



Private and Confidential

**Review of Safeguarding Practice
in the**

Missionaries of the Sacred Heart, Irish Province

**The National Board for Safeguarding Children in the
Catholic Church in Ireland (NBSCCCI)**

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Provincial of the Missionaries of the Sacred Heart, Irish Province**

August 2012

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Preamble

The National Board for Safeguarding Children in the Catholic Church in Ireland (NBSCCCI) was asked by the Sponsoring Bodies, namely the Episcopal Conference, the Conference of Religious of Ireland (CORI) and the Irish Missionary Union (IMU), to undertake a comprehensive review of safeguarding practice within and across all the Church authorities on the island of Ireland. The purpose of the review is to confirm that current safeguarding practice complies with the Standards set down within the guidance issued by the Sponsoring Bodies in February 2009 *Safeguarding Children: Standards and Guidance Document for the Catholic Church in Ireland* and that all known allegations and concerns had been appropriately dealt with. To achieve this task, safeguarding practice in each Church authority is to be reviewed through an examination of case records and through interviews with key personnel involved both within and external to a diocese or other authority. (The methodology employed for the Review is described in detail on the NBSCCCI website [ww.safeguarding.ie](http://www.safeguarding.ie).)

This report contains the findings of the Review of Safeguarding Practice within the Missionaries of the Sacred Heart (MSC) undertaken by the NBSCCCI in line with the request made to it by the Sponsoring Bodies. It is based upon the case material made available to us by the MSC, along with interviews with selected key personnel who contribute to safeguarding within the Society. The NBSCCCI believes that all relevant documentation for these cases was passed to the Reviewers, and the MSC Provincial of the Irish Province has confirmed this.

The findings of the review have been shared with a Reference Group in redacted form before being submitted to the MSC, along with any recommendations arising from the findings. The membership of the Reference Group comprises three eminent and experienced professionals selected for their expertise and objectivity.

Introduction

The National Board for Safeguarding Children in the Catholic Church in Ireland (NBSCCCI) was asked to undertake a review of safeguarding practice in the Irish Province of the Missionaries of the Sacred Heart (MSC). The request was made by the Provincial on behalf of his Provincial Leadership Team (PLT) who came into office on the 1st August 2011. The NBSCCCI accepted the request and began the review almost immediately.

In February of 2009, the Irish Province of the MSC entered into an agreement with the NBSCCCI to comply with and adhere to the content of *Safeguarding Children: Standards and Guidance Document for the Catholic Church in Ireland* which had been adopted by the three sponsoring bodies for the NBSCCCI, namely the Irish Bishop's Conference, the Conference of Religious of Ireland, and the Irish Missionary Union. They did this by signing a Memorandum of Understanding drawn up between the MSC and the NBSCCCI. The review methodology was specifically created to provide information on compliance with these standards.

Up until engaging with the MSC, the NBSCCCI had undertaken reviews in six dioceses. These reports have been published by each of the dioceses involved. This occurred in November of last year (2011). They were positively received by the clergy, staff, volunteers, and lay faithful in each of these dioceses. The NBSCCCI would encourage that this approach should be repeated in respect of all of the Church authorities that participate in the reviews. However, it is a matter solely for the subject of the review to decide upon. The NBSCCCI does not have any authority to release any of the details of the reviews without the prior consent of the subject of that review.

This first review of a religious community made apparent the need for some changes to the review methodology previously employed. The aim remained unchanged but we needed to take account of the fact that structures were different and leadership roles changed regularly in compliance with their constitution. The dispersed nature of the MSC and the fact that their General Council and Superior General were based in Rome, also gave rise to some issues for the reviewers.

The MSC have 56 members living in Ireland and 62 abroad. The Irish Province extends to include England, Russia, parts of the United States, Venezuela, South Africa and Namibia.

Background

In August 2011, the NBSCCCI sought to begin the review of safeguarding practice requested by the MSC. Within a day, this process was suspended as reading the case files had quickly brought to light a number of very worrying situations involving the alleged abuse of children. It further appeared that some of these had not been reported to the appropriate authorities, namely the Garda Síochána and the Health Service Executive (HSE). This fact was shared with the new ¹Provincial and also with his incoming PLT. All confirmed that they had up until then been unaware of the content of the case files and did not know the detail of the allegations recorded within them.

The need to report the allegations without further delay to the statutory authorities was recognised as paramount. To that end, immediate contact was made with both the Children's Services directorate of the HSE and with the National Bureau of Criminal Investigation (NBCI), Garda Síochána. This resulted in both statutory agencies responding to the situation and engaging with the MSC and the NBSCCCI. It was agreed that the scale and nature of the inquiries to be undertaken could best be progressed under the leadership of the HSE invoking the powers which they held under Section 3 of the Child Care Act. To that end, the NBSCCCI participated in a series of meetings under the chairmanship of the HSE to which a report on the progress of their work with the MSC was given. They undertook this role with the agreement of the Provincial and his PLT.

The Gardaí have the power and a specific responsibility to investigate crime. The initial reading of the files had indicated that allegations of abuse had not been passed on to them as would have been expected within the Church. To allow them to inquire into these matters fully, the Gardaí took possession of all of the case records held within the MSC that related to safeguarding matters. This was done on a consent basis by the Provincial and he was supported in that by his PLT.

The NBSCCCI had initially engaged with the MSC to undertake a review and to employ the methodology that it had devised to confirm compliance with the *Safeguarding Children: Standards and Guidance Document for the Catholic Church in Ireland*. As a consequence of what had come to light, it was agreed that the immediate need was for an investigation aimed at providing the new leadership with an assessment of the safeguarding practice followed to date, and a series of recommendations that were to be implemented immediately to address the situation. The investigation would also seek to confirm what allegations had been received and what actions, if any, had been taken in respect of these. In this way, the exact number of individuals who were thought to be a risk to children could be identified and an immediate review of their present situation confirmed.

At the request of the MSC provincial, the NBSCCCI worked in partnership with the statutory authorities throughout the "Section 3 Inquiry" process. It also produced a report commenting on the management of child protection cases within the Irish

¹ The Provincial took up office on August 1st 2011

Province of the MSC and supplied that to provincial. This report drew four conclusions highlighting the unacceptably poor practice of the MSC which needed to be addressed without delay.

