an overview of the outcome of such complaints / allegations

10.11. Quality Assurance and Standards

Commentary

As has been indicated above, the new contract arrangements envisaged between the Health Service Executive and the agencies will have a much stronger focus on a multi-dimensional accountability framework which in particular focuses on safety, standards and quality of service for service recipients.

In this respect it is noted that the Health Service Executive is not the agency with designated responsibility for the development and monitoring of standards in respect of the disability services. This responsibility rests with the newly established agency Health Information and Quality Authority (HIQA) and there is urgency for HIQA to develop the appropriate processes, best practice standards and associated monitoring/inspection arrangements.

It is also evident that the Health Service Executive as the commissioner/funder of services should retain significant responsibility and have a duty of care to persons in receipt of such services. Contractual arrangements between the Health Service Executive and the agencies need to ensure that the information is available to assure the Health Service Executive of the safety and quality of the service provision and such other requirements as may be necessary. This is of particular importance in the transition period before the HIQA service becomes fully operational but should continue in an appropriate format into the future.

Recommendations

10.11.1 That the Health Information and Quality Authority, the agency with responsibility for the development and monitoring of standards in the services for people with a disability, put in place the appropriate processes, best practice standards and associated monitoring/inspection arrangements as matter of urgency.

10.11.2 That, the Health Service Executive, as funders/commissioners of services, develop substantive assurance processes as part of its contractual arrangements with the Brothers of Charity Services. This will be of particular importance in the transition period before the Health Information and Quality Authority becomes fully operational but should continue in an appropriate format into the future.

APPENDIX A 1

BROTHERS OF CHARITY GUIDELINES

GUIDELINES FOR THE INVESTIGATION AND MANAGEMENT OF ALLEGED INCIDENCES OF NON-ACCIDENTAL INJURY AND SEXUAL ABUSE 1993 (updated in December 1998)

1. Purpose of the Guidelines

The aim of these guidelines is to make available to all personnel working within the Brothers of Charity Services a set of procedures to be followed in the event of their suspecting or knowing that physical, sexual or emotional abuse has taken place. It is important that all those working within the Order's Services be aware of these procedures and their legal responsibilities.

2. Type of Guidelines

The Services provided by the Brothers of Charity varies from region to region. It includes the provision of services for children as well as adults. In the case of alleged abuse of clients under the age of 18 years, the Department of Health Child Abuse Guidelines (1987) should prevail.

It is proposed that the procedural guidelines should be sub divided into the following three categories:

1. **Alleged abuse of clients which occurs outside the Order's Services.**
2. **Alleged abuse of clients which occurs within the Order's Services**
3. **Alleged abuse of clients by an employee of the Order's Services**

Proposed guidelines

In the event of it being known or suspected that a client of the Order's Services is being abused, is at risk of being abused or is abusing, the following procedure should be followed.

3. Alleged abuse of clients outside the Brothers of Charity Services

The person who knows or suspects that a client is being abused or is abusing is obliged to report this verbally and in written form to the Designated Person of the service and Medical Director after informing and consulting with his or her immediate superior.

Each centre should appoint a Designated Clinical Person who will have responsibility for the coordination of the investigation and assessment of abuse.

The Designated Person will ensure that the following steps are taken:

An investigation of the alleged abuse will take place within 24 hours of receiving the report. The Designated Person may do this him/herself or may appoint someone else to do so.

All information relating to the alleged abuse of the client will be recorded in written form and made available to the Designated Person.

An initial assessment of the level of ongoing risk to the client will be made. The Designated Person in consultation with the team will take the necessary action to protect the client.

The Designated Person will ensure that all staff involved have recorded in detail any information about the alleged abuse including conversations with parents and/or other parties.

The Designated Person will chair a clinical meeting to decide the nature of the alleged abuse, the factual circumstances surrounding the suspicions and the action which should be taken. A record should be kept of the minutes of the meeting indicating clearly the decisions reached and the recommendations made.

The Designated Person will ensure that the client's parents or guardians are informed about the alleged abuse and the course of action to be taken.

The Director of Community Care should be informed of the alleged abuse. An agreement can then be reached with the Director of Community Care regarding further conduct of the case.

