Independent Review of the Handling of Past Complaints of Abuse in St John Ambulance Ireland

Dr Geoffrey Shannon SC

Commissioned by St John Ambulance Ireland

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PREFACE

This independent Review has been written by Dr Geoffrey Shannon SC with the assistance of Ms Hilary Coveney and Dr Cian Ó Concubhair. The Review and the research involved is broken down into two parts as informed by the following Terms of Reference, published by Saint John Ambulance Ireland ("SJAI") on 8 March 2021:

"PART 1

- the manner in which the aforesaid complaints in relation to sexual abuse made to the SJAI were dealt with when first made taking into account government guidance and SJAI policies on child protection available at that time (see Appendix I); the manner in which such complaints were dealt with when re-reported in 2013 taking into account government guidance on child protection and SJAI policies available at that time (see Appendix I);

- whether there were any other complaints (whether in writing or verbal to any person in a position of authority) regarding grooming or abuse in relation to the volunteer concerned over his period of involvement with SJAI, and

- any other complaints (whether in writing or verbal to any person in a position of authority) relating to any other individual based on reports made to and/or records held by SJAI: and

PART 2

- the adequacy of arrangements now in place for the protection of children and vulnerable adults who may come into membership of SJAI having regard to TUSLA's assessment in July 2019;

all with a view to identifying learning and making recommendations for the organisation".

In keeping with these Terms of Reference, the Review does not reach any conclusions in relation to any individual but rather considers how complaints were handled at an organisational level within SJAI. It is based on a large number of interviews conducted with key stakeholders and a review of the available documentation.

Every care has been taken not to identify any of the participants. In order to provide additional safeguards of anonymity, the Review has not identified the SJAI division the volunteer came from. Moreover, the Review has, as far as possible, avoided including any details that may lead to the identification of participants.

In a bid to preserve the anonymity of participants, each has been assigned an identifying letter. This device is used solely as a means of distinguishing each person for the purpose of fulfilling the remit of the Review and is not intended to detract in any way from the trauma suffered by the victim-survivors.

The review team has made, and continues to make, every effort to ensure the anonymity of participants to the Review. The Review has developed a document management system to ensure that data is secure and that participants are only identifiable to members of the review team. The review team has also taken care to use procedures that refrain from naming individuals to the greatest extent possible as and between the review team. The Review instead used anonymised codes to refer to participants. As the review team explained to all participants, while the Review will endeavour to ensure that names are not used and will endeavour from that point of view to ensure participants' anonymity, it is possible that the Review may be subject to a legal obligation to disclose certain documents such as, for example, if that was directed by order of a court. If such an order was made, the review team would be legally obliged to comply. As such, the review team cannot guarantee the full anonymity of data.

The Review would like to acknowledge the assistance of SJAI with the narrative on the history of the organisation.

It is recognised with regret that the publication of this Review may cause additional distress to victim-survivors as well as to the professionals who worked on the cases discussed. This is not the intention.

What was clear from this Review is that improvements have been made by SJAI in recent years with a view to ensuring the child's experience in the voluntary organisation is not traumatising. In this way, the Review believes that there is a clear difference between SJAI in the past and the organisation today. However, there remain aspects of SJAI's culture and practices that still require change and improvement. These include a pervasive denial about past failures by some in the

organisation. The Review has made a series of recommendations about the changes that must be made in order for SJAI to strengthen its commitment to robust and effective child protection systems.

Nobody could fail to be affected by the circumstances surrounding the lives of some of victim-survivors, particularly in those cases discussed in Chapter 7.

The Review would like to commend the victim-survivors for their bravery and dignity in telling their story.

All reports inevitably contain some errors. One of the challenges in examining the cases discussed in this Review was as a direct result of the difficulties encountered in investigating the files due to sub-optimal record keeping. In some cases, this may have led to errors appearing in the completed text although every effort has been made to prevent this.

Dr Geoffrey Shannon SC
November 2022

Executive Summary

Introduction

The Board of St John Ambulance Ireland (hereinafter "SJAI") commissioned an independent Review (the "Review") to be carried out by Dr Geoffrey Shannon SC with the assistance of Ms Hilary Coveney and Dr Cian Ó Concubhair into the manner in which historical complaints of sexual abuse of members of SJAI under the age of 18 were dealt with by the organisation taking into consideration government guidance and SJAI policies on child protection at that time, and the adequacy of the organisation's current arrangements in place for protecting children and vulnerable adults who may come into membership within SJAI. The Review was initially recommended by the Child and Family Agency/Tusla and the Department of Children, Equality, Disability, Integration and Youth following a number of complaints of historical sexual abuse against a former volunteer in SJAI.

As outlined, the Review is both retrospective and contemporary in focus. The Terms of Reference of the Review were published by SJAI on 8 March 2021 and the Review is bound by the strictures and parameters of same. The scope of the Review does not extend to the investigation of the merits of any complaint or to the making of any finding to uphold or dismiss any complaint made to or concerning any member of SJAI. The Review would urge any person who feels they have been subject to the kind of actions covered in the Review to bring their complaints to bodies with the legal powers to investigate them, such as An Garda Síochána and/or Tusla.

This Report ("the Report") contains several learnings identified from the evidence gathered. It also contains recommendations made by the Review to SJAI. These are summarised at the conclusion of this Executive Summary and discussed more fully in Chapter 9 of the Report. It is understood that it is the Board of SJAI's intention to publish the Report.

There were three phases to this Review: the Interview Phase, the Documentary Review Phase, and the Legal Review Phase.

It should be noted that as part of the Review, complainants and/or other individuals with knowledge pertinent to the Terms of Reference were invited to make contact with, and to share this information with, the Review. These disclosures necessarily generated documents referencing or recording the personal data of those complainants and/or other respondents. Similarly, as a result

of the Documentary Review Phase, the Review secured access from SJAI to a variety of files, some of which contained the personal data of third parties. Details as to how this data was duly secured, processed and used are detailed in Chapter 2 and Appendix 2 of the Report.

Key Learnings and Recommendations

For many participants interviewed, it seems that their time with the SJAI organisation was positive. Many participants spoke in particular of the deep sense of solidarity and belonging that they enjoyed during their time as cadets[1] in SJAI. Many participants were also keen to emphasise the valuable practical skills they learned through membership and undertaking training within SJAI.

The Review also notes how many participants had, because of their experiences in SJAI, gone on to work in healthcare and other frontline essential services in Ireland and abroad. The well-established career pathway in healthcare that SJAI membership offered was also a point of pride for many long-standing and senior-ranking members of the organisation who participated in the Interview Phase of the Review.

It is clear that SJAI's cadet programme provides a valuable sense of community for its young members, while building self-confidence and leadership qualities through its structure, training, and routine activities. For many, this positive and valuable experience continued as they transitioned into adult SJAI membership. This appears to have been a key reason for the organisation's ability to retain members despite the significant commitment membership demanded in terms of time and training.

Successive reports among those interviewed have confirmed that the period from approximately 2011 onwards in SJAI has been one of concerted reform and change. The Review believes that recent initiatives by SJAI represent a meaningful attempt by SJAI to develop and implement a robust and effective child protection system. Indeed, the dominant impression among interview participants—particularly those with current or recent experience volunteering within SJAI—is that SJAI is an organisation pursuing meaningful efforts to positively improve its structures and practices in a professional manner.

Before 2000, child protection in SJAI relied on trust in senior members in leadership positions, and the organisation's general faith in the capacity of the chain-of-command to identify and manage risks. Between 2000–2011, following the initial disclosures of abuse by one of the victim-survivors, it appears that SJAI attempted to put in place a child protection framework. That said, until the early to mid-2010s, the child protection system that operated in SJAI was inadequate and dysfunctional.

1 Cadets refers to members of SJAI under 18 years of age.

Those who participated in the Review described how child protection specific policies had been evolving within the SJAI organisation from the early 2000s, but that the organisation had largely struggled to implement these measures. Prior to the late 1990s, there was no formal child protection system in place: what little measures of safeguarding that were available were provided for through the traditional internal accountability system, provided for under SJAI's original 1947 Rules and Regulations.

Ultimately, and as recorded in the Report (see below "Child Protection Policies and Practices"), the Review believes that until the early to mid-2010s, SJAI did not have an adequate child protection policy framework.

Since 2011, it has become a core requirement for adult membership in SJAI to complete relevant Tusla child protection courses. The Review welcomes the recent improvements in child protection in SJAI. Interview participants were positive about the contemporary picture of child protection and safeguarding within SJAI.

This general impression of participants was based on three main factors:

1. the organisation's endeavours with regard to Garda vetting;

2. the development and independence of the child protection officer roles; and

3. a general culture change among rank-and-file, brought about by newer, younger membership and their generation's improved familiarity with child protection.

As will be discussed elsewhere in this Report, the Review believes that while there certainly have been significant improvements with regard to contemporary child protection practices in SJAI, there remains a number of practical areas that can be changed and improved further.

Queries were raised by the Review as to whether SJAI has any policies relating to internet safety and cyber bullying. No such documentation or information was contained in the files originally made available for inspection, although the latest draft policy on child protection within SJAI may make provision for these very important issues. As stated elsewhere in this Review, it is difficult to form a view in relation to the draft documentation supplied by SJAI which is clearly not in final form at the time of writing this Report.

It is the view of the Review that internet safety and social media are critically important areas for all organisations where children are involved. It is clear from interviews with victim-survivors that these technologies have, for some time, been used by individuals in ways that present new and

additional risks to children. It is critical that organisations ensure that they have policies in place that address these risks. These are clear and present dangers to child protection that cannot be ignored.

It is clear from interviews with participants that cadets are an essential and important part of the SJAI structure. The cadet divisions provide an opportunity for the organisation to recruit and train young people, with the hope of retaining those members as adults. In this way, the cadet divisions provide security for the future of the SJAI organisation, as well as revitalising it with a constant inflow of emerging new generations.

The cadet experience was also described by nearly all participants to have been a very positive experience. This included some of the victim-survivors who felt that many aspects of their cadet experience were positive. On these accounts, SJAI's cadet divisions provided, and continue to provide, a valuable opportunity for young people to acquire beneficial new skills, while contributing in an important civic institution. Membership of the SJAI cadets also enabled participants to access an alternative route to validation and socialisation other than the traditional routes of sport and academic success that often dominate validation pathways in Ireland.

The Review believes that there is a clear difference between SJAI in the past and the organisation today.

The Review has identified the following *key* learnings from the evidence gathered during the Review:

- The Review believes it is important for SJAI and others to be very conscious of the fact that several victim-survivors reported that they suffer ongoing and persistent trauma as a consequence of the abuse described in their testimonies.
- The Review believes that SJAI's structure and culture left the organisation vulnerable to grooming and sexual abuse of children within the organisational context. The Review believes that SJAI's accountability systems failed to intervene or investigate suspicions or knowledge of child protection risks despite potential risks being highly visible.
- The Terms of Reference of the Review require the Review to consider the manner in which complaints in relation to one former volunteer member who ceased volunteering with SJAI circa 2000/1 were dealt with. The Terms of Reference also require the Review to consider any other complaints (whether in writing or verbal to any person in a position of authority) relating to any other individual, based on reports made to and/or records held by SJAI. The substantial majority of the

testimony received by the Review concerned complaints and reports made against the former volunteer specified in the Terms of Reference.

- For the avoidance of doubt the Review believes that the alleged perpetrator referred to in the Terms of Reference was involved with the Z27[2] division of SJAI (which the Review understands ceased operating in the early 2000s). The accounts of participants to the Review in relation to that division covered a period from the early 1970s until the late 1990s.

- The Review also received testimony which suggested that there may have been more than one individual engaged in potential grooming or abuse in the pre-2001 period. However, the Review has not seen or heard any specific evidence that complaints or reports were made to any person in a position of authority in SJAI in respect of any individual in the pre-2001 period, other than the former volunteer specified in the Terms of Reference. With regard to the period after 2000/2001, the Review believes on the basis of the evidence and testimony received that complaints and reports in relation to other individuals were made to people in a position of authority in SJAI regarding grooming and/or abuse in this time frame. These other instances are addressed in Chapter 8 of the Report.

- It is open to any and all participants in the Review and indeed any other individual affected by the matters raised in this Report, to raise their concerns with An Garda Síochána. Indeed, the Review encourages anyone who may be affected by the issues raised in this Report, who has not already reported the matter to An Garda Síochána, to do so as soon as possible.

- The Review believes that there was a significant degree of organisational awareness in the organisation of serious threats to children within SJAI.

- The Review believes, based on the evidence available, that SJAI failed to undertake any meaningful investigation into known or suspected threats to children prior to 2000. The Review believes this failure to investigate was part of the broader weak accountability mechanisms within SJAI.

- The Review believes that SJAI's failure to initiate any formal investigation following a full disclosure of serious grooming and child sexual abuse was a serious failure of SJAI's ethical duty of care to its membership, which included hundreds of cadets.

2 More particularly dealt with at Section 5.5 of this Report.

- The Review believes, based on the available evidence, that SJAI failed to act on knowledge or suspicions of risk because of a misguided belief that a criminal standard of evidence had to be reached before their intervention was permitted.

- The Review believes that paralysis in the face of the first formal complaint was a strong driving force in SJAI's response to allegations of grooming and child sexual abuse within the organisation.

- The Review believes, on the basis of the evidence furnished to the Review, that SJAI's failure to act on a suspected or known threat was partially based on a fear of litigation. The Review has not found any evidence that SJAI sought formal independent legal advice on this matter.

- The Review believes that SJAI operated under a rigid hierarchical structure, which placed a high value on trust, deference and compliance. The Review believes that some aspects of that structure persist within SJAI at some levels.

- The Review believes that SJAI's hierarchical structure facilitated predatory behaviour within the organisation in the past, and insulated that behaviour from effective intervention and accountability.

- The Review believes that SJAI operates under a highly formalised and quasi-military structure. This structure, and the culture which informs it, places a high value on obedience to rank, and a low value on autonomy.

- The Review believes that the core military structures of SJAI remain to be fully expunged. The Review believes these structures informed and shaped the hierarchical structure of SJAI, and the accountability structures within the organisation. The Review believes that these military structures are not appropriate for a healthy child protection and safeguarding culture.

- The Review believes that some members of SJAI perceive some of its governance culture and practices to be dysfunctional.

- The Review believes that the SJAI cadets are, in principle, a positive component of the organisation.

- The Review believes that some issues remain with regard to the governance and management of SJAI's cadet system, to include supervision and ensuring the safety and well-being of all cadets at all times.

- The Review believes that the structural and cultural features of SJAI's hierarchy and chain-of-command inhibited accountability for senior-ranking members. The Review believes this led to impunity for more senior-ranking members of the organisation from scrutiny or accountability across a wide range of areas, and response paralysis of SJAI leadership in the face of known or suspected threats and wrongdoing.

- The Review believes that this culture of deference, if not completely eliminated, undermines the implementation of robust and effective child protection systems and practices.

- The Review believes that the document and file management systems within SJAI, to include the management of contact information, are unsatisfactory and do not meet the standards required of a voluntary organisation working with children.

- The Review believes that beyond pre-hospital best practices, SJAI lacks professionalism in some of its operative culture by relying too heavily on volunteers. The Review believes that this lack of direct professional input weakens the implementation of robust and effective child protection systems.

The Review makes the following *key* recommendations:

- The Review recommends that SJAI should offer an apology in comprehensive terms to victim-survivors and others. It is recommended that SJAI should look to other organisations who have been deficient in child safeguarding for assistance in this regard.

- The Review recommends that SJAI puts in place appropriate therapeutic support for those who came forward to speak with the Review, expanding on its offer of a consultation and a maximum of six sessions with a counselling service.

- The Review recommends that the cadets should be maintained as a core component of SJAI, subject to appropriate rules in place regarding supervision and management of cadets.

- The Review recommends that SJAI undertakes a broad re-examination of its internal governance, transparency and accountability mechanisms. The Review also recommends as part of this process an examination of the potential for putting certain key roles on a professional basis within SJAI to support and facilitate a more dynamic and responsive approach to volunteerism.

- The Review recommends a reconsideration of the hierarchical structure and culture of SJAI. The Review recommends the creation of robust internal accountability frameworks which are transparent and apply equally to all ranks of the organisation.

- The Review recommends enhanced ongoing communications processes for those who make complaints, and that complaints processes are managed with a greater emphasis on transparency and institutional confidence building for the membership.

- The Review recommends that the national safeguarding officer should be independent of SJAI.

- It was noted on one of the files made available for inspection during the Review that an internet safety education session was held by SJAI in one division, involving both parents and cadets and An Garda Síochána. It is the view of the Review that such education and training sessions should be provided to all members and divisions within SJAI.

- The Review recommends that SJAI should institute a system of typed and dated reports for each complainant and every incident or suspected incident affecting child protection or raising child safeguarding concerns.

- The Review recommends that typed and dated notes and records of each meeting where any child protection concerns are considered should be kept in hardcopy format. These must be accessible by the national safeguarding officer and by the relevant state agencies (Tusla and An Garda Síochána). All information should be kept securely in offices or premises of SJAI, and must not be taken to the residences of SJAI members or officers, or any other locations.

- The Review recommends that membership officers in each branch should be aware of the renewal policy, including the requirements for regular re-training and re-vetting. Membership and contact lists must be kept up to date and safely retained at all times.

- The Review believes that SJAI is now committed to robust implementation of child safeguarding practices and procedures. The recommendations made by the Review are designed to further enhance the present safeguarding regime in SJAI, such that insofar as is possible, SJAI offers an environment in which children can safely participate, learn and grow.

- The Review believes that SJAI is now alive to its safeguarding obligations and remains committed to putting the safety and well-being of its cadet membership at the top of its priorities and to resource its child safeguarding work accordingly.

- The Review sees a clear distinction between SJAI in the past and today in terms of the central importance it places on living out its child safeguarding obligations and responsibilities. It is essential that complacency never sets in, in this regard, as child safeguarding requires organisational vigilance at all times.

The Interview Phase

The Interview Phase was designed to gather information on the child protection and safeguarding culture and practices of SJAI from both an historical and contemporary perspective. It was also intended to provide respondents with the opportunity to have their experiences documented and acknowledged.

The Review received interview testimony from many participants, ranging from victim-survivors to former members of SJAI as well as currently serving members of SJAI. Interview participants had a wide range of years of service in SJAI. None had less than three years' service, with a number having been members of the organisation for several decades. All participants were adults at the time of interview.

Recruitment of participants was realised through two approaches:

1. Advertisement by SJAI of the Review and its Terms of Reference using its own communication channels and contact lists.

2. Advertisement by the Review through a specially created website: *https://stjohnambulancereview.ie/* (see Appendix III). The site was launched in March 2021 and, at the date of writing, has attracted over 3,800 visitors. It should be noted, however, that not all of said visitors made contact with the Review.

All in-person interviews took place in one of three locations. Two of these locations were SJAI premises: the SJAI Headquarters on Leeson Street in Dublin, and the Cork city divisional headquarters. The third location was a private meeting room in a hotel in central Dublin, which was hired by the Review. A number of participants were also interviewed remotely using the Zoom secure video-conferencing platform.

Significant efforts were made to ensure that voluntary consent was obtained from each participant prior to interview. All respondents were informed as to the scope and focus of the Review and were informed as to how their personal data would be gathered, stored and used. These efforts are further detailed in the body of the Report (Chapter 2). Questionnaires were devised for use during the interviews which took the form of open-ended and information-specific questions (see Appendix IV). Details as to the recording, transcription and analysis of the interviews are discussed in the body of the Report (Chapter 2). Security and data protection were of the utmost importance to the Review and an extensive and exhaustive series of measures were undertaken to ensure the integrity of the Review from an ethical and legal perspective in this regard. Further information is detailed in the body of the Report (Chapter 2).

As stated above, for most participants interviewed, it seems that their time with the SJAI organisation was very positive. However, the Review received repeated reports relating to SJAI's previous structures, authority and influence over younger members which also had problematic ramifications. Both the structural and organisational culture of SJAI is discussed in more detail in the body of the Report (see Chapters 5 and 6 respectively) with reference to data collected during the Interview Phase.

With regard to structure, issues pertaining to hierarchy, assorted cultural problems and accountability were repeatedly cited by participants during the Interview Phase.

Hierarchy

Interview participants described SJAI as employing quasi-military, command-and-control governance practices and as one of its conclusions, the Review believes that SJAI operated under a rigid, highly formalised hierarchical structure, which placed a high value on deference and compliance. Some aspects of this structure still endure within SJAI.

Participants described the lack of transparency which persists as a direct result of this hierarchical structure, especially as it pertains to decision-making by those in positions of authority. The structure and the culture which results, places a high value on obedience to rank, and a low value on autonomy.

The Review believes that SJAI's hierarchical structure and the reportedly unquestioning deference that it preferred, facilitated predatory activity within the organisation, and insulated those activities from effective intervention and accountability. Further, the Review believes that SJAI's hierarchical structure had, in the past, resisted significant organisational reform in areas such as child protection policies and practices.

Interviewees described the structure of SJAI as rule-centric, with specific import placed on the 1947 Rules and Regulations, which established the rank system. For some participants, it appears that the Regulations and rank system were prioritised above other considerations.

It was also suggested that the hierarchy created opportunities for abuse of power, generating competition for rank status and creating unhealthy centres of unaccountable control. The high value placed on obedience reportedly led to scenarios where the deep power imbalances created by the organisation's hierarchy were reportedly exploited and abused.

As stated above, the Review believes that the core military structures of SJAI remain to this day and the influence of same may continue to influence the culture of SJAI and the accountability structures in place within the organisation. The Review believes that these military structures are not appropriate for a healthy child protection and safeguarding culture.

The Review recommends that SJAI abandons all remaining military structures and cultural norms.

Culture Problems

Common concerns and complaints among participants pertained to so-called "culture problems" within SJAI.

Transparency issues, for example, especially as they pertained to the way in which decisions were made by the higher echelons of the organisation's hierarchy, impacted governance and accountability significantly. Decision-makers reportedly worked in organisational silos, disconnected from the bulk of the membership, and incapable of addressing many of the structural and cultural issues within the organisation.