The report contained seven recommendations for the PLT to address as a matter of urgency. It was agreed that until this was done, it would not be helpful to undertake a review of safeguarding practice employing the agreed methodology. For that reason, the NBSCCCI agreed to postpone the full review for a further period to allow these recommendations to be acted upon and for the changes to be bedded down before being subject to further scrutiny.

Continued full co-operation with the statutory authorities was required along with the appointment of a suitably qualified and experienced lay person to take the role of safeguarding delegate for the MSC. This person's sole responsibility would be safeguarding children.

The investigation report was submitted to and accepted by the Provincial who, supported by his PLT, has applied himself diligently to implementing each of the recommendations. This was not seen as a simple task as it involved seeking to change the culture that had grown up within the MSC. Matters that had previously been dealt with in a covert way would now be subject to scrutiny and compliance with agreed policies and practice. Inevitably this would involve challenge but it is very much to the credit of the current PLT that they appear to have not wavered in their determination to deal fairly and effectively with all concerns that are shared with them. Risk assessments have been completed on all the alleged and known offenders with the support of the HSE. Risk management plans have been implemented in respect of these individuals. It is also understood that the Gardaí are close to concluding their inquiries into the allegations of abuse relating to members of the MSC in the Irish Province.

The investigation report in full follows.

Report into the Management of Child Protection within the Irish Province of the Missionaries of the Sacred Heart

Executive Summary

This report presents the findings of an investigation undertaken by the National Board for Safeguarding Children in the Catholic Church in Ireland (NBSCCCI) into the management of child protection concerns communicated to the Missionaries of the Sacred Heart (MSC) in Ireland. The investigation was primarily records based but was supplemented by interviews with survivors, and members of the current leadership team. A total of seventeen members were identified and their case records made available for review. The content of the records was largely unknown to the present leadership team who came into post at the start of August this year. As a consequence, the investigation brought to light matters that showed that the Society in the past had failed to take action to protect vulnerable young children and had allowed those who caused harm to them to avoid being held accountable by statutory agencies by not passing critical information to the Garda Síochána or the Health Services Executive. In particular, attention was focussed on alleged abuse within a secondary boarding school in the Cork area. Such actions are contrary to Church guidance and are currently the subject of investigations by the state authorities.

Please note that almost all the allegations referred to in this report are not proven and this report makes no determination as to their veracity. Where admissions are recorded as having taken place this is noted. One conviction has already taken place of a priest who worked within the school referred to and a custodial sentence served.

Background to the Investigation by the NBSCCCI

1. On the 26th July 2011 a Senator named a priest whilst participating in a debate in the Oireachtas as having allegedly been involved in the abuse of children. At the time, he was speaking within the Senate and was therefore subject to Oireachtas privilege. The matter received considerable media attention and the following day the Society issued a press release in which they stated that all allegations known to them had been reported to the statutory authorities. Although those issuing the release state that they believed that this was true, it is now regretted and understood to not be the case.
2. An invitation was made to the NBSCCCI to undertake a review of their known cases by the Society. The original request was for a review to take place in line with those already undertaken in a number of dioceses. This would concentrate on current safeguarding practice and the management of risk. The belief was that this would quickly establish that the Society was compliant with Church guidance and that all relevant information concerning known abuse had been passed on to the Church and state authorities. Full co-operation

was promised and given to the review with access to all files and related documentation.

3. On Monday 15th August the review began on site at the Province's administrative headquarters at 65 Terenure Road West, Dublin. The case files were made available for reading along with other summaries and notes that had been recently produced by the administrative staff within the Society. In a very short period of time, it became clear that the files contained records of admissions by priests to alleged abuse with no indication that these admissions had been passed on to the appropriate authorities of the Garda Síochána or the HSE. It was also clear that important gaps existed in the case records. Documentation that related to important meetings was not in the files. This made it impossible to understand why decisions had been taken.
4. After consultation with the new Provincial, it was agreed that the NBSCCCI would suspend the review for a period of a week to allow the Society to undertake a search for the missing records. Letters were sent to past Provincials asking if they could assist in securing any of the missing documentation. Also a comprehensive search of all existing records within the Society's administrative centre was undertaken. Both these initiatives proved to be unsuccessful in turning up any additional records. After this period, it would review all of the files as quickly as possible and report its findings to the Society, and to the state authorities who had already been put on notice of the developing situation by the NBSCCCI. After the week no new records were found and it was decided that an investigation would be undertaken, putting the review on hold until it had been completed.
5. A meeting involving the National Director of Children's Services in the HSE, Detective Superintendent of the National Bureau for Criminal Investigation, and the Chief Executive Officer of the NBSCCCI took place on the 19th August at which it was agreed that the matters brought to light within the MSC through the work of the NBSCCCI with the full support of the present leadership team of the Province, should be responded to through the mechanism of a "Section 3 Inquiry." An Inquiry of this nature may be set up under part of the Child Care Act of 1991 that provides the opportunity for the key statutory agencies to work together in the light of particular circumstances to ensure the wellbeing of vulnerable children. The responsibility for convening and leading the Inquiry would lie with the HSE. It was thought that the possibility of hitherto unreported abuse which we had focused on would constitute suitable grounds for such an inquiry to be held.
6. As more information has emerged regarding the number of alleged perpetrators involved and the frequency of the abuse, the response from each agency has been developed further. Specific complaints have been made to the Garda Síochána which has meant that grounds exist for them to undertake a formal investigation which is now underway.