4. Alleged abuse of clients within the order's services

Where abuse is alleged within the Order's Services, the steps outlined above with the following addition

The Designated person should inform the Director of Services

5. Alleged abuse of clients by any person (paid or unpaid) connected with the Order's Services

Where allegations of abuse are made against any person (paid or unpaid) connected with the Order, the following guidelines should apply:

The Designated Person on receiving the report of the alleged abuse should immediately inform the Director of Services and the Administrative Director.

The Director of Services will then, in consultation with the Administrative Director and the Designated Person, decide what course of action should be taken.

Where the client is under 18 years of age the Director of Community Care should be informed of the alleged abuse.

6. Recommendations regarding implementation

In adapting procedural guidelines, individual services will need to adapt them to their individual circumstances but the steps outlined above should be adhered to.

Each region should establish a small committee to draw up procedural guidelines and this committee should meet at regular intervals to review the policy and procedures as amend as necessary.

Each region should have procedural guidelines drawn up within a stated time period.

A series of seminars should be arranged by each centre so that all those working within the Service will be informed about the guidelines and will know how to implement them.

Each person, currently and in the future, connected with the Brothers of Charity Services should have the guidelines readily available to them.

All clients, parents and next of kin should be informed that there are guidelines in place and these guidelines should be available to them if requested.

The Order should ensure that all necessary resources are made available to prevent abuse where possible and ensure that staff training continues in this area so that expertise will be further developed

The issue of the involvement of volunteers and scheme workers with clients of the Order's Services will need to be clarified with particular reference to their supervision and accountability.

Initial Procedures for staff

Stage 1. Report verbally and in writing to Designated Person immediately.

Stage 2. Obtain medical opinion and ensure safety of alleged abused person.

Staff should familiarize themselves with the Department of health Child Abuse Guidelines

Checklist for Designated Person

Stage 1: Consult medical opinion (parents' permission to be sought as appropriate) and call together appropriate people to assist initial assessment of situation and obtain written reports.

Stage 2. Inform Director of Services where allegations of abuse involve an employee or where an offence is suspected.

Stage 3 Inform Manager of Child & Family Services (Community Care) when alleged victim is under 18 years and ensure that the family are informed.

Stage 4 Designated Person informs Gardai if an offence is suspected.

Stage 5 Plan for client's immediate and long term wellbeing.

The list of Designated Persons and their contact details are included. The documentation contains recommendations regarding implementation of the Guidelines.

APPENDIX A 2

BROTHERS OF CHARITY GUIDELINES AND PROCEDURES FOR THE INVESTIGATION AND MANAGEMENT OF ABUSE ALLEGATIONS 1996

After the introduction and definitions of abuse there is a section on procedures which is reproduced below.

"WHAT TO IF YOU SUSPECT, WITNESS OR ARE TOLD OF AN INCIDENT OF ABUSE".

A. If you witness abuse:

Stop the abuse

Inform the abuser that you will be reporting the incident

B. If you suspect abuse:

Inform your supervisor immediately.

Inform the Designated Person.

Complete incident form/written report as soon as possible and before going off duty.

In cases of emergency or danger, supervisor should obtain immediate medical help and ensure safety of victim.

C. If someone else informs you that abuse or suspected abuse has taken place i.e. a third party such as a client, family member, other, inform them that you'll act on the matter and complete steps (iii) – (iv) above.

D. Anonymous calls/letters:

Details should be registered with supervisor and designated person. (Use incident form).

DESIGNATED PERSON

The Designated Person to whom all abuse allegations are reported should be a Senior Clinical Person i.e. Senior Social Worker or Medical/Clinical Director. His/her role as Designated Person should be included in his/her job description.

Designated Person must:-

1. Ensure that victim/client is made safe and arrange for immediate provision of medical help if necessary.

2. Inform relevant people on a need to know basis i.e. partner/carer.

3. Call together appropriate people to assist in initial validation and obtain written reports.

4. Inform Director of Services and if the allegation involves an employee, the Director of Services will inform the Personnel Administration and together they shall decide what future action should be taken.

5. Act and report in accordance with current legislation e.g.

Child Care Act
Mental Health Act
Department of Health Guidelines

6. Ensure that a suitable plan of care and treatment is drawn up for the client's immediate and long term well-being within a reasonable period of time.

If perpetrator is an employee:

The Director of Services should with the Personnel Administration decide what needs to be done regarding:

Investigation
Disciplinary action
Support for the accused

If perpetrator is another client:

Designated Person has a responsibility to inform family/carer and ensure necessary assessment, care and treatment are provided.