The Review believes that a lack of openness has, in the past, manifested itself as a culture of secrecy. The Review believes that this culture of secrecy was closely linked to dysfunctional accountability structures and practices within SJAI. The Review also believes that this culture of secrecy inhibited the effective functioning of child protection practices within SJAI.

Based on data established during the Interview Phase, the Review believes that there was also a culture of conservatism within SJAI, that may have incorporated homophobic myths into its early child protection training (as discussed below). The Review believes that this conservatism may have undermined SJAI's initial attempts to develop a formal child protection system in the late 1990s and early 2000s. The Review rejects the contention that such a position can be defended by reference to supposed cultural norms of that time. This conservatism also seems to have informed a resistance to change. This culture of resistance to change was reported to be in part, related to, if not rooted in, the structural themes of hierarchy and militarism in SJAI, as aforementioned, and the cultural theme of deference to rank and status.

This culture of resistance to change reported at the Interview Phase also lends itself to the persistent and pervasive culture of denial and avoidance of responsibility within SJAI in certain sections of the organisation's leadership. The Review believes that there is a long-standing and persistent cultural antipathy towards change within some aspects of SJAI. The Review believes that

this culture of resistance to change poses an ongoing threat to the implementation of robust and effective child protection systems and practices.

Notwithstanding the foregoing, the Review notes successive reports among those interviewed that the period from approximately 2008 onwards in SJAI was one of concerted reform and change. The Review also believes that this period represents a meaningful attempt by SJAI to develop and implement a robust and effective child protection system.

Cadets are also an integral part of the organisation and its structure; the cadet divisions providing an opportunity for the organisation to recruit and train young people, thereby investing in the future of SJAI. The Review believes that the SJAI cadets are, in principle, a positive component of the organisation and therefore, the Review recommends that the cadets should be maintained as a core component of SJAI. However, it does not appear that SJAI has an effective central membership management system for its cadets. During the Review, it appeared from interviews that accurate figures for the number of cadets in the organisation may not be available. Following queries to clarify the position, SJAI advised that there are 451 cadet members of SJAI, as at July 2022.

Early on in the Review, a number of interview participants (including, but not exclusively, victim-survivors), drew the Review's attention to what they believed were unusual features of the "Z27 Division"[3] of SJAI. A number of interview participants claimed the Z27 Division did not have an official cadet division, although it appears a number of cadets were based at that division. From questions that were put by the Review to leadership figures of the organisation, it appears it was unusual for cadets to be based in an adult-only division. The data from interviewees suggests that the Z27 Division allegedly operated with a high degree of autonomy and very little oversight from SJAI. This, it is alleged, extended to a failure by SJAI to intervene to stop the transfer of children into a division that was widely understood to pose risks to children. The Review believes that the Z27 Division operated with an unusually high degree of autonomy and impunity within SJAI. The Review believes that cadets were permitted to transfer to the Z27 Division, despite the absence of a co-located cadet division. The Review believes that this was a highly unusual state of affairs.

Given the seriousness of the various allegations made with regard to the Z27 Division, the lack of adequate documentary evidence made available to the Review is concerning. SJAI's failure to manage its documents and files in a comprehensive manner is described and discussed below and again more thoroughly in the body of the Report.

The Review recommends that SJAI invests appropriate resources to resolve outstanding issues with regard to the membership information and management systems.

3 See page 139.

Further, regarding cultural issues of significance in SJAI, it is of note that the dominant impression among interview participants—particularly those with current or recent experience volunteering within it—is that SJAI is an organisation pursuing meaningful efforts to positively improve its structures and practices in a professional manner. This view concedes that the organisation was previously exclusively volunteer and part-time managed, but is striving to improve. Echoes of a lack of professionalism may be seen in the administrative and record-keeping practices of the organisation which have been observed by the Review and are detailed more thoroughly in Chapter 8 of the Report. The Review believes that greater professionalism is required to mitigate any continuing risk to the implementation of robust and effective child protection systems.

Finally, a number of interview participants raised the complex issue of socio-economic class as an unspoken organising norm of SJAI in both structural and cultural terms. In particular, some participants—specifically some of the victim-survivors—believed that victimisation tracked along socio-economic class.

The Review recommends SJAI undertakes a broad re-examination of its internal governance, transparency and accountability mechanisms. The Review also recommends as part of this process that SJAI examines the potential for putting certain key roles on a professional basis within SJAI to support and facilitate a more dynamic and responsive approach to volunteerism, which is fit for the demands of contemporary pre-hospital care.

Accountability

Most participants reported in interviews that they were never made aware of any formal grievance procedures within SJAI. A number believed that no such system existed. Others, who had some experience of attempting to raise grievances within SJAI, claimed that the mechanisms that did exist were typically informal in nature and that the primary accountability mechanism in SJAI was the chain-of-command. The Review believes that the chain-of-command was a wholly inappropriate approach to accountability from a child protection perspective as it failed to account for the possibility that individuals in that chain-of-command hierarchy may have been implicated in the victimisation complained of. The Review believes that defaulting to the chain-of-command as the principal accountability mechanism imported other problematic features of the organisation's quasi-military structure and culture.

The Review believes that SJAI's accountability system is generally structured around the assumption that wrongdoing is committed by lower-ranking members.

The Review recommends that SJAI develop formal guidelines to deal with grievances and complaints.

A number of participants described their experiences with the Court of Inquiry, a formal accountability process, which was, again, reportedly distinctively military in nature. The Review believes that the Court of Inquiry process within SJAI lacks adequate transparency, and that SJAI has failed to explain to the membership what its processes and functions are. The Review believes that the Court of Inquiry process was primarily used to discipline junior members of the organisation. This in turn reinforced, in punitive terms, the structural and cultural features of SJAI that prioritised hierarchy and rank. From interview data received, the Review believes that the Court of Inquiry process contains many concerning features which fail to respect individuals' constitutional rights to natural justice and fair procedures. In this way, the Review believes that the process is profoundly procedurally flawed, wholly inadequate and fails to offer a meaningful or effective accountability mechanism.

During the Documentary Review Phase, discussed in Chapter 8, the Review was unable to find evidence or notes from any Court of Inquiry process, other than one handwritten note which was furnished in the Supplemental Disclosure received in July 2022. It appears that contemporaneous notes of these procedures were rare and were either not routinely taken, or were not retained. No rules or policies of the Court of Inquiry were furnished to the Review during this phase.

The Review recommends that the Court of Inquiry process in SJAI be significantly reformed to address these critical issues.

The Review was directed to rule 122 of the 1947 Rules and Regulations by a participant when describing their experience of the Court of Inquiry. The rule states that:

> "Legal action shall not be taken by an Officer or member against any other Officer or member of the Brigade as such, without the sanction of the Commissioner having been first obtained in writing".

The Review believes that rule 122 of the 1947 Rules and Regulations of SJAI (reprinted in 1994) is problematic in that it seeks to constrain the constitutional rights of SJAI members. The Review strongly recommends that rule 122 be removed from the SJAI Rules and Regulations.

With regard to accountability, the Review received a number of similar complaints relating to SJAI not holding senior-ranking members to account for wrongdoing. It was posited that this so-termed response paralysis was rooted in the culture of pride in the organisation, and the desire

to protect its reputation. The Review believes that the structural and cultural features of SJAI's hierarchy and chain-of-command inhibited accountability for senior-ranking members. The Review believes that this led to impunity for more senior-ranking members of the organisation from scrutiny or accountability across a wide range of areas, and response paralysis of SJAI leadership in the face of known or suspected threats and wrongdoing. The Review recommends a reconsideration of the hierarchical structure and culture of SJAI. The Review recommends the creation of robust internal accountability frameworks which are transparent and apply equally to all ranks of the organisation.

As discussed above, SJAI placed a high cultural value on deference to rank and seniority, and the Review believes that the effect of this deference was to inhibit the development of robust and effective accountability mechanisms within the organisation. The Review believes that this included the directing of disciplinary measures towards more junior ranks and away from senior ranks, facilitating a culture and practice of impunity from accountability. The Review believes that this culture of deference posed a threat to the implementation of robust and effective child protection systems and practices.

Organisational Responses to Allegations and Suspicions of Abuse

The testimony given by victim-survivors was consistent in describing instances of abuse within the SJAI organisation. Some testimony received contained references to incidents outside the SJAI context. However, this testimony also described SJAI as the key institutional context that facilitated the incidents described.

Testimony from victim-survivors described various actions which would generally be regarded by child protection specialists as strategies of grooming and abuse. These included: bringing children on weekend trips that were not officially sanctioned; purchasing of alcohol for victim-survivors; the exploitation of SJAI rank status, training and mentorship roles to gain access to areas with younger members of the organisation; campaigns of intimidation, humiliation and manipulation; and providing children with paid work opportunities outside SJAI. Victim-survivors described being routinely sexually assaulted by an individual during SJAI branch and cadet meetings, and during public duties. Other participants described prolonged sexual harassment and sexual assault.

Victim-survivors who spoke to the Review described predatory and abusive behaviour over a number of decades in SJAI. The Review believes that the structure and culture of SJAI during these periods was such as to facilitate the kind of grooming strategies described by victim-survivors.

The Review believes that SJAI's accountability systems failed to intervene or investigate, despite evidence of potential risks.

The Review believes that there was a significant degree of organisational awareness in SJAI of persistent and serious threats to children within SJAI. For example, the Review believes, on balance, that there were widely discussed rumours of a specific threat to children in SJAI.

To this point, the Review believes that informal warnings were routinely given to young male cadets. Most of these informal warnings seem to have been motivated by a concern about a child protection risk. The Review concludes that these warnings came from both peers and senior-ranking members, and reflected a deep organisational awareness of the potential risk posed in SJAI. The Review also believes that awareness of specific threats to child safety in SJAI was well-established by the early to mid-1990s.

As regards investigations into said complaints or rumours, the Review concludes that in most cases, no formal investigations were carried out by SJAI. Indeed, the Review has been unable to find documentary evidence directly relating to any formal investigation into the question of child abuse prior to 2011, even where it appears that formal disclosures of abuse were made. Nor, it appears, did SJAI in these cases refer complaints to the relevant statutory agencies: An Garda Síochána or the local health board with responsibility for child protection. Regardless of whether the organisation was legally obliged to respond at the relevant time of a disclosure, the Review believes SJAI's failure to initiate any formal investigation following a full disclosure of serious grooming and child sexual abuse was a serious failure of SJAI's ethical duty of care to its membership, which included hundreds of cadets. Further, it was suggested by a number of interview participants that a key factor in SJAI's inaction in the face of known or suspected child protection risks was its fear of litigation.

A number of interview participants defended SJAI's failure to intervene due to a lack of "hard evidence" of wrongdoing. The Review believes, on balance, that some elements within SJAI failed to act on knowledge or suspicions of risk because of a misguided belief that a criminal standard of evidence had to be reached before its intervention was permitted. The Review finds it difficult to imagine how "hard evidence" could be found if there was no attempt to investigate suspicions properly.

More fundamentally, the Review believes that this position by some within SJAI reflected a clear lack of awareness of the ethical duty of the organisation to protect the interests of its many vulnerable members. The SJAI organisation could have, and should have, taken action to investigate and involve the appropriate authorities as soon as there were any suspicions or complaints of serious misconduct and victimisation.

The Review therefore believes, on balance, that SJAI failed to act due to fear of litigation arising from removal of threats or suspected threats to child safety. The Review has not found any evidence that SJAI sought independent legal advice on these matters. The Review also believes, from data established on foot of the Interview Phase, that SJAI felt powerless to act to address known or suspected threats because of misguided beliefs about the necessary evidential thresholds for their own interventions. The Review believes, on balance, this avoidance of responsibility was primarily due to a desire to protect the reputation of the organisation.

The Review believes that responses to wrongdoing more generally in SJAI were profoundly inadequate and reflected an instinct to protect the interests of the organisation rather than its ordinary members. Any responses that were initiated seem to have been hampered by delay and hesitancy. It seems that this organisational inadequacy in terms of accountability and safety remained the case until recently.

A number of very serious allegations of "cover-up" were made by some victim-survivors and other participants during the Interview Phase of the Review. Many of these are extremely difficult to verify due to the poor record keeping of SJAI during the relevant time periods. One claim that the Review was able to partially verify relates to the attempted offer of informal cash compensation to one of the victim-survivors after a formal complaint was made. While there is no documentary evidence in the SJAI records to verify this, a number of interview participants in leadership positions believed that it was accurate.

Testimony of Victim-Survivors

The Review heard accounts from victim-survivors of experiencing ongoing and persistent trauma. Many of the victim-survivors informed the Review that the trauma remains with them to this day, and that they found it difficult to share their stories during their interviews with the Review. The Review would like to again commend the victim-survivors for their bravery and dignity in telling their story.

The Review notes that SJAI apologised to one of the victim-survivors of abuse. It is recommended that SJAI offer an apology in comprehensive terms to the victim-survivors and others. It is also recommended that SJAI puts in place adequate therapeutic support for those who came forward to speak with the Review.

The Review also recommends enhanced ongoing communications processes for those who make complaints, and that complaints processes are managed with a greater emphasis on transparency and institutional confidence-building for the membership, as appears to be the case today.

The Documentary Review Phase

Following its initial establishment, the Review, in accordance with the Terms of Reference, made requests for all files and documentation relevant to the Terms of Reference. The following documentation was provided by SJAI in May 2021:

1. Child Protection Policy dated 2002;
2. Child Protection Policy dated 2013;
3. Child Protection Policy dated 2017;
4. Child Protection Policy dated 2020;
5. Redacted scanned correspondence from Tusla to SJAI dated 21 September 2020;
6. Copy correspondence from Tusla to SJAI dated 12 November 2020.

Documentation was made available by SJAI for inspection by the review team in the week commencing 2 May 2022. It was stipulated by SJAI that such documentation would only be made available for inspection at the SJAI Office in Leeson Street, Dublin 2. The following further documentation was made available for inspection at that time:

1. Lever arch folder containing correspondence and information on various files and members;
2. Lever arch folder titled "Correspondence";
3. Two document folders on child protection cases.

The Documentary Review Phase was concluded at the end of May 2022. Subsequently, in light of issues raised in the course of the Interview Phase, a comprehensive list of queries and requests for further documentation was forwarded to SJAI in June 2022. Replies were received from SJAI together with a lever arch folder of further correspondence and documentation on 18 July 2022 (the "Supplemental Disclosure"). This reply stated that access to all files in SJAI's possession had been provided to the Review, save files on two child protection matters and correspondence on other matters, which SJAI advised had been "located very recently" and which were subsequently provided.

The files made available for inspection betray deficiencies in record keeping. Many files contained incomplete accounts. Information relating to different individuals often appeared together in one file or, indeed, duplicated in different files. Some documents were supplied in redacted form only. Complaints and notes were recorded in handwritten script which proved very difficult to read and understand. In most cases, it was not clear who had authored the records, the context of the records or when they were written.

It is the view of the Review that, given the importance attaching to all child protection matters, all notes on file should be typed and dated and clearly set out all relevant information in a consistent and readily accessible manner.

The Review understands that there are currently 476 adult members and 451 cadet members in SJAI. As a result, the provision of four folders of documentation pertaining to all child protection and other matters arising from the Terms of Reference appears particularly inadequate. The paucity of documentation on particular complaints was especially noted by the Review.

Of the documents provided, some notes were furnished which described instances where child protection issues had arisen or concerns were raised. These varied in nature and are detailed further and more fully in Chapter 8 of this Report. Most of the records pertaining to same followed the same themes and suffered from the same deficiencies as the balance of the files furnished: records were incomplete, often in handwritten form, and included errors or inconsistencies.

The files made available for inspection contained a number of cases where child protection concerns had arisen through the use of social media. Again, a number of these documents failed to assist the Review in gaining a clear picture as to the allegations made and actions taken in response.

From the review of the files made available for inspection, it appeared that referrals to Tusla were not made in every case where a child protection issue arose or when such an allegation was made. Responses to reported child protection concerns as recorded, seemed to vary. In some cases, the alleged perpetrator appeared to have been suspended pending the outcome of an internal investigation. In other cases, alleged perpetrators were asked to step down from the organisation pending investigation. It is the view of the Review that any decision to suspend a member should be clearly and unambiguously communicated in writing, in accordance with fair procedures.

Out of all of the files made available for inspection, the Review noted only one file where a follow-up or review appears to have taken place, following a suspension. In this case, the senior SJAI official who had originally dealt with the matter undertook a review after six months and reported accordingly.

The Review noted various instances of difficulties with maintaining contact details of members in the files made available for inspection. It is the view of the Review that difficulties in the management of contacts should not occur in the present day. An up-to-date database of contacts, to include all contact details, must be maintained and updated regularly.

Finally, with regard to records kept of child protection training completed by members, it is the view of the Review that considerable importance should attach to the meticulous retention of records. The Review was concerned to read a note on a file from 2016 which stated that a person who was the subject of a child protection matter had not attended any child protection training, despite having been a member for four years.

Legal Review Phase

During the Legal Review Phase, the Review examined the child protection policies, guidelines, frameworks and practices in place in SJAI, in the context of those obligations and duties imposed by domestic legislation, including:

- Protections for Persons Reporting Child Abuse Act 1998;
- Criminal Law (Sexual Offences) Act 2006;
- Criminal Justice Act 2006;
- Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012;
- Children First Act 2015; and
- National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016.

In order to afford the reader a more global picture as to the extent of these obligations and duties, Chapter 3 of the Report details the current legal position on vicarious liability[4] and the chronology of the evolution and development of child protection guidelines in this jurisdiction.

This Report places significant emphasis on the *Children First* guidelines in examining the adequacy of SJAI's policies as they pertain to child protection. *Children First* contains detailed guidance to

4 Vicarious liability is when a third party is held legally responsible for the wrongdoer's actions if the wrongs are committed while carrying out their duties for that third party, i.e. where the organisation is legally responsible for any wrongdoing committed by its members while they are carrying out activities as part of that organisation.

organisations such as SJAI as to best practice relating to reporting procedures for complaints, retrospective disclosure etc. These guidelines were not put on a statutory and mandatory basis until the Children First Act 2015 was commenced in 2017.[5] The 2015 Act places obligations on organisations such as SJAI. However, it should be noted that the absence of such national guidance would not be sufficient to alleviate any relevant organisation of liability, in accordance with the ordinary principles of vicarious liability.

The 1947 General Regulations of SJAI (re-published in 1994) provide detail on the organisation's structures. There is a section on discipline therein, but no reference to child protection. Reference is made to an internal Court of Inquiry to investigate so-called "objectionable conduct or misbehaviour" of members.[6]

There are five published editions of SJAI's Child Protection Policy (2000, 2002, 2013, 2017 and 2020). The Draft 6th edition of the policy is to be published in 2022. Broadly, the development of said policies track the development and strengthening of national guidance and successive state publications of *Children First* from 1999 to 2019. However, there are clear areas where the policies fall short of legislative developments and child protection guidance.

The 2000 and 2002 Policies, for example, were narrow in focus; written as a handbook for its own members on how to deal with reports or suspicion of abuse, without giving guidance to children or their families on the procedures they could use to report abuse. There was no complaints procedure in either the SJAI 2000 Policy or the 2002 Policy documents. Another marked divergence in these editions of the policy as compared with *Children First* (1999), is that the policy did not include any provision on retrospective reporting.

The 2013 Policy represented a significant advance on the previous edition. It included, for example, a reference to retrospective disclosure. It also was written to have wider scope, providing guidance to parents/guardians and not just members. A detailed complaints procedure was provided in the 2013 Policy, under the heading "*Complaints Procedure for Members, Parents and Children*". The inclusion of this section reflected the wider audience of the document. There was a clear reporting procedure set out therein and it further detailed the role of a child protection officer as the designated liaison person, in compliance with *Children First* (2011).

Provision for vetting and safe recruitment did not appear in *Children First* (1999) but was referred to in *National Review of Children First* (2008) and *Children First* (2011). The SJAI 2013 Policy duly in-

5 Children First Act 2015 which gave statutory basis to the various versions of the state's *Children First* guidelines. The Act was commenced on 11 December 2017. Mandatory reporting became law under the 2015 Act, and this provision was also commenced on 11 December 2017.

6 General Regulations, paragraph 128, pages 25–26.

cluded a section heading titled "Safe Recruitment". Its opening paragraph referred to the requirements of *Children First* and necessitated vetting for all prospective applicants along with cadets themselves once they turned 18. The 2013 Policy, however, made a significant omission in failing to reference the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.

The 3rd edition (2017) and 4th edition (2020) of the policy were in effect, simply republications of the 2013 edition, with no difference in substance to the text. As such, the comments above, pertaining to the content of and improvements made in the 2013 Policy should also be read to apply to the 2017 and 2020 editions. However, the Review notes that, critically, these latter editions did not refer to the Children First Act 2015, which put the *Children First* guidelines on a statutory basis.

The Draft 6th edition of the policy is due to be published in 2022. It promises to compensate for the omissions of past editions by making explicit reference to the Children First Act 2015 and the General Data Protection Regulation 2018 in its introduction. However, as the draft is not yet published, it is therefore subject to amendment. Its weight as evidence of SJAI's current compliance with statutory obligations and child protection norms is consequently diminished.

Data from the Interview Phase also informed the Legal Review Phase. For example: interview participants described how, prior to the late 1990s, there was no formal child protection system in place and what little measures of safeguarding that were available were provided for through the traditional internal accountability system, provided for under SJAI's original 1947 Rules and Regulations. Participants indicated that child protection specific policies had been evolving within the SJAI organisation from the early 2000s, but that the organisation had largely failed to adequately implement these measures in the early years. Ultimately, and as recorded in Chapter 8 of the Report, the Review believes that until the early to mid-2010s, SJAI did not have a fully functioning child protection policy framework.