The Review of Case Material held by the Missionaries of the Sacred Heart

1. The MSC co-operated fully with our request to read all available documentation in respect of identified alleged abusers within it. The case files record that a total of seventeen alleged perpetrators were known to the Society. The total number of victims has not been established and is growing through new complaints being received. Of these alleged perpetrators, nine had made admissions to the abuse to varying degrees. One of these has died and three others have left the Society. None of them currently minister as priests. In some cases, when asked if they had abused a child they not only confirmed that they had but added the names of other children that they could also recall abusing. In one particular case, this admission includes details of the form of abuse and also the frequency. There is no record that any of this critical information was passed on to the Garda Síochána or to the HSE. There is also little evidence that any appropriate preventative actions were taken by the Society in respect of some of these members.
2. Of the known seventeen alleged perpetrators identified, six of them are known to have worked within the secondary boarding school, although not all at the same time. The main alleged abuse involved three members that were part of the staff there for several years. In respect of one of these members there are also allegations of abuse in another setting that he was associated with.
3. The MSC also ran a boarding school in England which was apparently highly regarded. Allegations emerged against one MSC there, who had been attached to the boarding school in Cork several years earlier. This MSC subsequently moved on to minister in a diocese in the Irish midlands, where further allegations were received against him. These were reported by the diocese to the Garda Síochána, & he was prosecuted, convicted, & served a custodial sentence. He has now left the priesthood.
4. Within the files, records exist which indicate that members in positions of leadership in the Society were aware that abuse had been admitted to by particular members. There are also records of correspondence with the Garda Síochána in respect of these members in which no reference is made to their admission to the alleged abuse. The practice would appear to be that when an allegation had been received in respect of an identified member, when it was passed on to the Garda Síochána it would not be accompanied with any other information even where it was known that the abuse had already been admitted to. The response by the Garda Síochána would have been hindered by this lack of information.
5. The picture that emerges from the files is that important child protection information that was held by the Society was not passed on to those who

needed to know it. As a consequence it was not taken account of by them. This failure to communicate was not only directed at the Garda Síochána or the HSE but also applied within the Society itself. As a result, a misleading impression held currency amongst members of the Society as to what the true incidence of abuse allegations was. Their awareness bore no relation to the true situation that existed.

6. Gaps are present within the files that make it difficult to understand why an alleged perpetrator, who was taken out of ministry at one time, was then allowed back into ministry at a later date. These deficits are all the more remarkable when you consider the diligence with which other matters are recorded both in the files and elsewhere in the records. There is also at least one example of critical information about a priest who had admitted to abusing children within the school, not being passed on to another Church authority for whom he was intending to work.
7. Records show that one priest had admitted to abuse and further to this admission named a number of other boys he had harmed but this information was not passed on to the Garda Síochána at that time. The full extent of the Society's knowledge of this priest's admissions was not given to an Garda Síochána prior to August 2011.
8. The suffering of victims has on occasions caused them to engage in self-harming. There is a record of one young man who died by suicide where it is noted in the files that the abuse that he suffered was seen as a contributing factor if not the main cause of his death.
9. It is not clear from the case records that sufficient attempts were made to respond to victims in a pastoral way. There is reference within the records to the need to respond robustly to any allegation and communicate a willingness to resist any claims made by victims. This response was experienced by victims as uncaring and aggressive. It contributed to a sense of intimidation being felt by at least one victim who was advised that legal action would be initiated if he persisted with his allegation.

Assessment of Child Protection Practice

1. The practice of the Society was deeply flawed. It failed to take account of admissions by perpetrators by passing them on to the appropriate authorities. It even failed to alert other Church authorities of the risks posed by identified individuals.
2. People in positions of leadership failed to discharge their responsibilities to protect vulnerable young people who would come in contact with members against whom credible allegations had been made or who had admitted to abuse. They appeared to maintain a culture of secrecy which allowed known abusers to continue to live within the community without the full extent of the suffering that they had caused to vulnerable young people being known by their fellow members.
3. There was no adequate attempt made by anyone to manage risk that was known to exist relating to the placement of offending members in the society. Other members with whom they would have contact were not even informed of the fact that they were a risk.
4. The child protection guidance in place within the Church and the Society's own policies were not adhered to or complied with except in a nominal way. For example, an Advisory Panel did exist for several years but in at least one case in 2004 critical information regarding the past history of an alleged offender was not shared with it, and a decision was made that the Garda Síochána would not be informed of new concerns about him on that occasion as this could lead to an investigation that may disrupt the running of the school in which he had worked

Conclusions

1. It is difficult to express adequately the failure of this Society to effectively protect vulnerable children. Their actions indicate a disregard for the suffering of victims and a misunderstanding of the nature of the problem within the Society.
2. As a result of the abuse that should have been prevented, it is reasonable to speculate that a great deal of suffering has occurred. In the assessment of the NBSCCCI it could have been prevented but those who should have taken action to prevent it either chose not to do so or were effectively blocked from doing so by a wall of secrecy which did not permit child protection information to be shared. This worked very much in the favour of those who had caused harm to children and wanted to continue to prey upon them.
3. People who were aware that abuse had been admitted to saw no need to report that fact to the Garda Síochána. The internal communication that took place with the Superior General in Rome, we are told, was verbal in nature and not recorded. Although it seems extraordinary that such serious matters should be dealt with in such an informal way, this must be seen as yet another example of the lack of understanding that existed in this Society and that what they were dealing with actually mattered very much.
4. Two basic principles underpin the current Church safeguarding policies in force in the Catholic Church in Ireland today. They are that children should be protected from harm and those that cause harm to them or allow it to happen, should be held accountable for their actions. The investigation of the child protection practice in this religious community is an excellent example of why those principles are now in place in the Church in Ireland, and why they must be adhered to by everyone within the Church without exception.

Recommendations

1. The Society should continue to co-operate fully with the current Garda investigation into the abuse for which they are holding complaints. All supporting information should be shared with the Garda Síochána fully and in a manner that facilitates the successful completion of their task.
2. Risk management plans should be created in consultation with the HSE in respect of all known members against whom a credible allegation has been made or who has admitted to the abuse of a child.
3. A new delegate should be appointed who has the necessary skills, knowledge and experience to provide support to the new leadership team as they seek to address the matters that have been brought to light through this investigation.
4. The needs of victims must be prioritised by the Society and ways sought to reach out to them to provide redress and support.
5. A coherent and “fit for purpose” safeguarding framework for the Society must be created which includes policies and procedures that are fully compliant with those endorsed by the Church in Ireland, namely the *Safeguarding Children: Standards and Guidance for the Catholic Church in Ireland*.
6. Notification to the Congregation for the Doctrine of the Faith (CDF) should take place in respect of all members that are the subject of credible allegations of sexual abuse with a view expressed as to how the Society should seek to deal with the matter.
7. A date should be agreed at which a review of the implementation of these recommendations will be undertaken by the NBSCCCI.