If a crime has been committed the Director of Services should inform the Gardai.

The Designated Person should ensure follow-up, i.e. Review Case Conferences, to ensure initial recommendations have been followed and that there are appropriate written reports/records of same.

The following are included:

An Incident Report Form referred to in B (v) above.
A pro-forma for recording details of a Case Conference
A pro-forma for a Review Meeting
Notes on Implementation of Guidelines

CONFIDENTIALITY
All information is to be recorded separately from main files to ensure full confidentiality of the abuse allegation at all times.
Information should be shared on a need to know basis only.
Confidential files should be cross-referenced.
A summary of procedures to be taken is appended in diagrammatic form.

APPENDIX A 3

BROTHERS OF CHARITY CONGREGATION PROTOCOL FOR RESPONDING EFFECTIVELY TO COMPLAINTS OF CHILD SEXUAL ABUSE (1997)

This protocol was designed to deal specifically with allegations against members of the Brothers of Charity Congregation.

In 1996 the Irish Bishop's Advisory Committee on Child Sexual Abuse by Priests and Religious published the document Child Sexual Abuse: Framework for a Church Response. This document was accepted by the Provincial Council of the Brothers of Charity and a protocol as recommended was developed. The Congregation decided that the protocol should be applied in respect of adults who have an intellectual disability, in addition to children.

The Provincial Council set up an Advisory Panel to advise the Provincial Superior on a confidential basis in respect of any accusation of child sexual abuse. He also appointed a Provincial Delegate to oversee implementation of the procedures outlined in the protocol. The Delegate could attend meetings of the Advisory Panel but was not a member of it. A Deputy Delegate was appointed to undertake the functions of the Delegate when the Delegate was unavailable.

A Support Person was to be appointed to be available to those who allege abuse that they have suffered and their families.

The following are the headings of the sections in the Protocol Document:

Procedures
Safety and Welfare of Children and Adults with Intellectual Disability
A prompt response
Reporting to the civil authority
Care for victims and their families
Child protection
The rights of the accused Brother
Our response to our congregation, the services, and the wider community
When a Brother returns to his Province after therapy
When a Brother has been wrongly accused
Conclusion

The Protocol came into effect on 1st October 1997 and was to be reviewed no later than October1999.

APPENDIX B

29 Individual Bound Documents comprising various Reports, Policy Documents, Assessments furnished by the Brothers of Charity Services.

NAME OF REPORT	**DATE**
Brothers of Charity Services, Renmore House, Woodlands, Galway Evaluation Report	November 1995
Orchard Centre Evaluation Report	July 1996
The Maples Evaluation Report	1997
Brothers of Charity, Deerpark Centre Evaluation Report	May 1997
External Evaluation Report Bruach Na Mara Services, Casla, Connemara	October/November 1997
Burrenview Evaluation Final Report	1998
Radharc Na Mara Evaluation Report	1998
Stepping Stones Evaluation Report	June 1998
Evaluation Report – Adapted Forms of Conductive Education: The Burren View and Rosedale Experience	October 1998
Clarenmore Residential Services Review	October 1998
Outside Reviewers Evaluation Fairlands C.E.D.C – Brothers of Charity Services, Galway	November 1998
Project "Regenerate" Employment Horizon – External/Internal Evaluation Interim Report	January 1999
Evaluation of Brothers of Charity Community Model Services	May 1999
Summary of Discussion of the Review Gathering (Part One) of the 10 Church Hill Team	18th June 1999
Community Services for School Age Children Evaluation Report	1999
Aftercare Services Evaluation Report	2000
Brothers of Charity Galway, Evaluation of Organisational Services – Report of findings of Staff Survey	July 2001
St Kevin's and St. Stephen's Evaluation Report	September 2001
Crannog Respite Services Evaluation Report	September 2001
Deerpark Services Evaluation Report Day/Residential/Respite Service	2002
Pastoral Care Services Evaluation Report	June 2002
Challenging Behaviour Programme Evaluation Report – Brothers of Charity Services, Kilcornan Centre, Clarinbridge, Co. Galway	July 2003
Woodbridge Services Evaluation Report	2003
Burren View Child Development Centre – Parent & Toddler Group Evaluation	October 2003

Cois Saile Services Evaluation Report	January 2004
Brothers of Charity Services, Galway Woodhaven Evaluation Report	September 2004
Tara House Evaluation Report	2005
St Claire's Evaluation Report	Undated
Early Childhood Evaluation: Achievements and Challenges	Undated

APPENDIX C

BROTHERS OF CHARITY SERVICES COMMENTS ON RECOMMENDATIONS IN CHAPTER 10 DIRECTLY RELATING TO THEM

10.1 Arrangements on Admission to Care/Services
Recommendations

10.1.1
Current Practice

10.1.2
Now available in some parts of the Services (for example ECS Galway) – will be developed across the Services

10.1.3
This is current practice as part of the Personal Outcomes System (IPPs)

10. 1.4
Personal Outcomes planning and service users' IPPs specify personal goals, target dates and review dates.