Interview participants were, however, more positive about the contemporary picture of child protection and safeguarding within SJAI. For example, all currently serving members interviewed spoke compellingly about the organisation's commitment to ensuring Garda vetting was properly integrated into SJAI's organisational structure. Despite this confidence, a number of participants reported that there remain outstanding gaps in SJAI's vetting system. These participants explained the issue is partly down to outdated duty sign-in systems, which remain paper-based, and which do not advise supervising officers about the vetting status of individuals rostered for duty. A number of participants also explained that these outstanding issues in Garda vetting would soon be resolved, as SJAI was in the process of acquiring the Traumasoft software package. Despite these reassurances, the Review was not provided with a detailed explanation of this software, or a timeline for its incorporation in SJAI. The Review believes that the current Garda vetting system

in SJAI remains incomplete. The Review also believes that avoidable child protection risks exist in SJAI, with the potential for unvetted individuals to gain access to children in the organisation.

The Review recommends that SJAI sets out and executes a clear timeline for the incorporation of Traumasoft software. The Review recommends that SJAI moves away from continuing reliance on paper-based forms of rostering, which make vetting verification challenging for members supervising public duties and other scenarios where members may have access to vulnerable people. The Review recommends that SJAI creates an effective compliance enforcement system for Garda vetting in the organisation. This system should involve making specific roles within SJAI responsible for undertaking this work, and recognition of the significant and onerous workload involved in such a role.

As part of the situational child protection question asked during interviews, the Review asked what currently serving members would do if they became aware that an unvetted person was working on a duty. Participants responded that they would immediately have the unvetted person stood down, and removed from duty. This response was consistent among participants. The Review notes that the practice of standing down unvetted individuals is an appropriate and welcome policy. However, the Review cautions against organisational complacency in SJAI about the capacity of a single tool such as Garda vetting to address complex child protection risks and threats.

As is already noted above, it appears that the child protection officer position was included in the 2002 Policy and contemporary reporting structures seem to have emerged from 2013 onwards where complaints or referrals were to be made directly to the child protection officer, as opposed to ascending up the chain-of-command. Of concern, however, is that a number of interview participants who are currently serving members of SJAI defaulted to the chain-of-command in their explanation for how they would address a hypothetical child protection risk they became aware of. This suggests that while efforts have been undertaken by SJAI to create a child protection officer role that is independent of the organisation's hierarchy, there are persistent tendencies towards the older norm of deference to the chain-of-command. When the possibility that some members were still defaulting to chain-of-command reporting structures was raised with senior members of SJAI during interview, some of these participants denied the issue, and blamed the individual members for failing to take "personal responsibility". The Review believes this response to be inadequate, as it fails to take account of SJAI's responsibility to ensure compliance among its membership with its child protection policies.

Before 2000, SJAI members undertook little or no training in the area of child protection. As with other aspects of child safeguarding during this period, SJAI relied instead on trust in senior members in leadership positions, and the organisation's general faith in the capacity of the chain-of-command to identify and manage risks. Between 2000–2011, following the initial disclosures of

abuse by one of the victim-survivors, it appears that SJAI attempted to begin incorporating child protection training for members, particularly those with responsibility for cadets. However, a number of participants who undertook this training during this period described it as, at best, outdated and irrelevant, incorporating in, at least one instance, homophobic content.

Since 2011, in parallel with Garda vetting, basic child protection training is now a core requirement for adult membership in SJAI. That said, records pertaining to such training, as described above, seem lacking. The Review welcomes recent improvements in child protection training in SJAI. However, the Review cautions against complacency about the capacity of basic training to address child protection risks.

The Review believes that SJAI operated an unsafe child safety culture in the pre-2011 period; however, it acknowledges that significant improvement has been made with regard to child protection policies and practices in SJAI over the past number of years. Despite policy improvements, the Review was presented with insufficient evidence with regard to compliance with these systems within SJAI. As such, the Review believes that while child protection policies have evolved to a significant positive degree, outstanding areas of development in terms of compliance management still remain. Further, the Review notes a pervasive denial about past failures at certain levels within the organisation.

The Review recommends that SJAI undertakes an ongoing compliance review with rigorous and routine unannounced inspection and monitoring.

Summary of Learnings and Recommendations

Learnings

- The Review believes that for most of its existence, SJAI operated under a rigid hierarchical structure, which placed a high value on deference and compliance. The Review believes that some aspects of that structure persist within SJAI.

- The Review believes, based on the available evidence, that SJAI's hierarchical structure was wholly unsuited to preventing past predatory behaviour within the organisation, and insulated that behaviour from effective intervention and accountability.

- The Review believes that SJAI's hierarchical structure had, in the past, resisted significant organisational reform in areas such as child protection policies and practices.

- The Review believes that SJAI operates under a highly formalised and quasi-military structure. This structure, and the culture which informs it, places a high value on obedience to rank, and a low value on autonomy.

- The Review believes that the SJAI hierarchy as it operated in SJAI generated competition for rank status within the organisation, and created often unhealthy centres of unaccountable power.

- The Review believes that the core military structures of SJAI remain. The Review believes that these structures informed and shaped the hierarchical structure of SJAI, and the accountability structures within the organisation. The Review believes that these military structures are not appropriate for a healthy child protection and safeguarding culture.

- The Review believes that some members of SJAI perceive some of its governance culture and practices to be dysfunctional.

- The Review believes that the SJAI cadets are, in principle, a positive component of the organisation.

- The Review believes that some issues remain with regard to the governance and management of SJAI's cadet system.

- The Review believes that discipline within SJAI, in the past, was often superficial, focusing on materially insignificant matters such as compliance with the uniform regulations, while ignoring or avoiding substantively serious matters.

- The Review believes that the primary accountability mechanism in SJAI was the chain-of-command. The Review believes that this is a wholly inappropriate accountability approach from a child protection perspective. The Review believes that this approach to accountability also fails to account for the possibility that individuals in that chain-of-command hierarchy may be implicated in victimisation. The Review believes that SJAI's accountability system was generally structured around the assumption that wrongdoing is committed by lower-ranking members.

- The Review believes that the Court of Inquiry process within SJAI lacks adequate transparency. The Review also believes that the Court of Inquiry process was primarily used to discipline junior members of the organisation. This in turn reinforced, in punitive terms, the structural and cultural features of SJAI that prioritised hierarchy and rank. The Review believes that the Court of Inquiry process contains many features which fail to respect individuals' constitutional rights to natural justice.

- The Review could find no rules governing the operation of the Court of Inquiry process.

- The Review believes that the Court of Inquiry process is wholly inadequate and fails to offer a meaningful or effective accountability mechanism. The Review also believes that the process is profoundly procedurally flawed, and poses a serious threat to the constitutional rights of SJAI members.

- The Review believes that the structural and cultural features of SJAI's hierarchy and chain-of-command inhibited accountability for those of high rank. The Review believes that this led to impunity for more senior-ranking members of the organisation from scrutiny or accountability across a wide range of areas, and response paralysis of SJAI in the face of known or suspected threats and wrongdoing.

- The Review believes that SJAI placed a high cultural value on deference to rank and seniority. The Review believes that the effect of this deference to rank inhibited the development of robust and effective accountability mechanisms within the organisation. The Review believes that SJAI's culture of deference conflated rank and status within the organisation, and in other discrete professions as equivalent to the skill, knowledge and integrity appropriate for their role. The Review believes that deference informed and inhibited SJAI's development of internal accountability

systems. The Review believes that this included the directing of disciplinary measures towards more junior ranks and away from senior ranks, facilitating a culture and practice of impunity from accountability. The Review believes that this culture of deference poses an ongoing threat to the implementation of robust and effective child protection systems and practices, if not completely eradicated.

- The Review believes that there is a long-standing and persistent cultural antipathy towards change within some aspects of SJAI. The Review believes that this culture of resistance to change posed an ongoing threat to the implementation of robust and effective child protection systems and practices.

- The Review believes that there was a culture of conservatism within SJAI, that incorporated homophobic myths into its early child protection training. The Review believes that this was likely to have significantly undermined SJAI's initial attempts to develop a formal child protection system in the late 1990s and early 2000s. The Review rejects the contention that such a position can be defended by reference to supposed cultural norms of that time.

- The Review believes that beyond pre-hospital best practices, SJAI needs additional professional resources to better ensure the implementation of robust and effective child protection systems.

- The Review believes that, in the past, SJAI's structure and culture left the organisation vulnerable to grooming and sexual abuse of children within the organisational context. The Review believes that SJAI's accountability systems failed to intervene or investigate, despite evidence of potential risks being highly visible.

- The Review believes it is important for SJAI and others to be very conscious of the fact that several victim-survivors reported that they suffer ongoing and persistent trauma as a consequence of the abuse described in their testimonies.

- The Review believes, based on the available evidence, that over several decades there was a significant degree of organisational awareness of serious threats to children within SJAI.

- The Review believes, based on the available evidence, that there were widely discussed rumours of a specific threat to children in SJAI.

- The Review believes that awareness of specific threats to child safety in SJAI was well-established by the early to mid-1990s.

- The Review believes, based on available evidence, that SJAI failed to undertake investigations into suspected threats to children. The Review believes that this failure to investigate was part of the broader weak accountability mechanisms within SJAI for most of its existence.

- The Review believes that SJAI's failure to initiate any formal investigation following a full disclosure of serious grooming and child sexual abuse in the late 1990s was a serious failure of SJAI's ethical duty of care to its membership, which included hundreds of cadets.

- The Review believes, on balance, that SJAI failed to act on knowledge or suspicions of risk because of a misguided belief that a criminal standard of evidence had to be reached before their intervention was permitted. The Review notes it was difficult to find "hard evidence" where it appears that no attempt was made to investigate suspicions.

- The Review believes that many members of SJAI appeared paralysed by a sense that they needed an evidential "smoking gun" before they could intervene in any way to assess or address potential child protection risks. The Review believes that this position by some within SJAI reflected a clear lack of awareness of the ethical duty of the organisation to protect the interests of its many vulnerable members. The SJAI organisation could have, and should have, investigated suspicions and complaints of serious misconduct and victimisation.

- The Review believes, on balance, that SJAI's failure to act on suspected or known threats was partially based on a fear of litigation. The Review has not found any evidence that SJAI sought independent legal advice on this matter.

- The Review believes that reputation protection had been a strong driving force in SJAI's response to grooming and abuse within the organisation.

- The Review was unable to comprehensively verify claims of an offer of a cash payment by SJAI to a victim in order to protect the organisation's reputation.

- The Review believes that the document and file management systems within SJAI, to include the management of contact information, were sub-optimal and did not meet the standards required of a voluntary organisation working with children.

- The Review believes that rule 122 of the 1947 Rules and Regulations of SJAI (reprinted in 1994) is problematic in that it seeks to constrain the constitutional rights of SJAI members.

Recommendations

- The Review recommends that SJAI should offer an apology in comprehensive terms to victim-survivors and others. It is recommended that SJAI should look to other organisations who have been deficient in child safeguarding for assistance in this regard.
- The Review recommends that SJAI puts in place therapeutic support for those who came forward to speak with the Review. SJAI had offered a consultation and a maximum of six sessions with a counselling service.
- The Review recommends that SJAI abandons all remaining military structures and cultural norms.
- The Review recommends that SJAI undertakes a broad re-examination of its internal governance, transparency and accountability mechanisms. The Review also recommends as part of this process that SJAI examines the potential for putting certain key roles on a professional basis within SJAI to support and facilitate a more dynamic and responsive approach to volunteerism.
- The Review recommends that the cadets should be maintained as a core component of SJAI, with the appropriate rules in place regarding supervision and management of cadets being rigidly enforced.
- The Review recommends that SJAI invests appropriate resources to resolve outstanding issues with regard to the membership information and management systems.
- The Review recommends that SJAI develops formal guidelines to deal with grievances and complaints.
- The Review recommends that the Court of Inquiry process in SJAI be significantly reformed.
- The Review recommends a reconsideration of the hierarchical structure and culture of SJAI. The Review recommends the creation of robust internal accountability frameworks which are transparent and apply equally to all ranks of the organisation.
- The Review strongly recommends that rule 122 be removed from the SJAI Rules and Regulations.

- The Review recommends enhanced ongoing communications processes for those who make complaints, and that complaints processes are managed with a greater emphasis on transparency and institutional confidence building for the membership.

- The Review recommends that the national safeguarding officer should be independent of SJAI.

- The Review recommends that SJAI should institute a system of typed and dated reports for each complainant and every incident or suspected incident affecting child protection or raising child safeguarding concerns.

- The Review recommends that typed and dated notes and records of each meeting where any child protection concerns are considered should be kept in hardcopy format. These must be accessible by the national safeguarding officer and by the relevant state agencies (Tusla and An Garda Síochána). All information should be kept securely in offices or premises of SJAI, and must not be taken to the residences of SJAI members or officers, or any other locations.

- The Review recommends that membership officers in each branch should be aware of the renewal policy, including the requirements for regular re-training and re-vetting. Membership and contact lists must continue to be kept up to date and safely retained at all times.

- The Review recommends that any decision to suspend a member should be clearly and unambiguously communicated in writing to that member, in accordance with fair procedures. The Review also recommends that consideration be given to effective supervision following suspension, to ensure that all terms of such suspension have been complied with and also to ensure the well-being of any cadet members of SJAI who are involved.

- It was noted on one of the files made available for inspection during the Review that an internet safety education session was held by SJAI in one division, involving both parents and cadets and An Garda Síochána. It is the view of the Review that such education and training sessions should be provided to all members and divisions within SJAI.

Chapter 1

Introduction

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Introduction

1.1 Overview

St John Ambulance is an international humanitarian organisation that can trace its origins back to the 11th century (see the "History of the Organisation" section below), and which has been providing first response training and event medical cover in Ireland under the governance of St John Ambulance Ireland (hereinafter "SJAI") for over 100 years. As a PHECC[7]-approved organisation, SJAI provides pre-hospital care at all clinical levels, including cardiac first response, emergency medical technician, paramedic and advanced paramedic levels. The organisation works with event organisers and statutory agencies to provide medical cover at events across Ireland, including sporting occasions and concerts, national events such as the Papal visits, as well as local community events and sports days. Its volunteers continue to be ordinary citizens, in the main, doing extraordinary work with various full-time paramedics, nurses and doctors also volunteering their services to the community through membership of the organisation.

Following a number of public allegations of grooming and child sexual abuse within the SJAI organisation, the Board of SJAI commissioned an independent Review (the "Review") to be carried out by Dr Geoffrey Shannon SC with the assistance of Ms Hilary Coveney and Dr Cian Ó Concubhair into the historic handling of child sexual abuse allegations by SJAI and the adequacy of their current practices in this regard. This Review was recommended and supported by the Child and Family Agency/Tusla and the Department of Children, Equality, Disability, Integration and Youth following a number of complaints of sexual abuse against a former volunteer in SJAI.

The scope of the Review was broken down into two parts as informed by the Review's Terms of Reference, published by SJAI on 8 March 2021:

> "PART 1
>
> - the manner in which the aforesaid complaints in relation to sexual abuse made to the SJAI were dealt with when first made taking into account government guidance and SJAI policies on child protection available at

7 PHECC is the "Pre-Hospital Emergency Care Council" which is an independent statutory agency with responsibility for standards, education and training in the field of pre-hospital emergency care. PHECC also maintains a statutory register of EMS practitioners—see https://www.phecit.ie.

that time (see Appendix I); the manner in which such complaints were dealt with when re-reported in 2013 taking into account government guidance on child protection and SJAI policies available at that time (see Appendix I);

- whether there were any other complaints (whether in writing or verbal to any person in a position of authority) regarding grooming or abuse in relation to the volunteer concerned over his period of involvement with SJAI, and
- any other complaints (whether in writing or verbal to any person in a position of authority) relating to any other individual based on reports made to and/or records held by SJAI: and

PART 2

- the adequacy of arrangements now in place for the protection of children and vulnerable adults who may come into membership of SJAI having regard to TUSLA's assessment in July 2019;

all with a view to identifying learning and making recommendations for the organisation".

There were three phases to this Review: the Interview Phase, the Documentary Review Phase, and the Legal Review Phase. Further information as to the format and execution of each phase is set out in Chapter 2 of this Report.

According to these Terms of Reference, the Review has both contemporary and retrospective components.

In its retrospective component, the Review's Terms of Reference require, in general terms, an examination of how the organisation has, over the past number of decades, managed the safety and welfare of children who are SJAI members. How complaints of abuse were responded to within the organisation is the principal focus. This process of examination necessarily included an assessment of the organisation's structure and culture, and how both features of SJAI informed its child safety culture and practices. These particular streams of enquiry called for a diversity of methodological approaches, including the legal and documentary reviews and interviews. Given the paucity of records, this component relied heavily on the Interview Phase to answer the questions which flow from the Terms of Reference.

In its contemporary component, the Review's Terms of Reference required an examination of current child safeguarding arrangements within SJAI. This included: an assessment of responses to child safeguarding complaints and investigations by SJAI; how the organisation engages with the statutory agencies, i.e. the Child and Family Agency/Tusla and An Garda Síochána; and the general culture of compliance management in child safety. Similar to the retrospective component, this necessarily included an examination of the current SJAI structure and culture. This contemporary component was also informed by the three review phases, including legal and documentary reviews, and the Interview Phase.

The Terms of Reference also provide for recommendations to be made to SJAI on foot of the Review. It is understood that it is the Board of SJAI's intention to publish the Report.

The scope of the Review is limited to the matters as aforesaid. The scope of the Review does not extend to the investigation of the merits of any complaint or to the making of any finding to uphold or dismiss any complaint. For the investigation of particular complaints or allegations, contact should be made with either SJAI directly or An Garda Síochána or Tusla. As mentioned, the scope of this Review is limited to the consideration of how SJAI handled specific complaints of grooming and child sexual abuse, and child protection more generally.

To give effect to the Terms of Reference, the Review was given access to personal data held by SJAI and contained within the following categories of documents/information:

- records of any safeguarding complaints received by SJAI;
- membership records of the complainants and SJAI's membership lists (if any);
- membership records of the person(s) against whom a complaint has been made;
- notes maintained of engagements with the complainants and persons complained against;
- all correspondence relating to the complaints with the exception of any legal advices sought/received;
- any documentation regarding SJAI's organisational structure;
- all correspondence and engagements with Tusla (not redacted);
- SJAI's policies and procedures and other documentation regarding current and past safeguarding practices; and
- any other documents of relevance to the issues the subject of the Review and which were disclosed by SJAI and/or requested by the review team.

As part of the Review, complainants and/or others with knowledge or information relevant to the Terms of Reference were invited to come forward to speak to the review team. The contents of any such voluntary disclosures/contributions were, and are to be, treated as confidential in so far as is possible.

As such, the Review secured access to personal data provided both by SJAI itself and arising from such voluntary disclosures/contributions forthcoming from complainants and/or others with knowledge and which generated documents referencing or recording such personal data. Further details as to how data was duly secured, processed and used are detailed in Chapter 2 of the Report.

Before discussing more fully the format, content and outcome of the Review, the following narrative is intended to provide historical context for the reader in relation to SJAI's origins, structure and function.

1.2 History of the Organisation

1.2.1 Early Beginnings

St John Ambulance traces its origins to the Order of Knights of the Hospital of Saint John of Jerusalem, also known as the Knights Hospitaller, founded in the 11th century. Its work began in Jerusalem when monks from Amalfi established a hostel to tend to pilgrims and to all who needed care regardless of creed. Blessed Gerard, one of the monks from Amalfi, took a leading role in the hostel and founded the Order of St John. Today, it is the oldest existing order of chivalry in the world. The Order of St John and the St John Ambulance exist side by side.

1.2.2 1877—History and Foundation in England

During the reign of Henry VIII, the English branch of the Order of St John of Jerusalem was suppressed as part of the dissolution of the monasteries in the English Reformation. Steps were taken in the late 1820s to re-establish the English branch of the Sovereign Order but over the years negotiations proved unsuccessful. The main difficulty was the admission of Protestant English knights into a Catholic order. Negotiations finally broke down in 1858 and in 1862 the would-be English branch declared itself to be the "Sovereign and Illustrious Order of St John of Jerusalem; Anglia"—an unofficial order with no connection with either the Sovereign Order or the British Crown. In 1875, it promulgated a new constitution, renaming the body as the "Order of St John of Jerusalem in England".

Through the mid-nineteenth century, the rise of industrial power reshaped the modern-day work of the Order of St John, as accidents and fatalities from workers employed in iron-making, textiles, breweries and the mines, as well as railway-related deaths rose in the thousands. With no civil organisation in place, this set the stage for the creation of the St John Ambulance Association in 1877 by three founders: Sir John Furley, Colonel Francis Duncan and Sir Edmund Lechmere. They were pioneers in first aid. In 1887, the St John Ambulance Brigade was established. While there were thousands now trained in first aid, the brigade of trained men and women in uniform quickly spread across the British Empire.

By its charitable and humanitarian activities and its royal patronage the Order, on 14 May 1888, gained recognition from the sovereign with its Royal Charter.

1.2.3 1880—The Foundation of a Teaching Centre in Dublin, St John Ambulance Association

Three years after its establishment in England, the first public meeting of the St John Ambulance Association in Ireland was held in 1880. As in England, the association was a teaching institution which organised lectures in first aid, home nursing and sanitation skills. For the next 23 years, the St John Ambulance Association brought critical skills in pre-hospital care and sanitation to homes, businesses, industry and the public sector in helping treat and tackle the many diseases of this period.

1.2.4 1903—The St John Ambulance Brigade in Ireland

The need to have a brigade established in Ireland was seen for several years but it did not come until 1903, when the chief medical officer of the Guinness brewery, Dr John Lumsden, organised the first class. In March of the same year, he enrolled over 30 members into the first division, St James' Gate Ambulance Division. The initiative was welcomed by the brewery, which at the time was the largest in the world, and it was supported by Lord Iveagh and the wider Guinness family. Lumsden was promoted to divisional superintendent and surgeon of the St James' Gate Division when it registered at St John's Gate, the head office of St John Ambulance in London.

Also in 1903, a decision was made to establish a new reserve following a review of the Royal Navy, leading to the formation of the Royal Naval Auxiliary Sick Berth Reserve (RNASBR), an auxiliary of men from St John Ambulance. It was a preparedness measure that was brought forward by the British admiralty at the time, preparing men with advanced training in anatomy, physiology and surgery so they could be called upon in war. This was a major advantage to members of St John Ambulance who received advanced training and received a small wage when travelling to various naval bases across England where they attended for training.