Signed: 

Ian A. Elliott
Chief Executive Officer
National Board for Safeguarding Children,
Catholic Church in Ireland

Date: November 2011

Review as re-commenced in May 2012

STANDARDS

This section provides the findings of the review, which took place following the initial investigation previously referred to. The template employed to present the findings are the seven standards, set down and described in the Church's *Safeguarding Children: Standards and Guidance Document for the Catholic Church in Ireland*. This guidance was launched in February 2009 and was endorsed and adopted by all the Church authorities that minister on the island of Ireland, including the MSC. The seven standards are:

Standard 1 A written policy on keeping children safe

Standard 2 Procedures – how to respond to allegations and suspicions in the Republic of Ireland and Northern Ireland

Standard 3 Preventing harm to children:

- recruitment and vetting
- running safe activities for children
- codes of behaviour

Standard 4 Training and education

Standard 5 Communicating the Church's safeguarding message:

- to children
- to parents and adults
- to other organisations

Standard 6 Access to advice and support

Standard 7 Implementing and monitoring the Standards

Each standard contains a list of **criteria**, which are indicators that help decide whether this standard has been met. The criteria give details of the steps that a Church organisation - diocese or religious order - needs to take to meet the Standard and ways of providing evidence that the standard has been met.

Standard 1

A written policy on keeping children safe

Each child should be cherished and affirmed as a gift from God with an inherent right to dignity of life and bodily integrity, which shall be respected, nurtured and protected by all.

Compliance with Standard 1 is only fully achieved when the subject of the review meets the requirements of all nine criteria against which the standard is measured.

Criteria

Number	Criterion	Met fully or Met partially or Not met
1.1	The Church organisation has a child protection policy that is written in a clear and easily understandable way.	Met partially
1.2	The policy is approved and signed by the relevant leadership body of the Church organisation (e.g. the bishop of the diocese or provincial of a religious congregation).	Met fully
1.3	The policy states that all Church personnel are required to comply with it.	Met partially
1.4	The policy is reviewed at regular intervals no more than three years apart and is adapted whenever there are significant changes in the organisation or legislation.	Met fully
1.5	The policy addresses child protection in the different aspects of Church work e.g. within a church building, community work, pilgrimages, trips and holidays.	Met partially
1.6	The policy states how those individuals who pose a risk to children are managed.	Not met
1.7	The policy clearly describes the Church's understanding and definitions of abuse.	Met fully
1.8	The policy states that all current child protection concerns must be fully reported to the civil authorities without delay.	Met fully
1.9	The policy should be created at diocese or congregational level. If a separate policy document at parish or other level is necessary this should be consistent with the diocesan or congregational policy and approved by the relevant diocesan or congregational authority before distribution.	Met partially

Over the course of the last year, and particularly since the appointment of the lay delegate, considerable effort has gone in to trying to create a range of new policies to address the gaps that previously existed in the safeguarding policy framework for the MSC. This effort is to be commended. However, it must also be noted that the MSC committed themselves to compliance with the *Safeguarding Children: Standards and Guidance Document for the Catholic Church in Ireland* in February of 2009. It is disappointing to find that there are still significant gaps in the policies available to members of the MSC so long after this commitment was given.

Recommendation 1: The Provincial ensures that the work currently being undertaken by the designated person to produce policies for the safeguarding of children is supported and brought to a conclusion.

It is recognised that a great deal of effort has already been invested by the MSC to address the situation that came to light in August 2011, reviewing and improving the existing policy framework to ensure that it complies fully with the *Safeguarding Children: Standards and Guidance Document for the Catholic Church in Ireland* must be seen as a priority. This should include liaison with the statutory authorities along with the NBSCCCI.

It should also be noted that the previous unacceptable practice that existed within the MSC cannot be fully explained by a lack of policies. A willingness to ensure that all that can be done to safeguard children is also necessary. The implementation of and compliance with policies requires a change in the attitude towards and understanding of the need to protect children by the elimination of risk. If an individual is thought to be a risk to children, that risk must be fully and promptly reported to the statutory authorities and the person posing the risk must be supervised. Although the policy and procedures may not yet be fully completed, it is accepted that they are needed and full implementation across the Irish Province of the MSC will be prioritised by the current Provincial, his PLT, and the lay designated person.

Standard 2

Management of allegations

Children have a right to be listened to and heard: Church organisations must respond effectively and ensure any allegations and suspicions of abuse are reported both within the Church and to civil authorities.

Compliance with Standard 2 is only fully achieved when the subject of the review meets the requirements of all seven criteria against which the standard is measured.

Criteria

Number	Criterion	Met fully or Met partially or Not met
2.1	There are clear child protection procedures in all Church organisations that provide step-by-step guidance on what action to take if there are allegations or suspicions of abuse of a child (historic or current).	Met partially
2.2	The child protection procedures are consistent with legislation on child welfare civil guidance for child protection and written in a clear, easily understandable way.	Met fully
2.3	There is a designated officer or officer(s) with a clearly defined role and responsibilities for safeguarding children at diocesan or congregational level.	Met partially
2.4	There is a process for recording incidents, allegations and suspicions and referrals. These will be stored securely, so that confidential information is protected and complies with relevant legislation.	Met fully
2.5	There is a process for dealing with complaints made by adults and children about unacceptable behaviour towards children, with clear timescales for resolving the complaint.	Met fully
2.6	There is guidance on confidentiality and information-sharing which makes clear that the protection of the child is the most important consideration. The Seal of Confession is absolute.	Met partially
2.7	The procedures include contact details for local child protection services e.g. (Republic of Ireland) the local Health Service Executive and An Garda Síochána; (Northern Ireland) the local health and social services trust and the PSNI.	Met fully

Table 1

Table of incidence of Safeguarding allegations received within the Missionaries of the Sacred Heart from 1st January 1975 to date. (21st May 2012)

1	Number of religious in the Missionaries of the Sacred Heart against whom allegations have been made since 1 st January 1975 to date.	17
2	Number of allegations reported to An Garda Síochána involving religious of the Society since 1 st January 1975.	61
3	Number of allegations reported to the HSE (or the Health Boards which preceded the setting up of the HSE) involving religious of the Society since 1975.	61
4	Number of religious against whom an allegation was made & who were living at the date of the review.	11
5	Number of religious against whom an allegation was made & who are deceased.	6
6	Number of religious against whom an allegation was made & who are “Out of Ministry” or who have left the Society.	10
7	Number of religious of the Society who have been convicted of having committed an offence or offences against a child or young person since the 1 st January 1975.	1
8	Number of religious against whom an allegation was made who are in ministry or retired.	1

Reporting:

Since September 2011, An Garda Síochána have been made aware of all cases known to the MSC.