10.1.5
To be developed

10.2. Record Keeping
Recommendations
10.2.1

- *Policy on Service Users' Information developed in 1996 and revised in 2005 – this specifies how information is gathered and stored, what information is gathered and how it is maintained.*
- *There is a current working group whose brief is to draw up templates for effective recording of information and make recommendations about how information can be most effectively accessible.*
- *There is work ongoing on the development of a system for electronic records. The ultimate goal is to develop an integrated electronic system of recording, storing and accessing service user records, however this will require development funds.*

10.2.2
Refer to 10.2.1 above

10.2.3
This is now in place and used by staff

10.2.4
Record keeping is part of central and local induction training. As systems are developed (as referred to in 10.2.1 and 10.2.2 above) there will be specific associated training packages for staff

10.2.5
The current Policy on Files and Records (2005) states that:
There will be an annual audit of all Main Files. The administrator for files in each service area will have responsibility to ensure that the audit takes place.

10.3. Guidelines on Personal and Sexual Relationships for Service Users
Recommendations
10.3.1
Personal Development, Relationships and Sexuality – Guidelines for Staff of Centre-Based and Residential Services (2001). The vision of the Services is to support the person with an intellectual disability to live as normal a life as possible, to have opportunities for personal development, the exercise of choice, the enjoyment of fulfilling relationships, the right to privacy, and to protection from exploitation. These guidelines deal with the complex issues of ensuring protection from abuse and exploitation at the same time as respecting the rights of people to understand and exercise their sexuality.

Code of Ethics and Ethical Guidelines for Staff Working in the Brothers of Charity Services Galway (2002.) The code of ethics deals with the rights of service users to dignity and respect, and the obligation on staff in their relationships with service users.

In recent years Personal Development Programmes that include sexuality and relationship education and stay safe training have been introduced into the adult services.

Procedure for Managing Risks (2006) – the procedure developed in 2006 and used by staff throughout in supporting service users to exercise their choices states:

"Choice is the foundation on which people build all the outcomes in their lives. The choices that people make direct their lives and reveal what is important to them.

Increasing the opportunity for people to make choices in their lives does not mean allowing people to act in ways that might expose themselves or others to undue risk. Choice must be balanced with responsibility. Achieving Personal Outcome Measures will involve risk taking and consequently the need for Risk Management Procedure.

If a risk has being identified, a Risk Assessment needs to be completed.
In attempting to keep people 'safe' we often deprive people of the ability and the rewards of taking risks in their lives. People learn through the experience of decision making which ultimately involves some level of risk. Even the opportunity to experience 'failure' can be a life-enriching and learning experience.

Providing support to people in taking risks does not mean exposing them to major failure for the sake of 'experience'. People should not have to take major risks without previous learning and without the necessary support if they make a mistake. It is impossible to list all possible risks that a person might be exposed to or a strategy for all possibilities. This

procedure describes how we can establish the level of risk associated with each situation and the basis for decision-making.

The principle underlying this procedure is that we problem-solve before we support a person to take risks or decide that the risk is unreasonable to take".

10.3.2
Guidelines are part of central and local induction. Policies and guidelines are reviewed and discussed at team meetings and are all on the Brothers of Charity Services website/intranet.

10.4. Protection of Vulnerable Adults Commentary
Recommendations

10.4.2
Good Practice Guidelines for Protection Against Abuse (2002, revised and updated 2005)
The good practice guidelines examine key areas in the protection of service users including:
Underlying principles,
Definition of abuse,
Good practice in communication with service users,
Handling intimate care,
Working with service users of the opposite sex,
Working alone with service users,
Good practice with regard to visitors to group homes,
Social outings with service users,
Home visits,
Recognising abusive behaviour, and
Staff support in the client protection process.