1.2.5 1905—The First Public Division in Ireland

In 1905, two people died after being overcome by poisonous gas on Burgh Quay where Dublin Corporation had been working. Several other people onsite were treated by a trained first aider, John Thompson, who had just recently completed training with the St John Ambulance Association. It was here that the idea of a public first aid division was born. Thompson approached the association and collaborated with Dr John Lumsden to bring it together. In December 1905, the first public division was registered as City of Dublin Ambulance Division. The division still exists

and is believed to be the oldest division in the world, which has consistently run every week (apart from holidays) since its inception.

From 1905, the St John Ambulance Brigade in Ireland division grew from strength to strength with the first female public division establishing in 1909. Competitions were held in Lord Iveagh Gardens, Merrion Square and St Stephen's Green, which became very competitive and attracted considerable public interest.

1.2.6 1913—The General Strike and Re-organisation

The first test for the Brigade was during the Lockout and General Strike riots in Dublin when workers and the police clashed. The impartial status of the organisation in attending to the wounded became embedded in public memory.

By 1912, there were over 23,000 Brigade members; all were volunteers who gave their time, their energy and often their money to aid humanity on a charitable basis when no national health infrastructure existed. By 1913, the St John Ambulance Brigade had expanded to such an extent that re-organisation became inevitable. The original five regions across Great Britain were now insufficient for effective control and efficient administration and so the country had been divided into 11 districts during the latter part of 1911. In 1913, the first nursing officers conference took place at St John's Gate, London, at which an Irish delegation attended. The conference discussed a wide range of topics, including hospital routine, duties of the commandants and quartermasters of voluntary aid detachments, and experiences during the Balkan Wars. These subjects were soon to have greater relevance as St John Ambulance Brigade brought their experience into the period of World War I.

1.2.7 World War I

The turbulence and unease in Europe after the Balkan wars escalated with the assassination of Archduke Franz Ferdinand, heir to the Austro-Hungarian throne, in Sarajevo in June 1914. The system of alliances led to a full-scale war across Europe (and later in large parts of the world). By August 1914, Britain had declared war with Germany, initially in defence of Belgium. The British Army called up all reservists and auxiliaries to fill duties at home and abroad. In the early months of the war, campaigns for recruitment were very active and by the end of 1914 there were 29 St John Ambulance divisions across the country. Each district then was represented by a deputy commissioner, with the chief commissioner residing at the headquarters in London. Up to 1913,

the Irish divisions were part of and managed by the largest district in Britain, No. 4 Lancashire District. Although Ireland was under the Lancashire District, it was guided under the counsel of its founder Dr Lumsden. Following the outbreak of the war, Ireland's divisions expanded to almost all of the 32 counties and it required its own leader to govern its affairs. Ultimately, Ireland became the No. 12 Irish District, with Dr Lumsden appointed as Deputy Commissioner.

Considerable support came from public officials and aristocrats who assumed honorary positions within the organisation. They helped drive the public message through newspapers and donated large sums of money. As the war progressed, they also provided the use of their large estates for the care of the wounded soldiers.

1.2.8 World War I and the 1916 Rising

During World War I, over 1,600 members of St John Ambulance left Ireland, with many also being members of the St John Voluntary Aid Detachments and the RNASBR. Men assumed positions aboard hospital ships while women spent their time in hospitals or driving ambulances of the wounded at the edge of battlefields. Unlike the general army, the men in the RNASBR did not take an oath and only made a declaration so they were not compelled to serve. Most of the men made it home during or after the war was over.

These included John J. Doyle, a member of City of Dublin Ambulance Division and later an instructor. He was promoted to director of medical services of the Irish Volunteers by Commandant General James Connolly. Doyle's skills in teaching and leadership were quickly realised and he was identified as the orchestrator for building the medical corps within the Irish Volunteers. Although he left to join the war effort in 1914, he returned and was later discharged by the admiralty in 1915 where he resumed his position in the Irish Volunteers.

During the Easter Rising, Doyle served in the General Post Office (the "GPO"), the battalion headquarters. Examining witness accounts and other sources show that Doyle had great confidence and trust in Cumann na mBan, an Irish republican women's paramilitary organisation which at the time was an auxiliary of the Irish Volunteers. The women of Cumann na mBan took a leading role in the first aid movement within their organisation and worked with Doyle in ensuring that there were sufficient members trained in first aid and readily available, should they be required.

Over 600 members turned out to treat the wounded during the Easter Rising and assist the civil authorities. One member, Holden Stodart (33) was killed on 26 April during the Battle of Mount Street Bridge while attending to the many wounded soldiers who were ambushed coming into the city.

1.2.9 Overview of Work at Home

Whilst over 1,600 volunteers served abroad, the St John Ambulance worked with the British Red Cross in Ireland and established a national civilian effort which was headed by Dr Lumsden as director-in-chief of the joint voluntary aid detachments in Ireland. Over 6,000 volunteers worked in 85 sub-depots across the country. The Irish War Hospital Supply Depot was established in Merrion Square, Dublin, and was also known as the Central Depot. Its aim was to supply hospitals across the front (and later in Ireland) with first aid, medical supplies and other hospital requisites such as artificial limbs to aid the wounded.

During the war, 23 auxiliary hospitals were set up in Ireland to alleviate pressure on the civil and military hospitals. Over 10,000 volunteers were trained in first aid during the war years, 46 hospital ships at North Wall carrying just over 20,000 soldiers were attended to, many sick and injured were transported and special trains were built to transport the injured to hospitals.

1.2.10 1918—The Greatest Single Loss of Life in the Irish Sea

The Irish-owned ship, the RMS Leinster, which was carrying a total of 694 passengers and 77 crew from Kingstown (now Dún Laoghaire) to Holyhead in Wales was torpedoed by a German submarine on 10 October 1918. At least 564 people died. St John Ambulance assisted with the rescue and recovery operation at the harbour. Three nursing members of St John Ambulance Brigade were among the dead. A special ceremony was held on the centenary in 2018 in honour of those who died and those who assisted with the rescue operation.

1.2.11 1922—The Civil War in Dublin

Members of St John Ambulance Brigade were again active during the Civil War. It is said that the reputation of SJAI came to public attention following its humanitarian activity during the war and during the Easter Rising. It was a common sight throughout the Civil War that both sides stopped firing when they saw St John Ambulance Brigade members attending to the wounded or removing them to safety.

1.2.12 The Cadets

In 1923, the cadet movement of St John Ambulance Brigade in Ireland began in Dublin with the establishment of the first boys' division, City of Dublin Division, and the girls' division, St Stephen's Green Division, later in the same year. Since then, the youth section of the organisation has expanded steadily and today the membership of the cadet divisions represents an important part of the organisation's strength.

The original idea was to afford an opportunity for girls and boys between the ages of 11 and 18 to learn elementary first aid and to develop an interest and initial training in the work of St John Ambulance. These cadet divisions were designed to work in conjunction with, and to be attached to, adult divisions to form a core recruiting ground for the adult divisions.

Since those early days, the idea of the cadet movement has been modified and greatly expanded. First aid and home nursing, the basic subjects of training, were to a certain extent inadequate to maintain the interest of the cadets from 11 to 18 years of age.

In the 1940s, St John Ambulance Brigade modified its training and recruiting strategy, as it was no longer the only first aid teaching charity in Irish society and faced competition among new organisations which formed before and during World War II. The curriculum of training of the cadets was expanded to cover many subjects beyond first aid, rescue, and lifesaving skills. Some of the new subjects introduced at the time were cookery, hygiene, child welfare, camping, firefighting, handicraft, housecraft, knowledge and care of animals, public service, and citizenship, signalling and swimming.

A President's badge was traditionally awarded by the President of the Council to cadets who qualified as proficient in 12 subjects.

From its early inception, a cadet rank structure was developed specifically for cadets, with positions of cadet leaders and officers. Members seeking selection had to be proficient in the various works of the organisation, be competent instructors, and possess the essentials for youth leadership. The cadet superintendent was the member in charge of the division, and with the cadet leaders, they organised outings and social events. Parents were encouraged to be involved with the cadet divisions and at one time the parents' committee were attached to some of the youth sections. The organisation encouraged active help and support of their relations and friends.

1.2.13 1925—Welfare

In 1925, the organisation broke new ground when they opened the St John Ambulance Brigade Welfare Department. Years of providing *ad hoc* relief to the poor and destitute across major cities in Ireland took a leap forward. The war brought many hardships with an international economic crisis, and unemployment was rife in the newly established Irish Free State. The welfare department became a fully functional department created by doctors and social workers within the organisation. Its mission was to treat and provide a diet plan for expectant mothers in order to give them and their children the basic right to live and grow healthily. It began as one room of 36 expectant mothers, with demand bringing this to four centres in the city of Dublin. The department was a novel idea by the organisation and became part of the child welfare scheme in the municipality, where grants supported the work and it developed further into the suburbs of Dublin. This work then grew steadily across Dublin before migrating into the larger cities and towns in Ireland such as Limerick, Cork, and Mullingar.

1.2.14 Lourdes

In 1924, the St John Ambulance Brigade began an annual pilgrimage to Lourdes, France. Pilgrims from across Ireland were assisted by members travelling by train to Dublin where they then made their way to North Wall at Dublin's docklands. The members still recall how, on one occasion, in September 1924, when a second Irish national pilgrimage travelled by liner direct to France, most of the pilgrims became sick and they worked day and night, comforting the pilgrims on the rough crossing. From that year, pilgrims were assisted annually by members of St John Ambulance Brigade to many of the holy shrines, including Knock, Co. Mayo.

1.2.15 1929–1932—The Catholic Emancipation and the Eucharistic Congress

Two important religious events were held in Phoenix Park, Dublin in 1929 and 1932 with the Centenary of Catholic Emancipation in 1929 and the Eucharistic Congress in 1932. The St John Ambulance Brigade was asked to provide two members to the organising committee in the Archdioceses of Dublin. These were the largest public events until the visit of Pope John Paul II to Ireland in 1979.

1.2.16 1935—The Dublin Blood Transfusion Service

The St John Ambulance Brigade started the first blood transfusion service in Ireland. The founder Sir John Lumsden was the driving force behind its success and saw its expansion across major cities where the public came forward to give blood. This service was taken over by the state as the National Blood Transfusion Association in 1948 (now the Irish Blood Transfusion Service). The Cork operations were absorbed by the state in 1975 and the Limerick operations in 1991.

1.2.17 1939–1945—World War II

On the outbreak of World War II, the St John Ambulance Brigade was approached by the Department of Defence and the local government in Dublin to undertake the entire responsibility of casualty operations in the county. First aid posts were established in the Dublin area under the Air Raid Precautions Scheme. The organisation's membership reached its highest since World War I and by 1940 alone, 6,694 certificates in First Aid and Air Raid Precautions were issued to members of the public.

Ireland did not participate in the war, but was not entirely spared from its direct impact. The first bombing in Ireland occurred on 26 August 1940, when the German Luftwaffe bombed Campile, Co. Wexford, killing three people. Counties throughout Ireland were affected by the bombings, with injury or fatalities in Dublin. On the morning of 2 January 1941, German bombs hit the Terenure area of south Dublin. A day later, 3 January, another bomb hit houses on Donore Terrace on the South Circular Road. Several people were injured, but no fatalities were recorded. On 31 May 1941, four German bombs fell in North Dublin, one damaging Áras an Uachtaráin, but with the greatest impact in the North Strand area, killing 28 people, injuring 90, and 300 houses were severely damaged. The volunteers of St John Ambulance Brigade staffed ambulances and a mobile unit day and night throughout the period of the war and were first on site to see the devastation caused by the bombing of the North Strand area. Members responded, working with local people and other volunteers in treating the wounded and rescuing those trapped under debris. Personnel and ambulances of the St John Ambulance Brigade crossed the border when bombs hit Belfast city in April and May 1941, working alongside the Ulster divisions of St John Ambulance Brigade and local authorities, regardless of politics or creed, as they had done since the foundation of the organisation in Dublin.

1.2.18 1945

In 1945, the St John Ambulance became independent of The Most Venerable Order of St John, the parent body of the St John Ambulance. St John Ambulance Brigade in Ireland became St John Ambulance Brigade of Ireland with its own constitution and controlled by an Irish council, while the Commissioner remained the head of the organisation. This request came from the Irish Government. The Irish organisation became an association of the Order of St John. The council consisted of citizens who were known to be interested in the work of the sick and injured who received first aid or assistance through its humanitarian work. The aims and activities of its work remained unaltered.

1.2.19 Public Duty

When St John Ambulance Brigade grew, the demand for members trained and readily available was welcomed by the public community. In 1907, the St John Ambulance Brigade began its first public duty at the International Exhibition at Ballsbridge. Its confidence and trust within the community grew when the public saw the benefit of having pre-hospital care should they fall ill or get injured. Members began regular duties at race meetings, equestrian events, concerts, cinemas and theatre, and sporting events from football and Gaelic games to rugby.

1.2.20 1979—Visit of Pope John Paul II

The visit of Pope John Paul II to Ireland saw over one million people attend Mass at the Phoenix Park. Members who had attended the church events in 1929 and 1932 brought their experience in planning for the arrangements. Their recollection of large-scale events was welcomed and afforded the organisers important advice in the planning of the visit in 1979. The St John Ambulance Brigade worked harmoniously with the Order of Malta and the Irish Red Cross in staffing the entire event from railway stations, to approach routes and onsite operating facilities. Collectively this was the biggest staffed and resourced event in Irish history.

1.2.21 Orders of St John of Jerusalem

Since 1961, a mutually Concordat Alliance has existed between the Sovereign Military Order of Malta which is Catholic and the Johanniter Orders of Germany, Sweden and the Netherlands which are Protestant, along with the Order of St John which is open to all regardless of faith. The criteria are that they follow a Christian ethos. The presidency of the Alliance rotates between the four Orders of Saint John.

1.2.22 The Organisation Today

From the 1960s onwards, St John Ambulance has been principally concerned with:

1. teaching first aid;
2. training its uniformed members in first aid skills such that they can provide first aid cover at various events; and
3. maintaining their membership ready to support the statutory services at a time of need.

The work of the former welfare side of St John Ambulance has diminished over the years as other providers, including the state, have assumed leadership in the provision of such services (999, blood transfusion, homeless services etc.).

St John Ambulance Ireland ("SJAI"), as the Brigade is now titled, offers first response training and event medical cover throughout Ireland as a PHECC-approved organisation delivering pre-hospital care at all clinical levels, including cardiac first response, emergency medical technician, paramedic and advanced paramedic levels. As such, it works with event organisers and statutory agencies to provide medical cover at events across Ireland. The type of events that they provide medical services at today include:

- rugby matches;
- soccer matches;
- GAA matches;
- concerts;
- local sports events;

— athletics;
— local community events;
— equestrian events; and
— festivals.

As stated above, among its volunteers continue to be ordinary citizens, in the main, with various full-time paramedics, nurses and doctors also volunteering their services to the community through membership of the organisation.

St John Ambulance also continues to work closely with statutory bodies such as the Health Service Executive ("HSE") and the Pre-Hospital Emergency Care Council, and at some major national events they also work in collaboration with other providers. Most recently, for example, SJAI volunteers assisted the national effort during Covid-19 at vaccination centres as well as assisting the National Ambulance Service ("NAS") at times when NAS needed to deploy additional resources to supplement its own resources. Previously, as with its sister organisations, St John Ambulance volunteers and ambulances were "called out" during extreme weather when the statutory services came under exceptional pressure.

SJAI also continues as a national first aid training organisation and describes itself as "a recognised training institution" with the Pre-Hospital Emergency Care Council and provides recognised training courses such as: "First Aid, Cardiac First Response, Emergency First Response and Emergency Medical Technician". Its instructors provide this training at its headquarters and regional bases, as well as onsite at company premises. Through its medical training faculty, it continues to provide training to the public, separate to the training of its uniformed volunteer members. Thus, private citizens can be given the fundamental training to provide initial assistance in case of an emergency in the home, at work or at play, while awaiting the arrival of the emergency services where required.

The organisation continues to be exclusively self-funding through charitable fundraising, including the payment for service provision, as a registered charity. Its current mission is:

> "To come together on a volunteer basis to provide the highest professional standards of pre-hospital and related care and training in the community at local, regional and national level in a professionally run, volunteer-based, organisation".

SJAI currently comprises several hundred adult volunteers as well as several hundred cadets aged from 10 to 17 years of age. It continues to be run by unpaid volunteers at all levels up to and including their Commissioner, who is the charity's CEO, and is supported by a small full-time administrative staff. The organisation is run nationally from its Dublin headquarters with groups of members training as "divisions" across the country, principally in Dublin, Cork and Limerick, with newer divisions in Kildare, Louth, Cavan and Mayo.

Chapter 2

Methodology

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METHODOLOGY

This chapter outlines and explains three distinct methodological approaches that were employed in the independent Review. These methodologies mirror the three core components of this Review: the Interview Phase, the Documentary Review Phase, and the Legal Review Phase.

2.1 Interview Phase Methodology

This section outlines the most significant methodological component of the independent Review: the Interview Phase.

This phase of the independent Review served two principal purposes. First and foremost, the Interview Phase was designed to gather information on the child protection and safeguarding culture and practices of SJAI from both an historical and a contemporary context. It was initially anticipated by the Review that interview data from this phase would buttress and support conclusions from the Documentary Review Phase in the Review. However, as is discussed in Chapter 8 of this Report, the poor quality and limited availability of records in the organisation for this time means the Review has had to overwhelmingly rely on interviews to inform the Review's examination of child protection in SJAI.

The second purpose of the Interview Phase was to provide victim-survivors, and other members and former members of SJAI with the opportunity to have their experiences heard by the Review. The Review was particularly concerned with ensuring victim-survivors' accounts of their experiences are documented and acknowledged.

2.1.1 Categories and Numbers of Interview Participants

The Review categorised individuals who participated in the Interview Phase under three general headings: victim-survivors, former members of SJAI, and currently serving members of SJAI.

Currently serving members of SJAI made up the significant majority of the 52 interview participants.

Victim-survivors: The Review interviewed participants who stated that they had experienced some form of victimisation as children. All these participants were male.

Former members of SJAI: The Review interviewed participants who were once members of SJAI, but who had since, for various reasons, left the organisation.

Currently serving members of SJAI: The Review interviewed participants who were at the time of interview currently serving members of the organisation. The majority of these participants were male.

2.1.2 Recruitment of Interview Participants

Participants were recruited using two principal methods.

The first method, which garnered the highest response rate, was facilitated by SJAI itself. Under this method, SJAI recruited participants by advertising the independent Review and its Terms of Reference using its own communication channels and contact lists. This method included SJAI emailing currently serving and former members with relevant information, and using the organisation's social media platform. The Review was not directly involved in monitoring and directing this method.

Under this method of recruitment, SJAI also facilitated a large number of interviews with currently serving members in positions of relevant authority. These interviews took place in SJAI premises in Dublin and Cork, and SJAI coordinated and arranged interview dates with members directly.

Some participants recruited through SJAI's advertising efforts did not approach the Review through SJAI's facilitation process. A number of participants contacted the Review directly and arranged to be interviewed in the Review's interview premises. These participants were typically concerned about being identified by SJAI as someone who had voluntarily come forward to be interviewed. These participants consistently alluded to concerns about victimisation for voluntarily participating.

The second recruitment method employed by the Review involved independently advertising the work of the independent Review. This was achieved through the creation of a website for the Review: *https://stjohnambulancereview.ie/* (see Appendix III).

The Review's website included the following:

— It set out the Terms of Reference and Timeline for the Review.

— It described the Review's process.

- It listed the members of the Review team.
- It provided a contact page for the Review.
- It provided contact details for the members of the Review.
- It provided information and contact details for a number of relevant support organisations.

The Review's website was launched in March 2021, and has at the date of writing this Report attracted 3,800 visitors, the overwhelming majority of whom accessed the site directly (see Appendix III).

It became clear that a number of participants who came forward to speak as part of the Interview Phase had done so because of media publicity around the Review. The work of the Review attracted significant and consistent media coverage, and there were a number of notable periods during the Review process where national news organisations wrote about SJAI, victim-survivors and the Review.

2.1.3 Locations and Format of Interviews

Participants were interviewed in three locations. Two of these locations were SJAI premises: the SJAI Headquarters on Leeson Street in Dublin, and the Cork city divisional headquarters. For a number of these interviews, one member of the Review dialled-in to the interview using the Zoom video-conferencing platform. Otherwise, these interviews were conducted in-person. The third location in which the remainder of in-person interviews were held, was a private meeting room in a hotel in central Dublin, which was hired by the Review.

A number of participants were also interviewed remotely using the secure Zoom video-conferencing platform. This facilitated interviews with people that were living outside of the jurisdiction, and others who were not available to interview in person for health, personal or work-related reasons. Much of the work of the Review took place during periods when restrictions due to Covid-19 were in place and some meetings were held remotely as a result. The Review found that the remote interview process worked well, and there did not appear to be any diminution in quality of interview data between in-person and remote interviews.

2.1.4 Informed Consent

All participants in the Interview Phase of the Review were adults.

Participation in the Interview Phase was voluntary. This was explicitly explained in the information documents and consent forms furnished to all participants (see Appendices V to VIII), and again at the beginning of each interview. Participants were advised that no adverse comment or finding would be made by their decision to withdraw from the interview at any point.

A letter was sent to all participants in advance of the Review which is appended to this Report at Appendix V. Conscious of the importance attaching to correspondence to all participants, the review team consulted with the National Adult Literacy Agency ("NALA") to ensure that the content was clearly set out in a straightforward and user-friendly manner. This letter acknowledged the difficulty which many participants might feel in engaging with the Review and attending at interviews. It also underlined our commitment to making the interview as comfortable as possible for all participants.