Only a few cases were reported to the HSE when they became known to the MSC. Nearly all cases were reported to the HSE in a composite report sent in Jan. 2010. Other cases were sent in block to the HSE in July 2011. A second composite report was sent to the HSE with all cases included in Sep. 2011, as part of the Section 3 investigation. The deficit in reporting to the HSE has now been fully rectified.

The MSC have experienced a high number of allegations in relation to their members. They were involved in schools for a long period and as a consequence a number of allegations arose from incidents within those settings.

It is clear that since the initial engagement with the MSC last year (2011), considerable efforts have been made to address the poor practice that took place previously. All the

information that was held on individuals has been passed on to the statutory authorities and attempts have been made to ensure that all areas of risk are assessed and managed. This is to be commended and is in sharp contrast to the practice which pre-dated 2011. The reviewers strongly wish to state that the situation that existed prior to August of last year should never have been allowed to happen. It could only do so if the guidance and policies agreed by the Church as a whole were being ignored. This appeared to be the case.

Assessing Risk:

The safeguarding structure advocated within the earlier guidance of the Church involved the creation of an Advisory Panel and the appointment of a designated person to take responsibility for the co-ordination and management of allegations when they emerged. Although this structure existed, it is clear that prior to 2011 the safeguarding framework did not perform well. A contributing factor may have been deficits in information sharing within the MSC; there appeared to be a culture of restricting the number of individuals who would be aware of an allegation having been received against a member. This restriction meant that on occasions those who should have been aware of risk were not informed and therefore it was not properly assessed or managed. This fact was confirmed by members of the PLT who reported that they were not aware of which members were in “good standing” and which were “out of ministry”. It also led to a situation where the community as a whole had no real idea as to what the reality was in respect of the behaviour of a number of their fellow members. This covert approach, within the Society, made the task of opening up the problem more difficult and challenging for the present Provincial and his PLT.

When the NBSCCCI first engaged with the MSC in August of 2011 it was stated that none of the previous or incoming PLT had read the case files which existed at that time. Therefore, any knowledge that they had as to the volume of cases or the nature of risk was rudimentary and partial. It was based on anecdotal knowledge. This is considered totally unacceptable and represented a situation that should never have been allowed to exist.

Recommendation 2: The Provincial and all members of his PLT should ensure that all who hold safeguarding responsibilities, including the PLT and Community leadership teams have a sound working knowledge of the cases that are being managed within each community. This information should be current through regular briefings from the designated person with particular emphasis on the compliance of any members that are subject to risk management plans.

Recommendation 3: When the Provincial and his PLT are coming to the end of their term of office they should ensure that the incoming leadership team are fully briefed on all of the cases that are held in the community. A written protocol should be created by the existing PLT, to ensure that this practice becomes part of the safeguarding practice of the MSC community as a whole.

Information Sharing:

Another important aspect of the inadequacy of the sharing of information involved the relationship between the Provincial and the Superior General who is based in Rome. Since 2001 within the Church, the Congregation for the Doctrine of the Faith (CDF) has taken responsibility for responding to incidents of clerical abuse. All Church authorities carry a responsibility to notify all credible allegations to the CDF when they emerge. In the Irish Province of the MSC, no reports had been made to the CDF, in spite of the MSC Society receiving a number of allegations. Upon investigation of this it was discovered that when an allegation was reported to the Provincial, it would be discussed with the Superior General and they would then decide as to whether the information should be passed on to the CDF in line with the directive issued in 2001. These discussions were not recorded and therefore no confirmation of their existence or content was available to the review. It is however remarkable and completely unacceptable that matters of such a serious nature should be dealt with by means of a discussion of which there is no agreed written record.

Recommendation 4: The Provincial should ensure that all credible allegations should be reported to the Superior General in writing with an expectation that they will be passed on to the CDF in line with current Church guidance. A copy of the papers submitted to the CDF should be held on file within the Irish Province. Where it is decided that an allegation does not warrant submission to the CDF this fact should be recorded along with the reasons as to why that decision was taken. A record should be placed on the case file and should be available for review.

Recent Practice:

This situation changed dramatically in 2011 when a new approach was initiated led by the incoming Provincial with the support of his PLT. They sought to engage with the entire MSC community and ensured that no matter how painful or difficult it might be, the members had to know the reality and extent of allegations against the members. The Society as a whole needed to accept collective responsibility for addressing the shortcomings of the past and placing the safeguarding of children at the top of their community's agenda. A number of site visits were undertaken by the Provincial who sought to engage all the members directly in dialogue. Meetings took place, whereby honest discussions about the situation that they found themselves in, were held, with a commitment sought to address it fully.

As part of this process of change, a new Advisory Panel has been created. The new members have relevant experience and expertise to assist and support the Provincial in ensuring best assessment and management of risk, and appropriate responses to allegations of abuse. Like any newly formed group, it will take time for the panel to become entirely comfortable within its role. It is important that it receives support and is allowed to develop its competence. Independent assistance in this regard has already been provided by the NBSCCCI who will remain available to them should they require it. In addition the MSC have joined the National Case Management Reference Group (NCMRG). This is an initiative recently set up by the NBSCCCI. It aims to provide advice and guidance to any bishop or religious provincial on how they should respond to a safeguarding matter and to the assessment and management of risk.

The MSC have also appointed a new lay designated person who is experienced with relevant professional expertise. An encouraging start has already been made on establishing a strategy for safeguarding, which includes structure, personnel, policies and procedures and importantly in the creation of a culture which places safeguarding children at centre stage. A schedule has been agreed with regard to addressing all the deficits in policy and procedures.

Recommendation 5: The Provincial and his PLT must ensure that continued support is given to the designated person in developing a comprehensive policy and practice framework for the MSC within a set time scale. Regular briefings should be given by the designated person to the PLT with particular emphasis on the identification of any new allegations and the compliance of respondent members to existing risk management plans.