Guidelines for the Investigation and for the Protection and Welfare of Adults & Children with a Learning Disability from Sexual Abuse in the Brothers of Charity Services Galway (2002, revised and updated 2004 and 2005)
The guidelines state the obligations of individual staff and management in relation to the reporting of concerns of, or incidents of sexual abuse, and the obligation on all staff to promote the welfare of service users and protect them from any form of abuse. The guidelines state the procedure for reporting abuse and actions to be taken subsequent to any incident of abuse.

Training on client protection is mandatory for all staff and training courses are run across the Services on a regular basis.

Client protection issues are discussed at central and local induction

10.4.3
Included in both the Central Induction and Client Protection Training that is mandatory for all staff.

10.4.4
Personal Development Programmes that include sexuality and relationship education and stay safe training have been introduced into the adult services.
Training has not yet been offered to families across the Services.

10.4.5
See response to 10.4.2 above

10.4.6
Ongoing.

The organisation's Strategic Plan 2007-2012 From Vision to Action states in Goal 5 (The Services are committed to the development of effective service delivery that is responsive to the individual needs and goals of people receiving services) Objective 2 "Policies will be clearly written, concise and accessible to all staff and to service users.

- *A process will be agreed to review and simplify current policies and will distinguish between policies and guidelines*
- *Service users, families and staff will be involved in policy development*
- *New policies will be presented to and explained to the Service Users Council*
- *Each new policy will be discussed at Sector and team meetings*
- *We will develop a policy to address cultural diversity"*

10.5. Complaints and Allegations Commentary
Recommendations
10.5.1
The existing Complaints Procedure was developed in 2003 and as part of that an information leaflet describing the procedure and advising a complainant on how to proceed was developed and is available to all service users and families. The Complaints Procedure is also available on the Brothers of Charity Services website.

The current Complaints Procedure is being reviewed and will be revised to comply with the obligations under the Health Act 2004, Regulations 2006, which require compliance with the newly published HSE Complaints Policy and Procedures. The current revision will include a version that will be readily accessible to service users and in particular to those who have literacy problems or who communicate without words.

10.5.2
Policy on Reporting Abuse in the Brothers of Charity Services Galway when Abuse is Suspected or Alleged (1993, revised and updated 1995, 1996, 1998, 2000, 2004, 2005 and 2006). The policy and guidelines it contains are currently undergoing a 2007 revision and update

10.5.3
See 10.5.2 above

10.5.4
This will be covered by the revised Complaints Procedure currently being developed

10.5.5
Guidelines for the Investigation of Complaints against Staff Members of Incidents of Abuse (2005). This details the process for any investigation of complaints, concerns or allegations. In relation to the staff member who may report abuse or concerns it states "the Complainant should be offered personal counselling/support throughout the period of the internal investigation. The Employee Assistance Programme Officer or Occupational Health Nurse

should arrange this and maintain contact with the employee throughout the period of the investigation".

NOTE: Legislation in relation to "whistle blowing" has not yet been published and it is envisaged that such legislation will also include guidelines for supporting staff who report abuse or concerns.

Adverse consequences of staff reporting concerns in relation to other staff members is also covered by the Anti-Bullying Policy (2004)

10.5.6

Advocacy is strongly supported within the services – this is evidenced by the strength and the profile of the Service Users' Council within the organisation. Advocacy groups meet on a regular basis in each part of the adult services – service users are supported to attend the meetings by key worker staff. Two service users from each centre are elected to the Service Users' Council by their peers and each centre provides a facilitator from the staff group to support the elected representatives. The Service Users' Council meets six times a year to discuss issues of importance to them, to negotiate on key issues, and to be informed of policy and organisational developments. The Chief Executive meets with the Service Users' Council on a number of occasions each year as do senior managers.