Participants were provided with the participant information and consent documents in advance of the interview. Most arrived at the interview having reviewed those documents. For those few participants that had not had the opportunity to review the documents in advance, the Review took time to go through those documents, explaining the work of the Review and its limits, highlighting the key issues and risks in their participating, and explaining how personal data would be gathered, stored and used.

The vast majority of participants signed a physical consent form. Some of the participants whose interviews were conducted remotely provided their consent orally, which was audio-recorded by the Review.

2.1.5 Interview Questions and Interview Consistency

Interviews followed set questionnaires (see Appendix IV). The Review designed a number of different questionnaires to reflect the different categories of participants. The questionnaires differentiated between victim-survivors and other participants. These questionnaires were occasionally amended to reflect information that the particular participant had already shared with the Review in their email correspondence before the interview.

In preparation for the interviews and in recognition of the personal difficulties which attendance at interviews might cause many participants, the review team met with a psychotherapist to ensure that we were sensitive to the many issues arising for participants and so that we might be better placed to assist them through this process.

The review team also drew on the resource entitled "Breaking the Silence: Terminology Guidelines for Data Collection on Sexual Violence against Children" launched by the Rape Crisis Network Ireland on 22 February 2022.[8]

The questionnaires included a combination of open-ended questions and information-specific questions.

The questionnaires were designed to both extract information relevant to the Terms of Reference of the independent Review, and to ensure consistency across the various categories of participants.

2.1.6 Recording and Transcription

All interviews during the Interview Phase of the Review were audio-recorded. Audio-recording of interviews formed a key part of the participant consent process, and participant consent was positively re-affirmed immediately before recording began. Participants were advised as to when recording began, and when the recording was concluded.

In-person interviews were generally audio-recorded using at least one digital voice-recording device. For a number of interviews, a backup digital audio-recording device was used. Where a member of the Review dialled-in to an in-person interview using Zoom, that interview was audio-recorded and video-recorded using Zoom's recording function. Interviews that were conducted wholly remotely were audio- and video-recorded using Zoom's recording function.

Members of the Review also took contemporaneous handwritten and/or typed notes on interviews throughout. This was put in place as a safeguard in the event that the audio-recording failed.

Audio-recordings of interviews were then transcribed by professional transcription services commissioned by the Review.

8 See https://www.rcni.ie/wp-content/uploads/RCNI-Breaking-the-Silence-1.pdf, Rape Crisis Network Ireland, 22 February 2022.

2.1.7 Analysis

Transcribed interviews were analysed using the NVivo qualitative analysis tool.

Interviews were analysed using thematic analysis. The approach adopted here was a combination of questionnaire-based themes, and grounded theory thematic development.

The NVivo tool was used to code interview transcripts according to these two sets of themes. The first round of coding involved coding the responses of participants to the questionnaire questions. The second round of coding sought to identify and refine nuanced themes that emerged during interviews.

This second, quasi-grounded approach was crucial in identifying some of the most important structural and cultural forces at play in the SJAI organisation and its approach to child safeguarding and protection.

2.1.8 Security

The Review undertook an extensive and exhaustive series of measures to ensure the integrity of the Review from an ethical and legal perspective. Data security was among the highest priorities from the outset. The Review adopted the following measures to ensure data security and integrity across all phases of the Review.

2.1.9 Email Security

In order to ensure the security of any data shared across email communications, the Review purchased email services from Tutanota. Tutanota provides end-to-end encryption for email messages. This served as the primary email system for the Review's business. Some email addresses using MS Outlook, with two-factor authentication, were also used for Review business.

The secure email account used for all correspondence between participants and the Review was monitored each day and every attempt was made to reply to each participant as speedily as possible, and on the same day if possible.

2.1.10 Data Sharing Security

All documents containing identifying information that were shared electronically were encrypted prior to being emailed. The Review used two encryption tools for this purpose: MS Word's own encryption tool, and Encrypto. Encrypto was primarily used to encrypt large folders, while individual documents were encrypted using MS Word's password-protected encryption tool.

Passwords were varied for documents and were shared by way of text message.

All audio- and video-recording files were also stored within encrypted folders using Encrypto. Where these files were shared with transcription services, the Review sought undertakings from those transcription services that their data security measures were adequate and had this reflected in agreements with these services. Files were shared with transcription services using email or MS SharePoint. The transcription services through various agreements also confirmed final deletion of all files once transcription was complete.

2.1.11 Interview Security

In-person interviews were conducted in three locations, as stated above. Where interviews were conducted on SJAI premises, a risk assessment was conducted in relation to data security. This involved ensuring no person was within hearing distance of the interview area, and doing multiple checks of the interview area prior to departure to ensure no sensitive data was accidentally left behind.

Similar precautions were undertaken in the hotel conference space hired by the Review to undertake other in-person interviews. The Review also instituted a policy of not using the hotel WIFI at this location.

2.1.12 Zoom Security

Remote interviews were conducted using the Zoom video-conferencing platform. To ensure the security of these meetings, the waiting room function was enabled. Once the participant was identified and confirmed, they were admitted to the meeting, and the meeting was locked.

2.2 The Documentary Review Phase Methodology

The Terms of Reference provided for the provision of documentation to the Review in line with the stated objectives of the Terms.

Following its establishment, the Review, in accordance with the Terms of Reference, requested all files and documentation relevant to the Terms, both in correspondence and in attendance at Board meetings.

Initial documentation was provided by SJAI to the review team in May 2021. At that time, the following documentation was provided:

1. Child Protection Policy dated 2002;
2. Child Protection Policy dated 2013;
3. Child Protection Policy dated 2017;
4. Child Protection Policy dated 2020;
5. Redacted scanned correspondence from Tusla to SJAI dated 21 September 2020; and
6. Copy correspondence from Tusla to SJAI dated 12 November 2020.

As evident from Chapter 8, the Review necessarily engaged in lengthy correspondence with SJAI having regard to observing all data protection and legal requirements and considerations.

Documentation was made available for inspection by SJAI in the week commencing 2 May 2022 in accordance with the Terms of Reference.

It was stipulated by SJAI that such documentation would only be made available for inspection at the SJAI Office in Leeson Street, Dublin 2. As a result, it was necessary for members of the Review to attend at these premises on several dates in May 2022, to ensure that the Review would be undertaken as speedily and as comprehensively as possible. The following documentation was made available for inspection by the Review at that time:

1. Lever arch folder containing correspondence and information on various files and members;

2. Lever arch folder titled "Correspondence"; and

3. Two document folders on child protection cases.

No schedule or list of documentation was provided with the documentation, with the result that it was necessary for members of the Review to spend considerable time in analysing and ordering the documentation provided and cross-checking between the various folders, some of which contained documentation relating to a number of matters and some duplicated material. This Review was concluded at the end of May 2022.

Following this Review and in light of issues raised in the course of various interviews, a comprehensive list of queries and requests for further documentation was forwarded to SJAI in June 2022. Replies were received from SJAI together with a comprehensive lever arch folder of further correspondence and documentation on 18 July 2022. This documentation is referred to in this Report as the "Supplemental Disclosure".

This reply stated that access to all files in SJAI's possession had been provided to the Review, save files on two child protection matters and correspondence on other matters, which SJAI advised had been "located very recently" and which were now subsequently provided. As referred to in Chapter 8, various additional documents were provided in this tranche of documentation.

All documentation has been examined by the Review and the results of this Review are set out in Chapter 8.

2.3 Data Protection

The Review employed extensive due diligence to ensure compliance with data protection rules, as set out below and in Appendix II to this Report.

As a result of both the Interview Phase and the Documentary Review Phase, in particular, it was necessary to process personal data of certain data subjects in accordance with both the General Data Protection Regulation (the "GDPR"),[9] and agreement reached on the specific types of personal data being shared with the Review and agreed access/processing restrictions.

As discussed in the Introduction Chapter of this Report, the scope of the Review is limited as per its Terms of Reference. The scope can be broken down into two parts.

In Part 1, the adequacy and effectiveness of the following were considered:

1. The manner in which complaints of sexual abuse were first dealt with by SJAI taking into account the relevant government guidance and SJAI policies at the time, and the manner in which re-reported complaints in 2013 were dealt with, taking into account the relevant government guidance and SJAI policies at that time.

2. Whether further written or verbal complaints were made in relation to the volunteer concerned during his time with SJAI.

3. Whether further written or verbal complaints were made in relation to any other person.

Part 2 of the Review examines the adequacy and effectiveness of the current arrangements which have been put in place by SJAI to ensure protection of children and vulnerable adults who may come into membership of SJAI.

One of the lawful bases for processing of data by the Review is the pursuit of legitimate interests under Article 6(1)(f) of the GDPR, which states that processing of data may be lawful only if and to the extent that:

> "Processing is **necessary** for the purposes of the **legitimate interests pursued by the controller** or by a third party, except where such **interests are overridden by**

9 A European regulation (Regulation (EU) 2016/679) on the protection of personal data and on the free movement of such data.

> **the interests or fundamental rights and freedoms of the data subject** which require protection of personal data, in particular where the data subject is a child"[10] [emphasis added].

A legitimate interests assessment was undertaken by the Review in advance of the commencement of the Review (the "LIA"). It sets out the details of the assessment undertaken for the purposes of Article 6(1)(f) of the GDPR, and records the outcome of same. Defined terms in this LIA have the same meaning as in the GDPR, unless otherwise specified. Details of this LIA are outlined in Appendix II and contextualised as they relate to Article 6(1)(f) of the GDPR.

The review team ensured that all necessary documentation arising on foot of requirements under data protection legislation was executed in accordance with legal advice and complied with all legal obligations.

10 Article 6(1)(f), Regulation (EU) 2016/679.

Chapter 3

Child Protection Policies

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CHILD PROTECTION POLICIES

3.1 The St John Ambulance Review: State Response to Child Protection

Towards the end of the twentieth century, the extent of abuse and criminal wrongs that had been perpetrated against children and young people in Ireland in settings outside the home came to public light. The state response to this emerged in stages, with a series of guidelines, policies, and statutory reform.

This response included the development of child protection policies, focused on the immediate threats to children in settings outside the home, such as vetting of employees or volunteers working with children, and means of reporting known or suspected abuse of children. The state bodies responsible developed this to incorporate reporting of historical offences. Policies were strengthened with a legislative basis, both for the policies as they applied to certain bodies, and the wider offences related to protection of children and a requirement to disclose knowledge of offences.

The first section below details the organs of the executive responsible for child protection and welfare. It should be noted that the names of the responsible ministers and state agencies have changed in the period under review.

The second section below details the statutory provisions relating to child protection since the 1990s.

The third section details the current legal position on vicarious liability, i.e. where the organisation is legally responsible for any wrongdoing committed by its members while they are carrying out activities as part of that organisation.

The fourth section details the chronology and development of state child protection guidelines, with a focus on various editions of *Children First*.

The fifth section details the sections of these guidelines that are relevant to SJAI, compared to the relevant sections of SJAI policies.

This chapter draws on relevant themes and data that emerged during the Interview Phase of this Review. This data and the analysis accompanying it is designed to enrich and contextualise the legal and policy review at the core of the Report.

3.2 Executive Responsibility for Child Welfare

Child welfare was formerly a responsibility of the Department of Health, renamed the Department of Health and Children in 1997. In December 2005, the government established the Office of the Minister for Children as a unit within that department with cross-departmental functions where other departments also had responsibility for children. This established the position as a distinct office, in a fashion not normally common for junior ministers. The Minister of State was also in attendance at all government meetings. It was renamed the Office of the Minister for Children and Youth Affairs in May 2008.

In 2011, the new government created the Department of Children and Youth Affairs, with a full government minister at cabinet. Responsibilities under the Protections for Persons Reporting Child Abuse Act 1998 and the Child Care Acts 1991 to 2011 were transferred to this department from the Department of Health.[11] In 2020, this department was renamed the Department of Children, Equality, Disability, Integration and Youth.[12]

At an agency level, child welfare was formerly a responsibility of eight health boards (expanded to 10 in 2000).[13] On 1 January 2005, these were dissolved and their functions were transferred to the Health Service Executive (the "HSE").[14] On 1 January 2014, the child care and child welfare functions of the HSE were transferred to the newly established Child and Family Agency, also known as Tusla.[15]

11 Office of the Minister for Children and Youth Affairs (Transfer of Departmental Administration and Ministerial Functions) Order 2011 (S.I. No. 218) and Child Care (Transfer of Departmental Administration and Ministerial Functions) Order 2011 (S.I. No. 488).

12 Children and Youth Affairs (Alteration of Name of Department and Title of Minister) Order 2020 (S.I. No. 437).

13 Child Care Act 1991 (No. 17), section 3.

14 Health Act 2004 (Commencement) (No. 2) Order 2004 (S.I. No. 887).

15 Child and Family Agency Act 2013 (Commencement) Order 2013 (S.I. No. 502).

3.3 Statutory provisions

3.3.1 Protections For Persons Reporting Child Abuse Act 1998

This was introduced as a private member's bill by Alan Shatter T.D., initially titled the Children (Reporting of Alleged Abuse) Bill 1998, and was accepted with amendments by the government.

Section 3 of this Act protects from civil liability a communication of an opinion, by the person reporting the abuse, to an appropriate person:

> "that—
>
> (a) a child has been or is being assaulted, ill-treated, neglected or sexually abused, or
>
> (b) a child's health, development or welfare has been or is being avoidably impaired or neglected,
>
> unless it is proved that he or she has not acted reasonably and in good faith in forming that opinion and communicating it to the appropriate person".

An appropriate person is either a member of An Garda Síochána or an officer designated by the HSE or the Child and Family Agency/Tusla (formerly designated by the CEO of each health board).

3.3.2 Criminal Law (Sexual Offences) Act 2006

The Criminal Law (Sexual Offences) Act 2006 established the separate offences of defilement of a child under 15 years of age (section 2) and defilement of a child under 17 years of age (section 3), after provisions of the Criminal Law Amendment Act 1935 had been found to be unconstitutional.[16] It is an aggravating factor if the offence in section 3 is committed by a person in authority, doubling the liability on indictment from five years to 10 years. A "person in authority" includes "any person who is, for the time being, responsible for the education, supervision or welfare of the victim" (section 1). The Criminal Law (Sexual Offences) Act 2017 inserted section 3A, establishing the offence by a person in authority.[17] Under this offence, a person in authority is liable if they engage in a sexual act with a child who has attained the age of 17 but is under the age of 18.

3.3.3 Criminal Justice Act 2006: Reckless Endangerment

Section 176 of the Criminal Justice Act 2006 established the offence of reckless endangerment of children.[18] Under this provision:

> "a person, having authority or control over a child or abuser, who intentionally or recklessly endangers a child by—
>
> (a) causing or permitting any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse, or
>
> (b) failing to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation,
>
> is guilty of an offence".

16 Criminal Law (Sexual Offences) Act 2006 (No. 15), commenced on enactment, 2 June 2006.
17 Inserted by section 18 of the Criminal Law (Sexual Offences) Act 2017 (No. 2), commenced on 27 March 2017 by the Criminal Law (Sexual Offences) Act 2017 (Commencement) Order 2017 (S.I. No. 112).
18 Criminal Justice Act 2006 (No. 26), section 176, commenced on 1 August 2006 by the Criminal Justice Act 2006 (Commencement) Order 2006 (S.I. No. 390).

3.3.4 Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012

This Act offers the same protections to the person reporting the abuse contained in the 1998 Act above, by requiring information about certain offences to be reported. It was also introduced by Alan Shatter T.D., then in his capacity as Minister for Justice and Equality.

In general, as Roche-Cagney noted, the purpose of the 2012 Act is to ensure the prosecution of past offences, "as this obligation applies in respect of past offences rather than anticipated crimes, it primarily aids the prosecution of offenders". However, its indirect effect may also be prospective, "where abuse is ongoing, reporting may indirectly assist imperilled victims by alerting authorities to their plight".[19]

In *Sweeney v Ireland* (2019),[20] Charleton J. compared these provisions with similar requirements of failing to alert the authorities of serious offences in the Offences against the State (Amendment) Act 1998:

> "[19] ... In addition to the offence challenged, there are other offences whereby persons in Ireland are required to disclose information. Most obviously, the abuse of children for perverted sexual gratification, by which they are the victims of sexual violence, has been a serious problem in this and in other countries. It is an offence that results in a lifelong blight for many victims. Experience has shown that the nature of perpetrators very often leads to multiple reoffending and the ensnaring of several other victims. Hence, it is appropriately within the scope of a legislative obligation to require those to whom such an offence is disclosed to report it. The effect may be predicted to be the prevention of further similar crimes taking place. Section 2 of the Criminal Justice (Withholding of Information on Offences Against Children and Vulnerable Persons) Act 2012 penalises those who, inter alia, know or believe that murder, manslaughter and sexual offences have been committed but fail without reasonable excuse to report information that might be of material assistance to the authorities. Section 3 casts identical obligations in relation to sexual offences against vulnerable persons". [21]

19 Roche-Cagney, "A Comparative Overview of the Law Regarding Rescue-Part I" (2014) 32 ILT 278.
20 *Sweeney v Ireland* [2019] IESC 39, [2019] 2 I.L.R.M. 457.
21 *Sweeney v Ireland* [2019] IESC 39, [2019] 2 I.L.R.M. 457, at page 468.

3.3.5 Children First Act 2015

The Children First Act 2015 gave a statutory basis to the Children First guidelines. The Act required organisations having contact with children to develop child safeguarding statements, and introduced a system of mandatory reporting to the Child and Family Agency/Tusla.

The section below on national guidelines details the development and publication history of *Children First*. The provision in the 2015 Act on guidelines was commenced on 11 December 2017.[22] This recognised the guidelines which had most recently been issued by the Minister, being those published earlier in 2017.

Mandatory reporting became law under the Children First Act 2015; section 14 places an obligation on mandated persons to report "knowledge, belief or suspicion" that a child has been harmed, is being harmed, or is likely to be harmed to the Child and Family Agency/Tusla as soon as practicable. There are limited exceptions to this duty, such as to avoid duplication of reporting between mandated persons, and to avoid reporting of older children engaged in sexual relationships which are not "intimidatory or exploitative".

Schedule 1 of the Children First Act 2015 outlines the relevant services. SJAI would fall under paragraph 2(c) of the Schedule, being a:

> "work or activity which is carried out by a person, a necessary and regular part of which consists mainly of the person having access to, or contact with, children in any hospital, hospice, health care centre or other centre which receives, treats or otherwise provides physical or mental health services to children".

Paragraph 5 of this Schedule also encompasses the activities of SJAI as it includes:

> "work or activity which consists of the provision of educational, research, training, cultural, recreational, leisure, social or physical activities to children".

Between these two paragraphs, both aspects of SJAI are covered, whether in the provision of services at events, or in providing training and other activities for young people, termed "cadets" by SJAI.

22 Children First Act 2015 (Commencement) Order 2017 (SI. No. 470).

3.3.5.1 *Mandated Persons*

Schedule 2 specifies those within the category of "mandated persons". Paragraph 15(i) includes a:

> "safeguarding officer, child protection officer or other person (howsoever described) who is employed for the purpose of performing the child welfare and protection function of religious, sporting, recreational, cultural, educational and other bodies and organisations offering services to children".

Paragraph 15(k) includes a:

> "person responsible for the care or management of a youth work service within the meaning of section 2 of the Youth Work Act 2001".[23]

Through either one of these sub-paragraphs, those persons which have variously been described as child protection officers or safeguarding officers within SJAI are mandated persons within the meaning of the Children First Act 2015.

The Children First Act 2015 places specific obligations on organisations which provide services to children and young people.

The 2015 Act does not itself impose criminal sanctions. However, as outlined in its later guidance, there are other consequences for non-compliance. As detailed in *Children First* (2017), at page 26:

> "There are a number of administrative actions that Tusla could take if, after an investigation, it emerges that you did not make a mandated report and a child was subsequently left at risk or harmed.
>
> Tusla may:
>
> - Make a complaint to the Fitness to Practise Committee of a regulatory body of which you are a member

23 In section 3 of the Youth Work Act 2001, "youth work" is defined as "a planned programme of education designed for the purpose of aiding and enhancing the personal and social development of young persons through their voluntary participation, and which is (a) complementary to their formal, academic or vocational education and training; and (b) provided primarily by voluntary youth work organisations".

- Pass information about your failure to make a report to the National Vetting Bureau of An Garda Síochána. This information could therefore be disclosed to your current or future employers when you are next vetted.

In general, many employers consider a failure to report a child protection concern to be a disciplinary matter. Employers are encouraged to include references to obligations in relation to mandated reporting in codes of conduct and contracts of employment for relevant persons.

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 requires that any person who has information about a serious offence against a child, which may result in charges or prosecution, must report this to An Garda Síochána. Failure to report under the Act is a criminal offence under that legislation. This obligation is **in addition to** any obligations under the Children First Act 2015". [emphasis in original]

A relevant and instructive recent case is *McGrath v Health Service Executive*.[24] In that case, Ms Justice Phelan held that the proper interpretation of section 14(1)(a) of the Children First Act 2015 imposes a reporting obligation on mandated persons where:

a) information has been received or acquired by a mandated person; and

b) based on that information, the mandated person has reasonable grounds to suspect that a child has been harmed, is being harmed or is at risk of being harmed.

As such, where an adult discloses to a mandated person information relating to past harm (within the definition set out in section 2 of the 2015 Act) suffered by them as a child, a report must be made to the Child and Family Agency/Tusla. The section does not require the consent of the person who has been harmed before a report must be made to the Agency.

Section 14(1)(a) does not require that the mandated person know the identity of the alleged perpetrator of the abuse, or that said perpetrator be identifiable at all, for the reporting obligation to be invoked.

24 *McGrath v Health Service Executive* [2022] IEHC 541.

3.3.6 National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016

The National Vetting Bureau (Children and Vulnerable Persons) Act 2012 provided a legislative basis for the vetting of persons who seek positions of employment relating to children or vulnerable persons. Prior to its commencement, persons applying for such positions were vetted on a non-statutory basis. This Act made this vetting mandatory.

The Act was commenced in April 2016. The purpose of the 2016 Act is to assist the rehabilitation of offenders.