It is important that the designated person works co-operatively with the HSE and with the Garda Síochána as well as the NBSCCCI. Good working relationships have already been established with all three agencies, which must continue as part of developing an open culture of safeguarding children.

Standard 3

Preventing Harm to Children

This standard requires that all procedures and practices relating to creating a safe environment for children be in place and effectively implemented. These include having safe recruitment and vetting practices in place, having clear codes of behaviour for adults who work with children and by operating safe activities for children.

Compliance with Standard 3 is only fully achieved when the subject of the review meets the requirements of all twelve criteria against which the standard is measured. These criteria are grouped into three areas, safe recruitment and vetting, codes of behaviour and operating safe activities for children.

Criteria – safe recruitment and vetting

Number	Criterion	Met fully or Met partially or Not met
3.1	There are policies and procedures for recruiting Church personnel and assessing their suitability to work with children.	Met fully
3.2	The safe recruitment and vetting policy is in line with best practice guidance.	Met fully
3.3	All those who have the opportunity for regular contact with children, or who are in positions of trust, complete a form declaring any previous court convictions and undergo other checks as required by legislation and guidance and this information is then properly assessed and recorded.	Met fully

Criteria – Codes of behaviour

Number	Criterion	Met fully or Met partially or Not met
3.4	The Church organisation provides guidance on appropriate/expected standards of behaviour of, adults towards children.	Met fully
3.5	There is guidance on expected and acceptable behaviour of children towards other children (anti-bullying policy).	Met fully
3.6	There are clear ways in which Church personnel can raise allegations and suspicions about unacceptable behaviour towards children by other Church personnel or volunteers ('whistle-blowing'),	Not met

	confidentially if necessary.	
3.7	There are processes for dealing with children’s unacceptable behaviour that do not involve physical punishment or any other form of degrading or humiliating treatment.	Met fully
3.8	Guidance to staff and children makes it clear that discriminatory behaviour or language in relation to any of the following is not acceptable: race, culture, age, gender, disability, religion, sexuality, or political views.	Met fully
3.9	Policies include guidelines on the personal/ intimate care of children with disabilities, including appropriate and inappropriate touch.	Met partially

Criteria – Operating safe activities for children

Number	Criterion	Met fully or Met partially or Not met
3.10	There is guidance on assessing all possible risks when working with children – especially in activities that involve time spent away from home.	Met fully
3.11	When operating projects/ activities children are adequately supervised and protected at all times.	Met fully
3.12	Guidelines exist for appropriate use of information technology (such as mobile phones, email, digital cameras, websites, the Internet) to make sure that children are not put in danger and exposed to abuse and exploitation.	Met fully

In June 2010 the PLT approved a document entitled “*Safeguarding Children*”. It set out the policy framework for preventive practice in the MSC community. It meets many of the expectations that would be held regarding the content of any safeguarding practice manual. It is also currently being revised and further developed by the designated person working along with a number of others.

Compliance with these policies is essential but they must also be accompanied by sensitivity to the vulnerability of children and their need to be protected. Creating a culture of safeguarding is helped by the existence of policies to underpin practice but it must also include a sense of abhorrence at the abuse of a child. This should ensure that compliance with these policies is not seen as a bureaucratic inconvenience but rather an essential task that is entirely in line with the foundational gospel principles upon which the community is based.

Standard 4

Training and Education

All Church personnel should be offered training in child protection to maintain high standards and good practice.

Criteria

Number	Criterion	Met fully or Met partially or Not met
4.1	All Church personnel who work with children are inducted into the Church's policy and procedures on child protection when they begin working within Church organisations.	Met partially
4.2	Identified Church personnel are provided with appropriate training for keeping children safe with regular opportunities to update their skills and knowledge.	Met partially
4.3	Training is provided to those with additional responsibilities such as recruiting and selecting staff, dealing with complaints, disciplinary processes, managing risk, acting as designated person.	Met partially
4.4	Training programmes are approved by the National Board for Safeguarding Children and updated in line with current legislation, guidance and best practice.	Met partially

It is critically important that training is provided to those who play a part in the safeguarding of children within the community. In essence, this means all members who are involved through their contact with children or because they live with a member who has been accused of abuse and who may present a risk to children. There are a number of members who are in daily contact with children through their ministry. Most members in Ireland live in communities where there are individuals who would be assessed as being a risk to children.

In the past, it would appear to be the case that there was a limited understanding of the phenomenon of child sexual abuse. In particular, the impact of the abuse on the victim and the addictive nature of the behaviour were poorly understood. This led to situations where individuals who were thought to have abused a child were sent for treatment to centres run by the Church. After a period of treatment, they were then optimistically often viewed as having overcome their difficulties. Experience showed that this frequently was not the case.

While awareness raising training has taken place (provided by the NBSCCI and other expert sources) further training should be provided that deepens the understanding particularly of those in leadership of the impact of child sexual abuse on victims. This will help to facilitate the process of change that is required to put in place a safeguarding culture within the community.

In addition regular training, appropriate for the role, should be provided to those in leadership (at Provincial and Congregational level) and others with specific responsibility for safeguarding.

Recommendation 6: The Provincial must ensure that training aimed at deepening the understanding of all those involved in leadership within the MSC of the impact of clerical abuse on victims should be provided.

Diligent attempts have been made to put in place risk management plans that are aimed at the prevention of further abuse by any identified offenders. It is disappointing to find that some of the members within the community are alleged to have offended on several occasions against children. This information places an emphasis on the importance of ensuring that the nature of offending behaviour is understood by those charged with the responsibility of managing it within the MSC. In particular, the Superiors in each of the main centres for the MSC must develop a working knowledge of offending behaviour and must also ensure that they have an understanding of the allegations made against anyone that resides in their centre.

Recommendation 7: The Provincial with the support of the designated person should seek to make available relevant training to the Superiors based in each of the main residences of the MSC, on all aspects of safeguarding and on the management of offenders.

The new designated person has initiated regular meetings with the Superiors to receive and give briefings in respect of any of the individuals who are subject to risk management plans. This development is to be commended and appears to be working well.