In addition to their work within the Galway services, the Service Users' Council plays a strong role in the development of self-advocacy nationally and internationally. They were pivotal in the development and publication of the Declaration and Charter of Human Rights which was launched in 2005 by Maurice Manning, Irish Human Rights Commission at the National Service Users Conference in Galway (organised by the Brothers of Charity Services Galway) who stated at the time "I am impressed by how clearly it is written and this is not an easy subject for a subject like rights. I hope it finds a place in every school and home. An important thing about this charter is that every single one of the rights is based in fundamental law"

A report from the Service Users' Council is included in the Annual Report of the Brothers of Charity Services each year and their 2006 Report highlighted the following:
Involvement in a number of consultation sessions with groups such as the NFVB and Rehab,
Presentations to students on various courses in NUIG including Clinical Psychology, Speech and Language Therapy and Occupational Therapy,
Attendance at conferences such as People First in Belfast, Inclusion Ireland and the National Advocacy Conference in Limerick,
Attendance at a meeting of the Board of Directors of the Brothers of Charity Services, Galway,
Seeking and acquiring funds to develop an independent advocacy service – funding acquired through Comhairle to employ a fulltime, independent advocate for two years starting in February 2007.
Their plans for 2007 included that more training would be provided for service users and the staff who work with them on human rights issues.

In the Children's Services a parent forum – ACT (Action for Children and Teenagers) was established as a representative group within the Brothers of Charity Services Galway. The group is recognised, supported and funded by the BoCS. The main aim of ACT is to establish a framework for the active involvement of parents as advocates for their children and

teenagers in the decision-making processes of the Brothers of Charity so that the services can better meet their needs.

10.5.7
Expected to be integral to the revised Complaints Process under the Health Act 2004

10.6. Challenging Behaviour
Recommendations
10.6.1
Ongoing in the plans for movement to community settings

10.6.2
An assistant psychologist was recruited to the Psychology Department in August 2007 and is working 3 days a week with the psychologist who is allocated to Kilcornan Centre 3 days a week to provide practical assistance to staff in relation to individuals exhibiting challenging behaviour. As we are undercomplement in the Psychology Department due to a retirement, the recruitment process is almost complete in terms of filling a vacant post which has a 4 day allocation to Kilcornan Centre and the new Clinical Psychologist has a starting date of January 9th 2008 as her graduation is in December 2007.

10.6.3
The Service has not used a Challenging Behaviour Team Model since 2003. Instead, an interdisciplinary approach is being used where various disciplines (nursing, psychology, psychiatry, social work, and on occasion occupational therapy services) work to focus jointly with a service user to intervene and provide a holistic intervention approach. This team approach provides key opportunities for all relevant front line staff to attend case conferences and assist with intervention planning. This then creates an environment where if there is a need to collect data the reasons for this are discussed and agreed at case conferences.

10.7. Service Developments
Recommendations
10.7.1
Ongoing in the plans for movement to community settings.

There has been a continuous drive by the Services to move people from campus settings to community. The numbers of people living in Kilcornan Centre have been reduced from 135 in 1982 to 64 in 2007. 15 more people will move from Kilcornan Centre to the community towards the end of 2007 reducing the numbers to 49 residents in Kilcornan. It is planned over the next two years to move the remaining residents to community locations. The number of people living in the John Paul Centre has been reduced from 55 in 1989 to 35 in 2007.

It is an ongoing priority for the Services to continue the reduction of the number of people living in campus accommodation and to continuously improve the standard of community houses. Housing initiatives, including the establishment of the Peter Triest Housing Association, partnership with the Department of the Environment and the City and County Councils, have supported these objectives. To date 64 people have benefited from the Peter Triest Housing Association and are living in smaller numbers in new houses or in individual apartments. Of the 337 people, who are now either in residential services or in supported living, only 30 still share a bedroom with another resident.

The last number of years saw the establishment and expansion of Family Support Services with a dedicated post of Team Leader and employment of family support workers. The Family Support Service aims to provide flexible services for families and service users within their homes and communities and includes home-sharing, shared care, in-home support, homework support and special holiday projects. In 2006 the Family Support Services moved to new accommodation which enabled the staff to expand the service to families at week-ends and at holiday times. The home sharing service was further developed by the successful recruitment campaign in partnership with the Galway Association (now Ability West) in 2006. In addition funding of €500,000 was acquired through a POBAL grant for the recruitment, training, support and supervision of Contract Families.