Section 3 of the 2012 Act provides that it does not apply to:

> "the giving of assistance by an individual—
>
> (i) on an occasional basis, and
>
> (ii) for no commercial consideration,
>
> at a school, sports or community event or activity, other than where such assistance includes the coaching, mentoring, counselling, teaching or training of children or vulnerable persons".

Therefore, SJAI would not be covered by this exemption.

Under section 14A, a conviction by the District Court need not be disclosed under certain circumstances. Certain offences are not exempt; these include sexual offences. Offences listed in Schedule 3 are not exempt. Of relevance to child welfare, these include: an offence under section 17 of the Domestic Violence Act 1996 or sections 33, 38 or 39 of the Domestic Violence Act 2018; an offence under the Non-Fatal Offences against the Person Act 1997; an offence under section 246 of the Children Act 2001 (cruelty to children); and an offence under section 176 of the Criminal Justice Act 2006 (reckless endangerment of children).

3.4 Civil Liability

The civil liability[25] of those other than the perpetrator, through vicarious liability,[26] was considered by the Supreme Court in two cases of historical sexual abuse, *O'Keeffe v Hickey*[27] and *Hickey v McGowan*.[28]

In *O'Keeffe v Hickey*, Ms O'Keeffe had brought an action against a school principal who had committed acts of sexual abuse against her. She named the Minister for Education and Science and other state parties as co-defendants. The High Court and the Supreme Court dismissed her claims against the state defendants, as there was no direct employment relationship between the first defendant and the state. However, in *O'Keeffe v Ireland*,[29] the European Court of Human Rights found that there had been a violation of Ms O'Keeffe's rights under Article 3 of the European Convention on Human Rights.

In *Hickey v McGowan*, Mr Hickey claimed to have been sexually abused by a teacher who was part of a religious order while he was a child in a national school between the years of 1969 and 1972. He sued both the teacher and the head of the religious order. The High Court found the teacher to have been liable for the sexual abuse and found the head of the order vicariously liable. The court also assigned vicarious liability to the school manager, who had not been a defendant.

On appeal, the Supreme Court upheld a finding of vicarious liability against a school for the actions of a teacher who was found liable for sexual abuse. In doing so, it reformulated the law on vicarious liability. The older test for vicarious liability required the activity to consist of either authorised acts, or proper or improper modes of carrying out that which had been authorised. The test adopted by the Supreme Court was whether there was a close connection between the acts the wrongdoer was engaged to perform and the wrongful acts about which the complaint was made. In this case, there was a close and sufficient connection between the teaching carried out and the criminal abuse of the complainant to satisfy this test for vicarious liability.

25 Civil liability is legal responsibility for damage caused to another person.

26 Vicarious liability is when a third party is held legally responsible for the wrongdoer's actions if the wrongs are committed while carrying out their duties for that third party, i.e. where an organisation is legally responsible for any wrongdoing committed by its members while they are carrying out activities as part of that organisation.

27 *O'Keeffe v Hickey* [2008] IESC 72, [2009] 2 I.R. 302.

28 *Hickey v McGowan* [2017] IESC 6, [2017] 2 I.R. 196.

29 *O'Keeffe v Ireland* 35810/09, Judgment 28 January 2014.

3.5 National Guidelines

Regrettably, the Irish Government did not issue clear guidelines to organisations having contact with children until 1999, and these were not put on a statutory and mandatory basis until 2017.

3.5.1 Child Abuse Guidelines 1987

In 1987, the Department of Health published a revision to its *Child Abuse Guidelines*, dealing with the identification, investigation, and management of child abuse. This document is set within the framework of child abuse occurring within the family. This is evident in the chapter on Legal Position, which identifies only Part II of the Children Act 1908 (a precursor to the Child Care Act 1991). Nevertheless, there are elements that would have informed organisations working with children at the time, in particular with regard to definitions of child abuse.

As summarised in a later report:[30]

> "The guidelines recommend that any person who knows or suspects that a child is being harmed, or is at risk of harm, has a duty to convey their concern to the local Health Board. Allegations made by close relatives, friends or neighbours or by a child or parents referring themselves for help, should be regarded as serious and investigated urgently. All reports of child abuse (including anonymous calls) should be investigated. The guidelines also recommend that where a General Practitioner suspects that the child may be the subject of abuse, either physical, emotional or sexual, he or she should seek an explanation from the parents or guardians of that child.
>
> The guidelines specify action to be taken by the Director of Community Care, who has overall responsibility for the monitoring and co-ordination of cases of child abuse occurring in their area. The emphasis of the guidelines is on the identification, investigation and management of child abuse referred to the health authorities. Moreover, the reference to parents and carers (that is persons who, while not parents, have actual responsibility for a child) would seem to point to family rather than institutional abuse".

However, this duty was not a statutory requirement.

30 *Report of the Independent Inquiry into Matters Relating to Child Sexual Abuse in Swimming* (1998), Chapter 9, paragraphs 2.3 and 2.4, page 85.

3.5.2 Law Reform Commission Report on Child Sexual Abuse 1990

In 1989, the Law Reform Commission published a *Consultation Paper on Child Sexual Abuse*.[31] It set out what was then the position in law:

> "Reporting and Investigation of Suspected Abuse
>
> 1.01 No statute lays down in express terms a duty on any person, private or official, to report child sexual abuse or suspected child sexual abuse. This applies to health care and child care workers, as it does to teachers, friends and neighbours. The criminal law does still contain a little known and seldom used offence called Misprision of Felony, which punishes failure to report the actual commission of certain serious offences (or felonies) such as rape and buggery. However, misprision does not extend to many of the offences relevant in the context of child sexual abuse (i.e. incest, indecent assault, unlawful carnal knowledge of a girl between fifteen and seventeen years of age). It possibly does not extend to felonies disclosed professionally to a lawyer, doctor or clergyman. In *Sykes v DPP* [[1961] 3 All ER 33], Lord Denning conceded that certain relationships, including those of doctor and patient and clergyman and parishioner, might give rise to a claim in good faith that it would not be in the public interest to disclose the felony. This concession has been criticised. The crime of misprision does not extend to a mere suspicion that a felony has been committed".[32]

The chapter proceeds to consider possible civil liability for doctors, the Gardaí, health boards and the Department of Health.

The following chapter considered proposals on mandatory reporting, asking:

> "Should the law require certain persons, such as doctors and other health care professionals, social workers and teachers, to report cases of suspected child sexual abuse to the police or health authorities?"[33]

31 *Consultation Paper on Child Sexual Abuse* (LRC CP 2-1989).
32 *Consultation Paper on Child Sexual Abuse* (LRC CP 2-1989), Chapter 1, paragraph 1.01, page 11.
33 *Consultation Paper on Child Sexual Abuse* (LRC CP 2-1989), Chapter 2, paragraph 2.01, page 23.

In its answer to the question, it proceeded to find:

> "We consider that doctors, health workers and professional social workers should be placed under this obligation. Voluntary social workers present somewhat greater difficulties. On one view, their moral obligation to report is no less strong by reason of the fact that they are not paid. However, the scope of the obligation may be far less easy to determine in the absence of terms of employment and a structured allocation of responsibility among the team of social workers. On balance we believe that the legal obligation to report should be placed on them".[34]

The Law Reform Commission issued its report the following year, *Report on Child Sexual Abuse*.[35] Chapter 1 reviewed proposals on mandatory reporting of child sexual abuse.

In specifying those who would be required to report, it recommended:

> "that doctors, psychiatrists, psychologists, health workers, social workers, probation officers and teachers should be placed under a legal obligation to report cases of suspected child sexual abuse".[36]

This proposal would not have encompassed the wide group later covered when mandatory reporting was eventually introduced in the Children First Act 2015. While not excluding sporting bodies, religious organisations and charitable bodies, the focus in 1990 was on abuse within the family.

34 *Consultation Paper on Child Sexual Abuse* (LRC CP 2-1989), Chapter 2, paragraph 2.06, page 28.
35 *Report on Child Sexual Abuse* (LRC 32-1990).
36 *Report on Child Sexual Abuse* (LRC 32-1990), paragraph 1.9, page 9.

3.5.3 Joint Oireachtas Committee Report on Matters Relating to Child Sexual Abuse in Swimming

In 1998, the Joint Oireachtas Committee on Tourism, Sport and Recreation issued a report, *Report of the Independent Inquiry into Matters Relating to Child Sexual Abuse in Swimming*.[37] It was authored by Roderick Murphy SC. This followed revelations of sexual abuse of children by coaches who were part of the Irish Amateur Swimming Association. Chapter 9 of this report is a section which is quite helpful for this current Review, "Guidelines for Prevention and Detection of Child Abuse". The report notes that it is significant that:

> "guidelines emerged only a decade ago; that these tended to be specific to Health and Education and that they were a response to abuses which were well-publicised in the media".[38]

The following guidelines, reports and other external information were considered:

- Child Abuse Guidelines, Department of Health (July 1987)
- *Procedures for Dealing with Allegations or Suspicions of Child Abuse*, Department of Education (November 1991)
- *Report on Child Sexual Abuse*, Law Reform Commission (September 1990)
- *Putting Children First: a discussion document on mandatory reporting*, Department of Health (1996)
- *Putting Children First: dealing with the Promotion and Protecting the Rights of Children*, Department of Health (1997)
- *Procedures suggested by the Irish Council for Civil Liberties* (1988)
- *Procedures of the Irish Society for the Prevention of Cruelty to Children* (1988)
- *Inquiry into Child Abuse in Cleveland* (1987)
- *The Prevalence of Child Sexual Abuse in Britain* (1995)

37 *Report of the Independent Inquiry into Matters Relating to Child Sexual Abuse in Swimming* (1998).
38 *Report of the Independent Inquiry into Matters Relating to Child Sexual Abuse in Swimming* (1998), Chapter 9, paragraph 1.2, page 84.

- Willis, Holden and Rosenberg, *Prevention of Child Maltreatment: Development and Ecological Perspectives* (John Wiley 1992)
- Safety, Health and Welfare at Work Act 1989 (No. 7)
- *Guide to Ethical Conduct and Behaviour and to Fitness to Practise*, Medical Council (4th ed., 1994)
- *Child Sexual Abuse in Swimming in England*

This outline alone is indicative of the lack of effective and relevant guidelines in place at the time of the report for the protection of children in sport, or, by extension, in a voluntary body such as SJAI. Such guidelines or professional regulations that existed were restricted to particular settings. The conclusion of this chapter is worth citing in full to appreciate the position in 1998:

"15. Need for Effective General Guidelines

15.1 The need for adequate guidelines is a common requirement for the implementation of the procedures recommended by each of the guidelines examined.

15.2 The drawing up of procedures to encourage children to **tell** and of educationalists and health workers to **listen** requires training. Information on its own is not enough. Skills are also necessary. Most important are the attitudes of adults entrusted with the care of children. Training must encompass the education of knowledge, skills and attitudes relating to child sexual abuse.

15.3 The prevention and detection of complaints requires professional and management resources which may deflect and tie up resources from supervising and listening to children.

15.4 Investigation and prosecution need to be prompt, detailed and thorough. It can never be assumed that a person accused of sexual assault of children will plead guilty when confronted with the Book of Evidence.

15.5 The balancing of a child's right to have an abuse restrained and to have an abuser sanctioned should be carefully balanced with an accused's presumption of innocence and right to fair procedures.

15.6 However, a child's faith in the legal process depends on the child's trust in adults to whom the child complains. The evidence given to this Inquiry corresponds to the findings in similar reports that, in the past trust was undermined by inadequate structures. Adults who had been abused lost faith. Children who are presently being abused will have little incentive to complain".[39]

3.5.4 Children First

Children First was first issued by the Department of Health and Children as national guidance in 1999 on a non-statutory and non-mandatory basis. This was the first clear advice and instruction issued by the government to organisations having regular contact with children on providing safeguarding and reporting. The areas of specific relevance to SJAI are detailed in comparison with policies put in place.

Our Duty to Care was published by the Department of Health and Children in 2003, "aimed at community and voluntary organisations of any size or type that provide services for children". In its introduction, it stated that it should be read in conjunction with *Children First*, and was not intended to be a practice manual, but to act as a practical guide. There is therefore considerable overlap and duplication in this guidance.

In 2006, the Office of the Minister for Children invited submissions on a review of *Children First*.

The *Analysis of Submissions made on National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children* (2008) was published by the Office of the Minister for Children and Youth Affairs. The non-mandatory nature of the guidelines was identified as a concern[40]:

"NON-MANDATORY NATURE OF CHILDREN FIRST GUIDELINES

Again, in this section attention was drawn to the non-mandatory nature of the Children First guidelines and the difficulties created by this situation. It was noted that in the absence of a legal framework, they are 'only guidelines, which in itself leads to inconsistency and apathy'. It was suggested that legislation should be

39 *Report of the Independent Inquiry into Matters Relating to Child Sexual Abuse in Swimming* (1998), Chapter 9, paragraph 15, page 105.

40 *Analysis of Submissions made on National Review of Compliance with "Children First: National Guidelines for the Protection and Welfare of Children"* (2008), page 32.

introduced as a matter of priority, to place the Children First guidelines on a statutory basis. The potential conflict was again highlighted in the hierarchy between guidelines and legislation where, for example, employment legislation provides a higher degree of protection to employees compared with guidelines to protect children".

The *National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children* (2008) was published by the Office of the Minister for Children and Youth Affairs. This publication was not itself a new state policy, but a prelude to later versions of the policy. In the area of protection, its headline recommendation was: "That measures be taken to reduce the risk of child abusers re-offending".

A new edition of *Children First* was published in 2011. A further edition of *Children First* was launched on 2 October 2017.[41] This edition was put on a statutory footing when the relevant provision of the Children First Act 2015 was commenced on 11 December 2017. It includes the following requirements for organisations having contact with children:[42]

> "
> - Keep children **safe from harm** while they are using your service
> - Carry out a **risk assessment** to identify whether a child or young person could be harmed while receiving your services
> - Develop a **Child Safeguarding Statement** that outlines the policies and procedures which are in place to manage the risks that have been identified
> - Appoint a **relevant person** to be the first point of contact in respect of the organisation's Child Safeguarding Statement". [emphasis in original]

In January 2019, the 2017 Guidance was amended by way of an addendum to ensure that online safety was specifically accounted for in child safeguarding statements.

41 "Children First Guidance and Legislation", Child and Family Agency; available at: *https://www.tusla.ie/children-first/children-first-guidance-and-legislation/*.

42 *Children First: National Guidance for the Protection and Welfare of Children* (2017), page 30.

3.6 SJAI Policies, Guidelines and Practices

This section focuses on the child protection policies, guidelines and practices in SJAI. It includes a descriptive overview of SJAI's policy and rule-based frameworks relevant for child protection, as well as relevant conclusions and data from the Interview Phase of this Review.

The central component of the Terms of Reference for this Review is concerned with child protection policies and practices within SJAI, both historical and contemporary. As a result, many of the questions put to all interview participants for the Review were focused on these issues.

Interview participants to the Review provided significant and invaluable insights into the internal functioning of SJAI's child protection system. The overarching theme from these responses is that until the early to mid-2010s, SJAI operated an inadequate and dysfunctional child protection system. Participants variously described how child protection specific policies had been evolving within the SJAI organisation from the early 2000s, but that the organisation had largely failed to satisfactorily implement these measures. Prior to the late 1990s, there was no formal child protection system in place; what little measures of safeguarding that were available were provided for through the traditional internal accountability system, provided for under SJAI's original 1947 Rules and Regulations.

Ultimately, and as recorded elsewhere in this Report (see below "Child Protection Policies and Practices"), the Review believes that until the early to mid-2010s, SJAI did not have an effective operational child protection policy framework.

Interview participants were, however, more positive about the contemporary picture of child protection and safeguarding within SJAI.

This general impression of participants was based on three main factors:

1. the organisation's endeavours with regard to Garda vetting;
2. the development and independence of the child protection officer roles; and
3. a general culture change among rank-and-file, brought about by newer, younger membership and their generation's improved familiarity with child protection.

As will be discussed elsewhere in this Report, the Review believes that while there has certainly been significant improvements with regard to contemporary child protection practices in SJAI, there remains a number of areas requiring change and improvement.

3.6.1 SJAI's Foundational Frameworks

The General Regulations of SJAI (re-published 1994) provided detail on the organisation's structures. There is a section on discipline, but no reference to child protection. There is a reference under the heading of Insubordination to "objectionable conduct or misbehaviour at any time or place", which can lead to the formation of an internal Court of Inquiry to investigate.[43]

Within the section on Public Duty, there is a distinction made between the role of men and women within the Ambulance:

> "199. When Ambulance Sisters are available, they should be distributed amongst the stations as detailed by the Officer in charge of the arrangements. Not less than two Ambulance Sisters are to be appointed to any station. As a rule the Ambulance men will be employed in patrolling, rendering first aid at a distance from the stations and transporting to the station or elsewhere the sick and injured who required further treatment, while the Ambulance Sisters will be more particularly employed in attending to women and children brought into the station, who are to be left as far as possible in their care.
>
> 200. When a female patient requires transport, an Ambulance Sister must, whenever possible, accompany the ambulance".[44]

This general sense of appropriateness based on the gender of those working in the ambulance who should treat patients is the only indication of an awareness of matters of personal protection against abuse, including sexual abuse, aside from the earlier reference to "objectionable conduct".

SJAI published its first *Child Protection Policy Handbook* in 2000 and it was substantially reproduced in December 2002 ("the 2002 Policy"). This 2002 Policy is subtitled: *A code of good practice for all adult members*, which reflects the audience of the material within; it is clear from the text in many sections that the intended audience is the membership of SJAI, rather than acting as a guide to all those who interact with SJAI. It was published relatively soon after the publication of *Children First* (1999) and reflects parts of this framework.

43 *General Regulations*, paragraph 128, pages 25–26.
44 *General Regulations*, paragraphs 199–200, page 37.

The *Child Protection Policy* (3rd ed., 2013) ("the 2013 Policy") represented a significant advance on the previous publication. This publication was informed by *Our Duty to Care* (2003, Department of Health and Children), *Children First: National Guidance for the Protection and Welfare of Children* (2011, Department of Children and Youth Affairs) and the *Child Protection and Welfare Practice Handbook* (2011, Health Service Executive). The intended audience was expanded in this and later versions; rather than being a handbook to its members, it also included advice to parents, guardians and others who may wish to understand the child protection policies or make a complaint. In this, it followed the direction within *Children First* (2011) on its use by an organisation "that is providing services for children or that is in regular direct contact with children".[45]

The 4th edition (2017) and 5th edition (2020) of the policy were in effect simply republications, with no difference in substance to the text. References below to the 2013 Policy therefore also apply to these two editions.[46] This is notable, as they do not refer to the Children First Act 2015, which put the *Children First* guidelines on a statutory framework.

The Draft 6th edition of the policy, due to be published in 2022, is a further expansion of the terms of the policy ("the 2022 Draft Policy"). It makes explicit reference to the Children First Act 2015 and the General Data Protection Regulation 2018 in its introduction. The term "child protection officer" is replaced with "safeguarding officer". As stated, at the time of writing, the edition is currently in final draft form, and notes in its introduction that it "needs updating to include reference to members of the public".[47]

The remainder of this section outlines provisions of *Children First* followed by the equivalent provisions in the child protection policies at SJAI.

45 *Children First* (2001), paragraph 1.3, page 5.
46 Side-by-side analysis performed using Text Compare tools.
47 2022 Draft Policy, page 3.

3.6.2 Reporting Procedure

Children First (1999) gave detailed advice to organisations working with children on recognising child abuse and reporting concerns. The sections that relate to reporting are detailed below, beginning with the generalised advice on reporting procedures:

"4 Basis For Reporting and Standard Reporting Procedure

4.1 Purpose

4.1.1 This Chapter offers guidance to the general public and to persons working with children who may be concerned or who suspect that children are being harmed or at risk of harm. It outlines the standard reporting procedure to be used in passing information to the statutory authorities about child protection concerns.

4.2 Responsibility to Report Child Abuse

4.2.1 Everyone must be alert to the possibility that children with whom they are in contact may be being abused. Concerns should be reported to the health board. This responsibility is particularly relevant to professionals such as teachers, child care workers and health professionals who have regular contact with children in the course of their work. It is also an important responsibility for staff and volunteers involved in sports clubs, parish activities, youth clubs and other organisations catering for children.

4.2.2 The guiding principles in regard to reporting child abuse may be summarised as follows:

(i) The safety and well-being of the child or young person must take priority.

(ii) Reports should be made without delay to the health board.

(iii) While the basis for concern must be established as comprehensively as possible, children or parents should not be interviewed in detail about the suspected abuse.

4.2.3 Any reasonable suspicion of abuse must elicit a response. Ignoring the signals or failing to intervene may result in ongoing or further harm to the child or young person. Children and young people may suffer long-lasting

emotional and/or psychological harm as a result of neglect, emotional abuse or sexual abuse. Physical abuse and neglect can be fatal, and some children may be permanently disabled or disfigured as a result of child abuse.

4.2.4 If a person has misgivings about the safety of a child and would find it helpful to discuss their concerns with a professional, they should not hesitate to contact someone in the health board such as a social worker, public health nurse or staff in a health centre to discuss the matter. This should help them to decide whether or not to formally report their concerns to the health board.

4.3 Basis for Reporting to a Health Board

4.3.1 A health board should always be informed when a person has reasonable grounds for concern that a child may have been abused, or is being abused, or is at risk of abuse.

[...]

4.4 Standard Reporting Procedure

4.4.1 If child abuse is suspected or alleged, the following steps should be taken by members of the public or professionals who come into contact with children:

(i) A report should be made to the health board in person, by phone or in writing. Each health board area has a social worker on duty for a certain number of hours each day. The duty social worker is available to meet with, or talk on the telephone, to persons wishing to report child protection concerns. (There is a list of contact numbers in Appendix Three).

(ii) It is generally most helpful if persons wishing to report child abuse concerns make personal contact with the duty social worker. This will facilitate the social worker in gathering as much information as possible about the child and his or her parents/carers.