The role of the Provincial is critical in the creation of and development of a safeguarding culture in the community of the MSC. Apart from decision making in cases, the Provincial is central to establishing a child friendly environment in all aspects of the practice of the MSC. It is important that an effective framework for safeguarding is created by the Provincial which is based on delegation of the tasks involved in safeguarding. There is a danger that the present Provincial becomes too involved and fails to stand back from tasks that could be undertaken by the designated person or by the Advisory Panel. This stems, undoubtedly from a desire to ensure that the bad practice of the past is not repeated, but care must be taken to ensure that adequate space is given to individuals and groups who are part of the safeguarding framework to grow into and develop their roles effectively.

Recommendation 8: The Provincial should seek advice and guidance with regard to the setting of boundaries between his role and those of the designated person, the Advisory Panel, and all others involved in the safeguarding structure.

Standard 5

Communicating the Church's Safeguarding Message

This standard requires that the Church's safeguarding policies and procedures be successfully communicated to Church personnel and parishioners (including children). This can be achieved through the prominent display of the Church policy, making children aware of their right to speak out and knowing who to speak to, having the Designated Person's contact details clearly visible, ensuring Church personnel have access to contact details for child protection services, having good working relationships with statutory child protection agencies and developing a communication plan which reflects the Church's commitment to transparency.

Criteria

Number	Criterion	Met fully or Met partially or Not met
5.1	The child protection policy is openly displayed and available to everyone.	Met fully
5.2	Children are made aware of their right to be safe from abuse and who to speak to if they have concerns.	Met fully
5.3	Everyone in Church organisations knows who the designated person is and how to contact them.	Met fully
5.4	Church personnel are provided with contact details of local child protection services, such as Health and Social Care Trusts / Health Service Executive, PSNI, An Garda Síochána, telephone helplines and the designated person.	Met fully
5.5	Church organisations establish links with statutory child protection agencies to develop good working relationships in order to keep children safe.	Met fully
5.6	Church organisations at diocesan and religious order level have an established communications policy which reflects a commitment to transparency and openness.	Met partially

Reference has already been made in this report as to the breakdown in communication that existed within the MSC and how this contributed to false perceptions as to what the reality was. An example of this was a statement to the media released in 2011 by the incoming Provincial with regard to the fact that all known allegations had been reported to the appropriate authorities. This statement was made in the belief that this was the case, but it was in fact untrue. This example is quoted to illustrate the importance of ensuring that openness and transparency also requires accuracy or else credibility will be destroyed.

There is a very different approach now evident within the Irish Province of the MSC. This fact should be communicated widely to ensure that a correct perception is formed of the practice of safeguarding within the MSC today. In order to ensure that this occurs, the Provincial supported by his PLT, should ensure that the findings of this review are communicated to the clergy, supporters, and staff of the MSC.

Recommendation 9: The Provincial must ensure that a communications plan is developed for the MSC which include the approach that will be taken to sharing the Review findings widely amongst the MSC community and their supporters.

Standard 6

Access to Advice and Support

Those who have suffered child abuse should receive a compassionate and just response and should be offered appropriate pastoral care to rebuild their lives.

Those who have harmed others should be helped to face up to the reality of abuse, as well as being assisted in healing.

Criteria

Number	Criterion	Met fully or Met partially or Not met
6.1	Church personnel with special responsibilities for keeping children safe have access to specialist advice, support and information on child protection.	Met fully
6.2	Contacts are established at a national and/ or local level with the relevant child protection/ welfare agencies and helplines that can provide information, support and assistance to children and Church personnel.	Met fully
6.3	There is guidance on how to respond to and support a child who is suspected to have been abused whether that abuse is by someone within the Church or in the community, including family members or peers.	Met fully
6.4	Information is provided to those who have experienced abuse on how to seek support.	Met partially
6.5	Appropriate support is provided to those who have perpetrated abuse to help them to face up to the reality of abuse as well as to promote healing in a manner which does not compromise children's safety.	Met fully

The Provincial and his designated person have strived hard to establish good access to advice and support from the statutory agencies and also from the NBSCCCI. The MSC have joined the National Case Management Reference Group (NCMRG) which is an initiative recently set up by the NBSCCCI. It aims to provide advice and guidance to any bishop or religious provincial on how they should respond to a safeguarding matter and to the assessment and management of risk.

Within the MSC, the appointment of a lay designated person with relevant experience and professional expertise is very helpful. This person ensures that advice is accessible to any member of the MSC from within their own structure.

Recommendation 10: The Provincial and his PLT should ensure continued membership of the NCMRG, along with appropriate liaison with the statutory authorities directly involved in the safeguarding of children.

Standard 7

Implementing and Monitoring Standards

Standard 7 outlines the need to develop a plan of action, which monitors the effectiveness of the steps being taken to keep children safe. This is achieved through making a written plan, having the human and financial resources available, monitoring compliance and ensuring all allegations and suspicions are recorded and stored securely.

Criteria

Number	Criterion	Met fully or Met partially or Not met
7.1	There is a written plan showing what steps will be taken to keep children safe, who is responsible for implementing these measures and when these will be completed.	Met partially
7.2	The human or financial resources necessary for implementing the plan are made available.	Met fully
7.3	Arrangements are in place to monitor compliance with child protection policies and procedures.	Not met
7.4	Processes are in place to ask parishioners (children and parents/ carers) about their views on policies and practices for keeping children safe.	Not met
7.5	All incidents, allegations/ suspicions of abuse are recorded and stored securely.	Met fully

The request to the NBSCCCI to undertake a review of safeguarding practice in the MSC is to be commended. It is evidence of the willingness that now exists to open practice up to scrutiny. This transparency is an excellent development and particularly so when account is taken of the very different past that they had experienced. The culture of secrecy has been addressed and is now replaced by a willingness to seek scrutiny as a way of determining how they should develop their practice.

The review undertaken by the NBSCCCI was records based. All files were read and assessed. It is important that the MSC create a means by which their practice in this area can be shown to be compliant with the expectations held within the Church without reference to an outside body. For example, if a directive is issued by the CDF such as was the case in 2001, it should be complied with fully.

In addition, there should be annual internal audit to ensure that all practice is monitored; that any non-compliance is detected and that all new allegations are responded to appropriately. The monitoring or self-audit tool should be sent to the NBSCCCI for information and review.