The organisation wishes to develop responsive systems which tailor supports to individual needs in relation to where people live and with whom they live. The Strategic Plan 2007 – 2012 Goal 1 (We are committed to building Person Centred Services) Objective 2 states "Individuals have the right to choose where and with whom they live)

- *We will develop a variety of housing options and supported living options which individuals can choose*
- *We will continue to expand options for respite and to explore different models including home sharing, in-home support and extended family support."*

10.7.2
See 10.7.1 above

APPENDIX D

BIBLIOGRAPHY

Department of Education (Circular 17/56) Guidelines Regarding Corporal Punishment, 1956 and 1965

Department of Health (1965) Report of Commission of Inquiry on Mental Handicap

Department of Education (1965) Rules for National Schools

Report of the Committee on Non-Accidental Injury to Children (1976)

Department of Health (1977) Memorandum on Non-Accidental Injury to Children

Department of Health (February 1980) Guidelines on the Identification of Non-Accidental Injury to Children

Department of Education Primary Branch (1981) Circular 9/81 Circular to Boards of Management and Principal Teachers of National Schools: Abolition of Corporal Punishment in National Schools

Department of Education Post-Primary Branch (1982) Circular M5/82 Circular to Managerial Authorities of Post-Primary Schools: Abolition of Corporal Punishment in Schools in respect of Financial Aid from the Department of Education

Department of Education Primary Branch (1982) Circular 9/82 Circular to Boards of Management and Principal Teachers of National Schools: Abolition of Corporal Punishment in National Schools

Department of Health (February 1983) Guidelines on Procedures for the Identification, Investigation and Management of Non-Accidental Injury to Children

UNESCO (1983) Terminology of Special Education

Department of Health (July 1987) Child Abuse Guidelines: Guidelines on Procedures for the Identification, Investigation and Management of Child Abuse

Department of Health (July 1987) Child Abuse Checklist: Checklist to help identification and investigation of Child Abuse; Physical and Sexual

Western Health Board (August 1989) Policy for Management of Child Abuse Cases in the Western Health Board.

The Law Reform Commission (1990) Report on sexual offences against the mentally handicapped

The Child Care Act 1991

Department of Education (October 1991) Guidelines towards a Positive Policy for School Behaviour and Discipline. Circular to Managerial Authorities of Post-primary Schools on Abolition of Corporal Punishment in Schools (Circular M33/91)

Department of Education (November 1991) Procedures for Dealing with Allegations or Suspicions of Child Abuse (National Schools)

Department of Education (June 1992) Procedures for Dealing with Allegations or Suspicions of Child Abuse (Post Primary Schools)

UN Convention on the Rights of the Child (September 1992)

Brother of Charity Services (May 1993) Guidelines for the Investigation and Management of Alleged Incidents of Non-Accidental Injury and Sexual Abuse (implemented November 1993 and updated in Feb 1996)

Department of Education (September 1993) Guidelines on Countering Bullying Behaviour in Primary and Post Primary Schools

Department of Education (1993) Report of the Special Education Review Committee

Western Health Board (June 1998) Child Protection: Child Care Policies and Guidelines

Department of Health (April 1995) Notification of Suspected Cases of Child Abuse between Health Boards and Gardai

Department of Education (1995) Circular 7/95 Procedures for dealing with allegations, made to officials of the Department, of abuse of children by teaching and other staff of schools

Irish Catholic Bishop's Advisory Committee on Child Sexual Abuse by Priests and Religious (1996) Child Sexual Abuse: Framework for a Church Response. Dublin: Veritas

Brother of Charity Services (April 1996) Guidelines & Procedures for the Investigation & Management of Abuse Allegations

Brother of Charity Congregation (October 1997) Protocol for responding effectively to complaints of Child Sexual Abuse

Department of Education and Science (undated) Boards of Management of National Schools: Constitution of Boards and Rules of Procedure

Department of Health (1997) Putting Children First – Promoting and Protecting the Rights of Children

Protection for Persons Reporting Child Abuse Act, 1998

Western Health Board (June 1998) Child Protection: Child Care Policies and Guidelines

Department of Health & Children (September 1999) Children First: National Guidelines for the Protection and Welfare of Children

Enchancing the Partnership (1996) Department of Health and Children

Department of Education and Science (2001) Child Protection: Guidelines and Procedures

McClean Brian (2003) Evaluation Report on Challenging Behaviour Programme at Brothers of Charity Services Kilcornan Centre Clarinbridge Co Galway

HSE Employer Representative Division (May 2005) Trust in Care1066

Consultancy & Healthcare Consultancy Ltd. (2006) An Independent Assessment of Proposals for Future Services at Brothers of Charity Services Kilcornan Centre Clarinbridge Co Galway

Mulvihill B, Murphy P (July 2007) Review of Current Practices for the Protection of Service Users within the Brothers of Charity Services Galway.

A Strategy for Equality: Summary of the Report of the Commission on the Status of People with Disabilities (undated)