(iii) In the event of an emergency, or the non availability of health board staff, the report should be made to An Garda Síochána. This may be done at any Garda Station".[48]

48 *Children First* (1999), page 37.

The section on abuse within a voluntary organisation is of specific relevance to SJAI:

> "10.11 Suspected Abuse in a Voluntary Organisation
>
> 10.11.1 Voluntary organisations working with children must be aware of the need to adopt child protection practices and to have in place procedures for dealing with suspected abuse.
>
> 10.11.2 Health boards should designate a social worker to act as liaison officer with voluntary and community organisations and to provide advice on child protection issues. Voluntary and community organisations should also be included in relevant training courses.
>
> 10.11.3 Where organisations suspect a member of staff or volunteer of abuse they should inform the health board who will begin child protection procedures. The organisation should notify the health board of any other organisations working with children with which the alleged abuser is thought to be involved. The health board should include these organisations in any investigation, if appropriate".[49]

There are tailored considerations in the case of organised abuse, that being abuse conducted by, or with the assistance of, more than one person:

> "10.13 Organised Abuse
>
> 10.13.1 Cases of organised abuse comprise only a very small proportion of the child protection concerns which come to the attention of health boards. Nevertheless, they are complex and require particularly careful handling. Essentially, organised abuse occurs when either one person moves into an area or institution and systematically entraps children for abusive purposes (mainly sexually) or when two or more adults conspire to similarly abuse children, using inducements.
>
> 10.13.2 Organised abuse can occur in different settings such as the community, the family or extended family or an institution.
>
> 10.13.3 The following factors are particularly associated with organised abuse:
>
> (i) Detection can take several years.

49 *Children First* (1999), page 103.

(ii) Calculating the number of victims involved can be difficult as many will have moved away from the area. Particular efforts, such as help lines and advertisements, may be required in order to contact victims.

(iii) Victims are often more powerless and vulnerable than those in other abuse cases. Many will have grown up in care.

(iv) Victims may be under particular pressure not to disclose, because of threats or feelings of shame and responsibility.

(v) Some victims may have colluded with abusers to entrap other children and may have gone on to become abusers themselves.

(vi) Families may have unwittingly colluded with the abuse by accepting gifts and friendship from the abuser and encouraging their children to associate with the abuser".[50]

The final section of specific relevance to SJAI is its guidance on handling allegations against employees and volunteers:

"12 Allegations of Abuse Against Employees and Volunteers

12.1 Purpose

12.1.1 This Chapter provides guidance to employers in a situation where an allegation of abuse is made against an employee. In this context, employees also include unpaid volunteers as well as foster-parents. Employers may encompass schools, crèches or non-governmental organisations such as sports clubs. The guidelines are offered to assist managers in having due regard for the rights and interests of the child on the one hand and those of the employee against whom the allegation is made on the other hand. Employers have a dual responsibility in respect of both the child and the employee. All employers should have agreed procedures to address situations where allegations of child abuse are made against an employee.

50 *Children First* (1999), pages 103–104.

12.2 General Procedures

12.2.1 It is important to note that there are two procedures to be followed here:

(i) the reporting procedure in respect of the child;

(ii) the procedure for dealing with the employee.

In general it is recommended that the same person should not have responsibility for dealing with both the reporting issues and the employment issues. It is preferable to separate these issues and manage them independently. These procedures should be followed in the event of suspicion or disclosure of abuse against an employee.

12.2.2 Staff/volunteers may be subjected to erroneous or malicious allegations. Therefore any allegation of abuse should be dealt with sensitively and support provided for staff including counselling where necessary. However, the primary goal is to protect the child while taking care to treat the employee fairly.

12.3 Guidance on Reporting

12.3.1 All organisations providing services to children should have clear written procedures on the action to be taken if allegations of abuse against employees are received. Guidance should be provided for both children and staff/volunteers on how to report suspected abuse. The need for awareness and to report concerns should be reinforced through training and supervision.

12.3.2 Employers should ensure that children and staff are aware of internal line management reporting procedures. Employees should also be aware of the appropriate authorities to whom they should report outside the organisation if they are inhibited for any reason in reporting the incident internally or where they are dissatisfied with the internal response.

12.4 Employer's Responsibility to Report to Statutory Authorities

12.4.1 Where an employer becomes aware of an allegation of abuse by an employee the standard procedure for reporting allegations to the Health Board should be followed without delay (see Chapter Four). Health Boards should have their own internal reporting procedures in place in regard to allegations made against their employees.

12.4.2 Action taken in reporting an allegation of child abuse against an employee should be based on an opinion formed reasonably and in good faith. When an allegation is received it should be assessed promptly and carefully. It will be necessary to decide whether a formal report should be made to the health board; this decision should be based on reasonable grounds for concern as outlined in Chapter Four.

12.4.3 When an employer becomes aware of an allegation of abuse of a child or children by an employee during the execution of that employee's duties, the employer should privately inform the employee of the following:

(i) the fact that an allegation has been made against him/her;

(ii) the nature of the allegation.

The employee should be afforded an opportunity to respond. The employer should note the response and pass on this information when making the formal report to the health board.

12.4.4 Organisations as well as individuals may avail of the immunity from civil liability provided in the Protections for Persons Reporting Child Abuse Act 1998 provided they report 'reasonably and in good faith' to the appropriate authorities.

[...]

12.5 Procedures for Dealing with Employees and Employer's Duty of Care to Children

12.5.1 When an allegation is made against an employee, the following steps should be taken:

(i) Action should be guided by the agreed procedures, the applicable employment contract and the rules of natural justice.

(ii) The Chairperson (or equivalent head of organisation) should be informed as soon as possible.

(iii) The first priority should be to ensure that no child is exposed to unnecessary risk. The employer should as a matter of urgency take any necessary protective measures. These measures should be proportionate to the level of risk and should not unreasonably

penalise the employee, financially or otherwise, unless necessary to protect children. Where protective measures do penalise the employee, it is important that early consideration be given to the case.

(iv) The follow up on an allegation of abuse against an employee should be made in consultation with the health board and An Garda Síochána. An immediate meeting should be arranged with these two agencies for this purpose.

(v) After these consultations referred to above and when pursuing the question of the future position of the employee, the Chairperson or equivalent head of organisation should advise the person accused of the allegation and the agreed procedures should be followed.

(vi) Employers/managers should take care to ensure actions taken by them do not undermine or frustrate any investigations being conducted by the health board or An Garda Síochána. It is strongly recommended that employers maintain a close liaison with these authorities to achieve this".[51]

Procedures for dealing with members and organisations' duty of care to children are also considered in *Our Duty to Care* (2003), under the heading "Responding to accidents and complaints or to alleged or suspected child abuse".[52]

51 *Children First* (1999), pages 109–111.
52 *Our Duty to Care* (2003), page 19.

3.6.3 Retrospective Disclosure

From its first edition, *Children First* (1999) included sections on retrospective disclosure:

> "4.6 Retrospective Disclosures by Adults
>
> 4.6.1 In recent years there have been increasing numbers of disclosures by adults of abuse which took place during their childhood. These revelations often come to light in the context of the adults attending counselling. In these situations it is essential that consideration is given to the current risk to any child who may be in contact with the alleged abuser. If any risk is deemed to exist, the counsellor/health professional should report the allegation to the health board without delay. Investigation of disclosures by adult victims of past abuse frequently uncovers current incidences of abuse and is therefore an effective means of stopping the cycle of abuse".[53]

The SJAI 2002 Policy did not include any advice on retrospective disclosure. This is notable as a divergence between the national guidelines and the SJAI policy. Even as a policy directed towards officers and staff of SJAI, it is evident that there should have been procedures within SJAI for responding to retrospective reports.

Children First (2011) also considers retrospective reporting, in a revised wording:

> "3.6 Retrospective disclosures by adults
>
> 3.6.1 An increasing number of adults are disclosing abuse that took place during their childhoods. Such disclosures often come to light when adults attend counselling. **It is essential to establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in such disclosures.**
>
> 3.6.2 If any risk is deemed to exist to a child who may be in contact with an alleged abuser, the counsellor/health professional should report the allegation to the HSE Children and Family Services without delay.

53 *Children First* (1999), pages 39–40.

3.6.3 The HSE **National Counselling Service** is in place to listen to, value and understand those who have been abused in childhood. The service is a professional, confidential counselling and psychotherapy service and is available free of charge in all regions of the country (see www.hse-ncs.ie/en). The service can be accessed either through healthcare professionals or by way of self-referral". [54] [emphasis in original]

The 2013 SJAI Policy included the following advice, reflecting the aforementioned language used in *Children First*:

> "Retrospective Disclosure: An increasing number of adults are disclosing abuse that took place during their childhoods. It is essential to establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in such disclosures. If any risk is deemed to exist to any child who may be in contact with an alleged abuser, these concerns must be reported to the Child Protection Officer".[55]

This is the first appearance within SJAI policies of instructions on responding to retrospective reports.

The guidance on retrospective reporting was revised again in *Children First* (2017):

> "**Dealing with a retrospective allegation**
>
> Some adults may disclose abuse that took place during their childhood. Such disclosures may come to light when an adult attends counselling, or is being treated for a psychiatric or health problem. If you are, for example, a counsellor or health professional, and you receive a disclosure from a client that they were abused as a child, you should report this information to Tusla, as the alleged abuser may pose a current risk to children.
>
> If, as a mandated person, you provide counselling, it is recommended that you let your clients know, before the counselling starts, that if any child protection issues arise and the alleged perpetrator is identifiable, you must pass the information on to Tusla. If your client does not feel able to participate in any investigation, Tusla may be seriously constrained in their ability to respond to the retrospective allegation.

54 *Children First* (2011), page 15.
55 2013 Policy, page 11.

> The reporting requirements under the Children First Act 2015 apply only to information that you, as a mandated person, received or became aware of since the Act came into force, whether the harm occurred before or after that point. However, if you have a reasonable concern about past abuse, where information came to your attention before the Act and there is a possible continuing risk to children, you should report it to Tusla under this Guidance".[56]

The same paragraph as in SJAI's 2013 Policy appears in its 2022 Draft Policy (with the substitution of safeguarding officer for child protection officer).[57]

3.6.4 Allegations Against a Member

In SJAI's 2002 Policy, the heading "Allegations or suspicions regarding a member of the St John Ambulance Brigade" gives guidance to its own members:

> "If allegations are made or suspicions occur regarding a Member/Officer (or anyone working with your people on behalf of our organisation) YOU MUST:
>
> **Inform the appropriate staff immediately**
>
> Immediately contact your immediate superior and notify them of the situation, if this is not possible for any reason notify the next in line in the channel of communications. They will then follow the appropriate procedures.
>
> **Keep a log**
>
> Make a written, factual record concerning the situation and have this available for the Panel of Inquiry or statutory authorities.
>
> **Assist as and when necessary**
>
> Do not obstruct any referrals to the Gardai or other authorities. Ensure the child or young person is being provided with adequate support by the St John Ambulance Brigade. Be aware that if parents/guardians have been informed they will also need support and clear, concise information. A senior officer should contact them at the earliest opportunity".[58]

56 *Children First* (2017), page 23.
57 2022 Draft Policy, page 23.
58 2002 Policy, page 15.

3.6.5 Reporting Procedure

The heading "Reporting Allegations of Abuse: Channels of Communication" in SJAI's 2002 Policy provides a flowchart of how to respond to a complaint by a parent or a young person, depending on whether there is an emergency.[59] It details a chain-of-command where there is not an emergency (i.e., a divisional officer should first inform the St John Child Protection Officer, who will in turn inform the Commissioner and the authorities), and where there is an emergency (i.e., the divisional officer should inform the authorities immediately, and then inform the St John Child Protection Officer, who will inform the Commissioner).

This follows the requirement referred to above in *Children First* (1999) that:

> "all organisations providing services to children should have clear written procedures on the action to be taken if allegations of abuse against employees are received".[60]

However, as the SJAI 2002 Policy was directed at members only, it did not comply with the requirements of *Children First* (1999) on giving guidance to children themselves on how to report abuse:

> "Guidance should be provided **for both children** and staff/volunteers on how to report suspected abuse … Employers **should ensure that children** and staff are aware of internal line management reporting procedures".[61] [emphasis added]

This can be compared with the equivalent provisions in the SJAI 2013 Policy, under the heading "Reporting Procedures":

> "Steps to take when concerned about a child:
>
> Anyone who has received a disclosure of child abuse or who has concerns of abuse should bring it to the attention of the Child Protection Officer immediately by direct phone contact and completion of the internal Child Protection Reporting Form (See Appendix B). The Child Protection Officer will assess and review the information that has been provided. The Child Protection Officer may contact the

59 2002 Policy, page 19.
60 *Children First* (1999), page 109, paragraph 12.3.1.
61 *Children First* (1999), pages 109–110, paragraphs 12.3.1 and 12.3.2.

HSE for informal advice relating to the allegation, concern or disclosure. After consultation with the HSE officials, the Child Protection Officer will then take one of two options:

Report the allegation, concern or disclosure to the HSE

Not make a formal report to HSE but keep a record of the concerns on file. The reasons for not reporting the allegation, concern or disclosure will be clearly recorded. The member who made the initial report will be informed if a formal report is not being made to the HSE and it is open to him/her to make a formal report themselves, directly to the relevant authority if they feel this is necessary (See Appendix D for details of HSE offices)

Where a formal report is made the HSE will then liaise with An Garda Síochána. It is likely that the HSE will want to speak to the person who first made the report to clarify facts and the circumstances of the report.

In the event of an emergency where you think a child is in immediate/severe danger and you cannot get in touch with the Child Protection Officer or the HSE, a report should be made directly to An Garda Síochána. Remember, the first priority is always for the safety and welfare of the young person and under no circumstances should a child be left in a situation that exposes him or her to harm".[62] [emphasis added]

The position of child protection officer had existed under the 2002 Policy. This section in the 2013 Policy further details the role of a child protection officer as the designated liaison person, in compliance with *Children First* (2011).

62 2013 Policy, pages 11–12.

This reporting procedure should be compared with the provisions in *Children First* (2011). Section 3 of this document includes guidance on the responsibility to report child abuse and neglect and provides for designated liaison persons. Specifically:

"3.2 Responsibility to report child abuse or neglect

3.2.1 Everyone must be alert to the possibility that children with whom they are in contact may be suffering from abuse or neglect. This responsibility is particularly relevant for professionals such as teachers, child care workers, health professionals and those working with adults with serious parenting difficulties. It is also an important responsibility for staff and people involved in sports clubs, community activities, youth clubs, religious/faith sector and other organisations catering for children,

3.2.2 The HSE Children and Family Services should always be informed when a person **has reasonable grounds for concern** that a child may have been, is being or is at risk of being abused or neglected.

3.2.3 Child protection concerns should be supported by evidence that indicates the possibility of abuse or neglect.

3.2.4 A concern about a potential risk to children posed by a specific person, even if the children are unidentifiable, should also be communicated to the HSE Children and Family Services.

3.2.5 The guiding principles in regard to reporting child abuse or neglect may be summarised as follows:

(i) the safety and well-being of the child must take priority;

(ii) reports should be made without delay to the HSE Children and Family Services.

3.2.6 Any reasonable concern or suspicion of abuse or neglect must elicit a response. Ignoring the signals or failing to intervene may result in ongoing or further harm to the child.

[...]

3.3 Designated Liaison Persons for reporting neglect or abuse

3.3.1 Every organisation, both public and private, that is providing services for children or that is in regular direct contact with children should:

(i) Identify a designated liaison person to act as a liaison with outside agencies and a resource person to any staff member or volunteer who has child protection concerns.

(ii) The designated liaison person is responsible for ensuring that the standard reporting procedure is followed, so that suspected cases of child neglect or abuse are referred promptly to the designated person in the HSE Children and Family Services or in the event of an emergency and the unavailability of the HSE, to An Garda Síochána.

(iii) The designated liaison person should ensure that they are knowledgeable about child protection and undertake any training considered necessary to keep themselves updated on new developments.

3.4 Standard Reporting Procedure

3.4.1 Any person reporting a child abuse or neglect concern should do so without delay to the HSE Children and Family Services. A report can be made in person, by telephone or in writing…

3.4.2 Before deciding whether or not to make a formal report, you may wish to discuss your concerns with a health professional or directly with the HSE Children and Family Services…

3.4.3 **Under no circumstances should a child be left in a situation that exposes him or her to harm or to risk of harm pending HSE intervention.** In the event of an emergency where you think a child is in immediate danger and you cannot get in contact with the HSE, you should contact the Gardaí. This may be done through any Garda station". [63] [emphasis in original]

63 *Children First* (2011), pages 13–14.

Of specific relevance to the Review is the heading on retrospective disclosures in *Children First* (2011):

> "3.6 Retrospective disclosures by adults
>
> 3.6.1 An increasing number of adults are disclosing abuse that took place during their childhoods. Such disclosures often come to light when adults attend counselling. **It is essential to establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in such disclosures**.[64] [emphasis in original]

An organisation may after its investigation decide not to report:

> "3.8 Cases not reported to the HSE or An Garda Síochána
>
> 3.8.1 In those cases where an organisation decides not to report concerns to the HSE or An Garda Síochána, the individual employee or volunteer who raised the concern should be given a clear written statement of the reasons why the organisation is not taking such action. The employee or volunteer should be advised that if they remain concerned about the situation, they are free as individuals to consult with, or report to, the HSE or An Garda Síochána. The provisions of the Protections for Persons Reporting Child Abuse Act 1998 apply once they communicate 'reasonably and in good faith'".[65]

These circumstances where a decision is taken not to report are reflected in the SJAI 2013 Policy as one of two options:

> "Not make a formal report to HSE but keep a record of the concerns on file. The reasons for not reporting the allegation, concern or disclosure will be clearly recorded. The member who made the initial report will be informed if a formal report is not being made to the HSE and it is open to him/her to make a formal report themselves, directly to the relevant authority if they feel this is necessary".[66]

64 *Children First* (2011), page 15.
65 *Children First* (2011), page 16.
66 2013 Policy, pages 11–12.

3.6.6 Accusations Against Members

The SJAI 2002 Policy gives guidance specific to its own members on how they should approach accusations, under the heading "Accusations against members of the St John Ambulance Brigade":

> "1. It is vital that ALL complaints are recorded and reported – even those that seem minor.
>
> 2. Remember to tell anyone concerned (child, parents, etc) that you cannot keep information confidential. The need to secure the safety and well-being of the child is paramount.
>
> 3. Brigade headquarters have established a Standing Panel of Inquiry for all allegations of abuse and other serious disciplinary issues.
>
> 4. Ensure that all allegations are reported to Brigade headquarters, via the correct channels.
>
> 5. In addition to providing support, guidance and advice, Headquarters can also assist in dealing with any media involvement.
>
> 6. Brigade General Secretary must also be informed of any suspensions or dismissals of St John Ambulance Brigade members. In the event of the arrest of a member, the individual must remain under suspension pending the result of both the Gardai **and** the St John Ambulance inquiries.
>
> 7. Under no circumstances 'cover-up' information, even where friends, colleagues or senior members of Brigade are concerned. You should not be afraid of revealing information, or feel intimidated by other members, or parents.
>
> 8. All allegations must be reported in writing to the relevant Health Board authorities". [67] [emphasis in original]

67 2002 Policy, page 20.

This is framed differently in the 2013 Policy, under the heading "Procedures for Allegations of Abuse Against a Member". Rather than guidance given to the member, it states the approach to be taken by SJAI:

> "Where an allegation of abuse is made against a member of St John Ambulance, there are two procedures that St John Ambulance will activate:
>
> - The reporting procedure in respect of the child
> - The procedure for dealing with the member
>
> In the case of the allegation being against a member of the St John Ambulance, the same person will not deal with both the young person and the alleged abuser. The Child Protection Officer will follow the normal reporting procedure in St John Ambulance. It will be the responsibility of the Commissioner of St John Ambulance to deal with the staff member against whom an allegation has been made.
>
> If there is an allegation or suspicion in relation to the Child Protection Officer, the Commissioner will deal with all aspects of the case, including the reporting procedure. If there is an allegation or suspicion in relation to the Commissioner, the President of the Council will appoint an independent person external to St John Ambulance to investigate the complaint.
>
> If an allegation is made against a member of St John Ambulance the following steps will be taken:
>
> - The allegation will be assessed promptly and carefully
> - The Commissioner of St John Ambulance will deal with all aspects of the case relating to the member
> - The allegation will be assessed by the Child Protection Officer to establish if there are reasonable grounds for concern and whether a formal report will be made to the statutory authorities, at this point. The Child Protection Officer may wish to contact the HSE for advice on the issue
> - The safety of the child is the first priority of St John Ambulance and all necessary measures will be taken to ensure that the child is safe. The measures taken will be proportionate to the level of risk

- St John Ambulance will ensure that no other children/young people are at risk during this period and will inform other relevant agencies or parents/carers as appropriate

- The measures which can be taken to ensure the safety of children and young people can include the following: suspension of duties of the member, reassignment of duties where the member will not have contact with children/young people, working under increased supervision during the period of the investigation or other measures as deemed appropriate

- The Commissioner will notify the member that an allegation has been made and what the nature of the allegation is. The member has a right to respond to this and this response should be documented and retained. This response will be forwarded to investigating authorities if a formal report is made

- St John Ambulance will ensure that the principle of 'natural justice' will apply whereby a person is considered innocent until proven otherwise

- St John Ambulance will work in co-operation with An Garda Síochána and the HSE and any decisions on action to be taken in regard to the member will be taken in consultation with these agencies, if required

- The person against whom the allegation is made will need support during this period and St John Ambulance will provide advice on how to access the relevant support services

- The Protection for Persons Reporting Child Abuse Act 1998 makes provision for the protection from civil liability of persons who have communicated child abuse reasonably and in good faith to designated officers within the HSE or any member of An Garda Síochána. This protection applies to organisations as well as to individuals".[68]

68 2013 Policy, page 18.