Recommendation 11: The Provincial must ensure that an annual audit of safeguarding practice is conducted and the findings are forwarded to NBSCCCI.

Recommendations

Recommendation 1: The Provincial ensures that the work currently being undertaken by the delegate to produce policies for the safeguarding of children is supported and brought to a conclusion.

Recommendation 2: The Provincial and all members of his PLT should ensure that all who hold safeguarding responsibilities, including the PLT and Community leadership teams have a sound working knowledge of the cases that are being managed within each community. This information should be current through regular briefings from the designated person with particular emphasis on the compliance of any members that are subject to risk management plans.

Recommendation 3: When the Provincial and his PLT are coming to the end of their term of office they should ensure that the incoming leadership team are fully briefed on all of the cases that are held in the community. A written protocol should be created by the existing PLT, to ensure that this practice becomes part of the safeguarding practice of the MSC community as a whole.

Recommendation 4: The Provincial should ensure that all credible allegations should be reported to the Superior General in writing with an expectation that they will be passed on to the CDF in line with current Church guidance. A copy of the papers submitted to the CDF should be held on file within the Irish Province. Where it is decided that an allegation does not warrant submission to the CDF this fact should be recorded along with the reasons as to why that decision was taken. A record should be placed on the case file and should be available for review.

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Recommendation 8: The Provincial should seek advice and guidance with regard to the setting of boundaries between his role and those of the delegate, the Advisory Panel, and all others involved in the safeguarding structure.

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Recommendation 11: The Provincial must ensure that an annual audit of safeguarding practice is conducted and the findings are forwarded to NBSCCCI

Signed: 
Ian A. Elliott
Chief Executive Officer

Date: July 2012

Review of Safeguarding in the Catholic Church in Ireland

Terms of Reference

(which should be read in conjunction with the accompanying Notes)

1. To ascertain the full extent of all complaints or allegations, knowledge, suspicions or concerns of child sexual abuse, made to the diocese / religious congregation by individuals or by the Civil Authorities in the period 1st January 1975 to date of Review (July 2012), against Catholic clergy and/or religious still living and who are ministering/or who once ministered under the aegis of the diocese / religious congregation and examine/review and report on the nature of the response on the part of the diocese / religious congregation.
2. If deemed relevant, select a random sample of complaints or allegations, knowledge, suspicions or concerns of child sexual abuse, made to the diocese / religious congregation by individuals or by the Civil Authorities in the period 1st January 1975 to date of Review (July 2012), against Catholic clergy and/or religious now deceased and who ministered under the aegis of the diocese / religious congregation and examine/review and report on the nature of the response on the part of the diocese / religious congregation.
3. To ascertain all of the cases during the relevant period in which the diocese / religious congregation:
 - knew of child sexual abuse involving Catholic clergy and/or religious still living and including those clergy and/or religious visiting, studying and/or retired;
 - had strong and clear suspicion of child sexual abuse; or
 - had reasonable concern;and examine/review and report on the nature of the response on the part of the diocese / religious congregation.
4. To consider and report on the following matters:
 - child safeguarding policies and guidance materials currently in use in the diocese / religious congregation and an evaluation of their application;
 - communication by the Diocese / religious congregation with the Civil Authorities;
 - current risks and their management.

Accompanying Notes

Note 1

Definition of Child Sexual Abuse:

The definition of child sexual abuse is in accordance with the definition adopted by the Ferns Report (and the Commission of Investigation Report into the Catholic Archdiocese of Dublin). The following is the relevant extract from the Ferns Report:

“While definitions of child sexual abuse vary according to context, probably the most useful definition and broadest for the purposes of this Report was that which was adopted by the Law Reform Commission in 1990² and later developed in Children First, National Guidelines for the Protection and Welfare of Children (Department of Health and Children, 1999) which state that ‘child sexual abuse occurs when a child is used by another person for his or her gratification or sexual arousal or that of others’. Examples of child sexual abuse include the following:

- exposure of the sexual organs or any sexual act intentionally performed in the presence of a child;
- intentional touching or molesting of the body of a child whether by person or object for the purpose of sexual arousal or gratification;
- masturbation in the presence of the child or the involvement of the child in an act of masturbation;
- sexual intercourse with the child whether oral, vaginal or anal;
- sexual exploitation of a child which includes inciting, encouraging, propositioning, requiring or permitting a child to solicit for, or to engage in prostitution or other sexual acts. Sexual exploitation also occurs when a child is involved in exhibition, modelling or posing for the purpose of sexual arousal, gratification or sexual act, including its recording (on film, video tape, or other media) or the manipulation for those purposes of the image by computer or other means. It may also include showing sexually explicit material to children which is often a feature of the ‘grooming’ process by perpetrators of abuse”.

Note 2

Definition of Allegation:

The term allegation is defined as an accusation or complaint where there are reasonable grounds for concern that a child may have been, or is being sexually abused, or is at risk of sexual abuse, including retrospective disclosure by adults. It includes allegations that did not necessarily result in a criminal or canonical investigation, or a civil action, and allegations that are

² This definition was originally proposed by the Western Australia Task Force on Child Sexual Abuse, 1987 and is adopted by the Law Reform Commission (1990) *Report on Child Sexual Abuse*, p. 8.

unsubstantiated but which are plausible. (NB: Erroneous information does not necessarily make an allegation implausible, for example, a priest arrived in a parish in the Diocese a year after the alleged abuse, but other information supplied appears credible and the alleged victim may have mistaken the date).

Note 3

False Allegations:

The National Board for Safeguarding Children in the Catholic Church in Ireland wishes to examine any cases of false allegation so as to review the management of the complaint by the diocese / religious congregation.

Note 4

Random sample:

The random sample (if applicable) must be taken from complaints or allegations, knowledge, suspicions or concerns of child sexual abuse made against all deceased Catholic clergy/religious covering the entire of the relevant period being 1st January 1975 to 1st June 2010 and must be selected randomly in the presence of an independent observer.

Note 5

Civil Authorities:

Civil Authorities are defined in the Republic of Ireland as the Health Service Executive and An Garda Síochána and in Northern Ireland as the Health and Social Care Trust and the Police Service of Northern Ireland.