3.6.7 Complaints Procedure

There was no complaints procedure in the SJAI 2002 Policy. By contrast, a detailed complaints procedure is provided in the 2013 Policy, under the heading "Complaints Procedure for Members, Parents and Children". The inclusion of this section reflects the wider audience of the document:

> "A complaint is a written or oral expression of dissatisfaction about the action or lack of action of St John Ambulance or about the standard of a service, where the action taken or the service was provided by a member acting on behalf of St John Ambulance.
>
> **Who may make a complaint?**
>
> Any child or adult involved in the service, either as a member or recipient of care.
>
> A parent/caregiver.
>
> Members of St John Ambulance.
>
> Any other person whom St John Ambulance deems to have sufficient interest in a child's welfare to justify consideration of his/her complaint.
>
> **How to make a complaint**
>
> A complaint can be made directly to any member of staff.
>
> A complaint should be made in writing which can be done with the assistance of a member but must be signed by the complainant. This written complaint should clearly explain:
>
> - What the problem/complaint refers to
> - What is the history of the situation if any
> - What actions have been taken so far in the resolution of the complaint
> - What would the complainant like to happen/what actions the complainant would like St John Ambulance to take
> - If the complaint refers to a child, what is the complainant's relationship status to this child
> - All the relevant contact details of the complainant so that we can make contact following receipt of the complaint

> Remember to include the name of the child that is involved if relevant. The complainant should be provided with a record of the complaint e.g., a copy of the complaint form. A complainant will receive a response from the St John Ambulance within 14 days of receipt by St John Ambulance".[69]

3.6.8 Vetting and Safe Recruitment

Provision for vetting and safe recruitment did not appear in *Children First* (1999). The SJAI 2002 Policy did not have any section on recruitment and vetting. This is reflective of its use as a handbook to existing members, but may also be understood in the context of the topic's absence within the national guidelines.

In relation to Garda vetting, *National Review of Children First* (2008) considered the availability of Garda vetting:

> "The GCVU (Garda Central Vetting Unit) provides information to prospective employers and, through its training of authorised signatories, endeavours to ensure that the value of this information is maximised. However, the final responsibility in ensuring suitability for employment rests with the employer, who should not rely on Garda information only since this is but one aspect of safe recruitment practices. Seeking references and thoroughly checking them out, where the employee or volunteer will have access to children or vulnerable adults, is an essential part of the child protection landscape".[70]

Children First (2011) included vetting within the roles and responsibilities of An Garda Síochána:

> "**Garda Central Vetting Unit**
>
> 4.5.3 The Garda Central Vetting Unit (GCVU) provides vetting on behalf of organisations employing personnel to work in a full-time, part-time, voluntary or student placement capacity with children and/or vulnerable adults. The GCVU provides its vetting service for each sector requiring vetting through a sectoral 'central point of contact', the task of which is to process vetting applications centrally for that sector. The Authorised

69 2013 Policy, page 38.
70 *National Review of Compliance with Children First: National Guidelines for the Protection and Welfare of Children* (2008), page 11.

Signatory is the point of contact appointed in each organisation to forward forms to the GCVU and any disclosures from Gardaí are returned to the Authorised Signatory confidentially, the implications of which can be assessed by prospective employers using a risk management approach. The GCVU does not deal with individual requests for vetting. An individual must make a written application through the organisation to which their area of work is affiliated.

4.5.4 Garda vetting is part of good recruitment practice. While Garda vetting is currently not statutory, it is intended to place it on a statutory basis. The GCVU does **not** decide on the suitability of any person to work with children and vulnerable adults. Rather, in response to a written request for vetting, the GCVU releases criminal history information on the person to be vetted to the prospective recruiting organisation. Decisions on suitability for recruitment rest at all times with the recruiting organisation and the results of vetting should form only one component of the recruitment decision.

4.5.5 Employers/heads of organisations where staff or volunteers have access to children should at all times implement safe recruitment practices, including vetting of applicants and staff, rigorous checking of references, interview procedures and monitoring of good professional practice". [71] [emphasis in original]

This was updated in *Children First* (2017) to reflect statutory requirements since the last publication:

"Vetting

Statutory obligations on employers in relation to Garda vetting requirements for persons working with children and vulnerable adults are set out in the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016. Under these Acts, it is compulsory for employers to obtain vetting disclosures in relation to anyone who is carrying out relevant work with children or vulnerable adults. The Acts create offences and penalties for persons who fail to comply with its provisions. Your organisation should ensure that it fully complies with all the requirements of this legislation.

71 *Children First* (2011), pages 20–21.

> The National Vetting Bureau of An Garda Síochána issues vetting disclosures to organisations employing people who work in a full-time, part-time, voluntary or student placement basis with children and/or vulnerable adults. The National Vetting Bureau does not decide on the suitability of any person to work with children and vulnerable adults. Rather, in response to a written request for vetting, the National Vetting Bureau releases criminal history and other specified information on the person to be vetted to the prospective recruiting organisation.
>
> **Decisions on suitability for recruitment rest at all times with the recruiting organisation and the results of vetting should form only one part of the recruitment decision**".[72] [emphasis in original]

The SJAI 2013 Policy has a section heading titled "Safe Recruitment". Its opening paragraph refers to the requirements of *Children First*:

> "St John Ambulance takes all reasonable steps to ensure that all people recruited are suitable to work with children. St John Ambulance operates a strict recruitment procedure in line with Children First National Guidelines for Child Protection and Welfare. All prospective applicants must be Garda vetted, have references checked and undergo core training in child protection. St John Ambulance advertises volunteer and paid positions as widely as possible, including advertising online, at events etc.
>
> [...] All applicants are required to sign a declaration stating that there is no reason why they would be unsuitable to work with young people, and declaring any past criminal convictions or cases pending against them.
>
> Garda vetting will be sought from all potential applicants at the time of initial application. If issues arise during the course of the Garda vetting process, the final decision regarding recruitment is made by the Commissioner following a review of all relevant information. Vetting is also required when all cadets turn 18".[73]

Vetting is also required under these provisions for cadets themselves once they turn 18.

72 *Children First* (2017), pages 37–38.
73 2013 Policy, page 15.

In the Draft 2022 Policy, it is expressed in essentially similar terms, with the provisions for vetting older cadets being more precise, and also providing for re-vetting:

> "St John Ambulance takes all reasonable steps to ensure that all people recruited are suitable to work with children. St John Ambulance advertises volunteer and paid positions as widely as possible, including advertising online, at events etc. St John Ambulance operates a strict recruitment procedure in line with Children First National Guidelines for Child Protection and Welfare. Our recruitment pathway includes all prospective applicants be Garda-Vetted, have references checked and undergo training in Safeguarding. This refers to the recruitment of persons from 18 years of age.
>
> [...] All applicants are required to sign a declaration stating that there is no reason why they would be unsuitable to work with young people and declaring any past criminal convictions or cases pending against them.
>
> **Garda Vetting**
>
> Garda vetting will be sought from all potential applicants at the time of initial application. If issues arise during the Garda vetting process, the final decision regarding recruitment is made by the Commissioner following a review of all relevant information. Garda vetting is carried out routinely in line with National Guidelines which since Jan 2021 is every three years".[74]

Garda vetting is generally accepted to be among the most important safeguarding measure to protect vulnerable people, such as children, from potential threats emanating from others. Legislative changes in many jurisdictions over the past 30 years have made Garda vetting a fundamental requirement for people and organisations with access to vulnerable people. While it is by no means a comprehensive or exhaustive child safeguarding tool, if employed correctly (i.e. through regular routine re-vetting procedures), Garda vetting enables organisations to remove the most obvious human threats to children.

Given that Garda vetting is now a legal and fundamental requirement of contemporary child safeguarding in Ireland, the issue necessarily formed part of the Terms of Reference for this independent Review. Interview participants were asked about vetting processes within SJAI, and

74 2022 Draft Policy, page 30.

part of the Review's situational child protection questions examined the importance interview participants placed on Garda vetting.

It appears that SJAI has, in recent years, placed significant effort and emphasis in creating a system that ensures the organisation's compliance with best Garda vetting practice. According to a number of participants, this existed as one of the organisation's objectives since 2011. Moreover, it appears that continuing efforts are being undertaken within the organisation to rigorously enforce the organisation's vetting policy.

All currently serving members interviewed spoke compellingly about the organisation's commitment to ensuring Garda vetting was properly integrated into SJAI's organisational structure, as well as routine re-vetting for all members every three years. These participants nearly all spoke with a high degree of confidence about the robustness of the SJAI vetting system.

Despite this confidence, the Review was made aware by an interview participant of a recent incident where SJAI's vetting system failed, and an individual who had not been vetted was brought out on duty. This incident was verified in subsequent interviews. The Review was not provided with any documentation about this incident during the Documentary Review Phase of the Review. As such, the Review is unable to comment on whether this was an isolated incident.

When this incident was raised, a number of participants familiar with SJAI's Garda vetting system reported that there remained outstanding gaps in SJAI's vetting system. These participants explained the issue is partly down to outdated duty sign-in systems, which remain paper-based, and which do not advise supervising officers about the vetting status of individuals rostered for duty.

A number of participants also explained that these outstanding issues in Garda vetting would soon be resolved, as SJAI was in the process of acquiring Traumasoft software. These participants explained that this software system would address the problem identified. Despite these reassurances, the Review was not provided with a detailed explanation of this software, or a timeline for its incorporation in SJAI.

As part of the situational child protection question asked during interviews, the Review asked what currently serving members would do if they became aware that an unvetted person was working on a duty. Participants responded that they would immediately have the unvetted person stood down and removed from duty. This response was consistent among participants, and suggests that the policy around such safeguarding threats has evolved to include a clear and

immediate response. The Review notes that the practice of standing down an unvetted person is an appropriate and welcome policy.

Finally, while the Review notes the absolute necessity in having a robust Garda vetting system, the Review urges caution against the complacency that such a system might generate in an organisation such as SJAI. Given its significant limitation as a child safeguarding tool, successfully achieving a robust Garda vetting system should not distract SJAI from the more significant body of work needed to create a responsive and alert child protection system in the organisation.

The Review believes that the current Garda vetting system in SJAI remains incomplete. The Review also believes that an avoidable child protection risk exists in SJAI, with the potential for unvetted individuals to gain access to children (and/or vulnerable adults) in the organisation.

The Review recommends that SJAI sets out and executes a clear timeline for the incorporation of Traumasoft software. The Review recommends that SJAI moves away from continuing reliance on paper-based forms of rostering, which makes vetting verification challenging for members supervising public duties and other scenarios where members may have access to vulnerable people.

The Review recommends that SJAI creates an effective compliance enforcement system for Garda vetting in the organisation. This system should involve making specific roles within SJAI responsible for undertaking this work, and recognition of the significant and onerous workload involved in such a role.

The Review cautions against organisational complacency in SJAI about the capacity of a single tool such as Garda vetting to address complex child protection risks and threats.

3.6.9 Child Protection Officer

Creating a role that makes individuals responsible for specific child protection duties—a child protection or safeguarding officer—is an important and valuable step an organisation can undertake in achieving effective child safeguarding. However, these individuals must be appropriately qualified and vetted, and be vested with the necessary independence and authority.

As is already noted above, it appears that the child protection officer position was included in the 2002 Policy. However, interviews undertaken by the Review suggest that SJAI created a specific child protection officer role prior to 2002, sometime in the late 1990s. That role appears to have evolved significantly in the past decade, beginning around 2011. Since then a programme of reform and skill-enhancement in the field of child protection was instituted by SJAI.

Interview participants described initial organisational resistance to this agenda. Participants gave varying reasons for why this was the case: a number observing that many senior members of the organisation already believed SJAI was undertaking good work in terms of child protection. Some participants described this early resistance de-escalating soon into the project of reform; one with direct experience in the programme felt in the end that there was significant "buy in" among SJAI's leadership to this particular strand of organisational change.

The Review was not provided with any policy documentation regarding the creation of the child protection officer role—, neither dates nor rationale for its creation—nor how complaints or referrals to the child protection officer would operate. The only insights the Review was able to gather about the child protection officer role beyond later policy documents reviewed in this Report came from interview participants' contributions. Interview participants who were familiar with the early years of SJAI's child protection officer role, described it as lacking meaningful status, impact, or effectiveness.

The reporting system during these early years—how those who were victimised, or who were concerned about victimisation, should raise their concern with the child protection officer—appears to have defaulted to the organisation's deeply-ingrained chain-of-command. If individuals had complaints or concerns to raise, these were to be made to their immediate superiors, not directly to the child protection officer. There are manifold problems and risks with such a child protection system. The most obvious of these is that in many cases, the immediate superior within the organisation may be the person responsible for such victimisation. Another major problem with such a structure is that it puts individuals between the complainant and the child protection officers who may not understand or appreciate the requirements of child safeguarding. This can lead to slow referrals, or non-referral to the child protection officer. The Review heard evidence

from interview participants of a number of examples of this kind of problem occurring in SJAI in the early years of its implementation of child protection policies.

As is discussed in greater detail later in this Report, the chain-of-command itself—given the deep commitment to protecting the reputation of the organisation—may have an interest in attempting to manage or contain such complaints.

In terms of contemporary reporting structures in SJAI—a system which appears to have emerged from 2013 onwards—it seems that the policies now provide for complaints or referrals to be made directly to the child protection officer. These recent reforms to the policy are designed, it seems, to subvert members' inclinations to default to the SJAI hierarchy when they have child protection-related concerns (this apparent cultural inclination to default to the SJAI chain-of-command is examined in detail below). Most interview participants who are familiar with SJAI's current child protection policies and practices described the child protection officer as being "outside the chain-of-command". These participants also answered situational child protection questions in a manner that was consistent with this emerging norm in SJAI.

Of note, however, is that all interview participants who are currently serving members of SJAI did not answer these questions in this way. A number of participants defaulted to the chain-of-command in their explanation for how they would address a hypothetical child protection risk they became aware of. This suggests that, while efforts have been undertaken by SJAI to create a child protection officer role that is independent of the organisation's hierarchy, there are persistent tendencies towards the older norm of deference to the chain-of-command.

In terms of the apparent recent, positive development of the child protection policies and practices in SJAI, a number of participants explained that this occurred in 2013 when an "outsider" (i.e. not an SJAI member) with professional expertise in child protection was appointed by a senior official in the organisation. Indeed, the Review's examination of SJAI's own records support this claim by interview participants (see "History of Child Protection in SJAI as seen in Documentary review" section in Chapter 8). From 2013 onwards, there appears to have been a substantial improvement in record keeping regarding what, if any, actions were taken in relation to child protection risks, threats or harms. However, despite these improvements, it should be noted that this significant burden of work falls on the shoulders of volunteers, many of whom are not child protection professionals. There are 451 cadets in SJAI: a very large cohort, which inevitably involves a substantial pool of safeguarding risk. The Review has concerns about the capacity of volunteers to ensure the safe operating of best practice in child protection within organisations such as SJAI, without recourse to professional assistance or guidance.

Nearly all interview participants were asked if they believed SJAI should move towards a more independent and professional model for child protection and safeguarding. In particular, participants were asked if the child protection role should be advertised externally to recruit non-member child protection professionals, and funded as a part-time position. Responses to this question were almost universal in their support. One such response was recorded as follows:

Interviewer: ... do you think there should be somebody external to the organisation with the responsibility for child protection?

Respondent: For the St John's Ambulance?

Interviewer: Yes.

Respondent: I don't know if you'd need them on a ... full-time basis.

Interviewer: Yes.

Respondent: There definitely should be some, something that would, some external person that puts the things in place but then you have to make sure that the stuff that they put in place, the guidelines and the procedures that they put in place are being followed. [Participant 5k]

These responses also emphasised the need for independent professionals to ensure compliance was being enforced on child protection. One such response was recorded as follows:

> "If you're going to come up, if you're going to have an independent person doing something like that and you're going to have guidelines and you're going to have how [these are] the procedures and you're going to have all this type of stuff, then you need somebody that would need to make sure that they are being followed and they do need somebody that is going to make sure that that's all properly done and not just a box ticked somewhere". [Participant 5k]

The following participant observed that there was an organisational resistance to creating compensated professional roles occupied by organisational outsiders, because of the proud voluntarist ethic of SJAI. This participant also noted that this was inappropriate given the nature of the child protection roles in the organisation.

> "But the first is I think that person absolutely that role needs to be paid, it needs to be there, but it needs to be external … it's very much an organisation, people join for life and often full families join. And everybody knows everybody in it". [Participant 3r]

A number of participants also raised serious concerns about the management of sensitive data by SJAI, particularly data relevant to children and victimisation. One participant again highlighted the challenges in achieving best practice in data governance when the organisation is staffed by volunteers without professional expertise in relevant fields.

3.6.10 Training

Child protection training and guidance is also a central issue to be examined by the Review under its Terms of Reference. All participants were asked about such training in SJAI. As with questions regarding Garda vetting, responses to questions about child protection training described three distinct time periods.

Before 2000, SJAI members undertook little or no training in this area. Aside from a mixture of formal and informal rules governing sleeping arrangements on camping trips and attendance at competitions, there were little or no protocols that were child protection-specific. As with other aspects of child safeguarding during this period, SJAI relied instead on trust in senior members in leadership positions, and on its general faith in the capacity of the chain-of-command to identify and manage risks relating to child protection.

Between 2000–2011, following the initial disclosures of abuse by one of the victim-survivors, SJAI attempted to begin incorporating child protection training for members, particularly those with responsibility for cadets. However, a number of participants who undertook this training during this period described it as, at best, outdated and irrelevant. One participant described attending a training event during this period, which was led by an older member of the organisation, where homophobic myths about the relationship between homosexuality and child abuse formed part of the presentation, much to the incredulity of attendees who were younger, and conscious of then-recent child abuse scandals.

Other participants described feeling, on reflection, deeply embarrassed about the nature of this training.

Since 2011, as part of broader reforms within SJAI, it appears that child protection training has grown to occupy a more central feature of SJAI's core training. In parallel with Garda vetting, basic

child protection training is now a core requirement for adult membership in SJAI. There are also a variety of training programmes available for those who take active leadership roles with the cadet divisions: programmes run and managed by SJAI's internal child protection teams.

The Review welcomes recent improvements in child protection training in SJAI. However, the Review cautions against complacency about the capacity of basic training to address child protection risks. As is noted elsewhere, some senior members dismissed evidence found by the Review of potential gaps in the existing child protection system as merely a failure of "personal responsibility". Such a response downplays the central importance of training and compliance management, post-training, in maintaining the highest child protection standards. As with the above recommendations in relation to Garda vetting, the Review cautions against using child protection training as a sole barometer for the organisational health of SJAI with regard to child protection standards.

3.6.11 Child Protection Policies and Practices

This section deals with the general theme of child protection policies and practices, which emerged from multiple lines of questions about child protection in SJAI. All interview participants were asked about child protection policies and practices in SJAI, and this theme generated among the most significant engagement and responses from participants.

As mentioned elsewhere, interview participants described three periods regarding child protection in SJAI. However, the key turning point seems to have emerged around 2011, where, according to participants, SJAI began to take child protection seriously. This coincided with the introduction of a child protection expert who was an organisational "outsider". A large number of respondents described this latter change in the child protection team as really crucial. Indeed, the Review's examination of documentation in SJAI validates this observation (see "History of Child Protection in SJAI as seen in Documentary review" section in Chapter 8).

It is clear that prior to 2000, SJAI's efforts to operate a formal child protection system were sub-optimal. One interviewee notes that:

> "Child protection really only came in, in early 2000 and it was still like a foreign culture to us. Because rightly or wrongly we believed within the organisation we were doing everything right. Now subsequently in hindsight we weren't. But at the time we believed everybody was safe and how could anybody come to harm within the organisation". [Participant 4h]

Multiple participants described an approach to child protection in the pre-2000 era as one based on "common sense", though the boundaries of this approach were hard to pin down. The only routine child protection policy the organisation appeared to consistently apply was gender segregation of cadets. When the Review sought to interrogate the nature of this "common sense" approach to child protection, by highlighting examples of concerning practices described to the Review, these participants almost always fell back on a "culture of the time" defence. This defence is examined in greater detail below (see "Child Safety Culture" below and also "Reaction by SJAI Reflective of Culture of Time" section in Chapter 7).

Many participants described an organisational context which had invested heavily in faith that rigorous discipline could address any threats or risks, whether these were child-protection-related or not. This feature of SJAI culture is examined in a later chapter (see "Deference and Discipline" at Chapter 6).

Other participants described the early attempts to institute child protection systems during the period around 2000 as a "box ticking" exercise: a superficial attempt to demonstrate compliance with improving standards in the aftermath of the clerical and institutional child abuse scandals.

A number of interview participants described the early implementation of child protection policies, where SJAI reportedly prioritised the organisation's interests over child protection best practices. Some participants described this response as rooted in the weak and outdated structure of the organisation, found in the 1947 Rules and Regulations. These Regulations do not address child protection, despite reportedly being reprinted in the 1990s. A number of interview participants therefore identified the 1947 Rules and Regulations as *the* key issue. According to these participants, many older members were inclined to prioritise the foundational regulations where they had not received training on child protection, or where child protection policies were not readily available to consult. Some suggested the instinct to prioritise the 1947 Rules and Regulations was operative even where members had received some training. Other participants believed the root cause to be a deeper cultural ambivalence within SJAI towards child protection; originating in both in a desire to protect the organisation's interests and reputation, and scepticism about whether SJAI had anything to learn from external best practice.

Indeed, the Review encountered elements of both explanations during the Interview Phase. For example, while the Review accepts that significant changes have been undertaken in how the organisation manages child protection risks, threats and harms—particularly with respect to reporting structures outside the organisation's hierarchy—the Review also found a number of examples of senior members not being familiar with this essential pillar of SJAI child safeguarding policy. These instances emerged when interview participants were asked situational child protection questions, which invited participants to explain how they would respond to a hypothetical child

protection risk. In these few instances, participants defaulted to the organisation's traditional chain-of-command structures for dealing with grievances: a wholly inappropriate and unsafe child practice for child protection.

Here is an example of one such response:

Interviewer: Yes the other question I have, if a cadet approached you and raised concerns that an adult SJAI member was involved in an intimate relationship with a cadet, what would your approach be?

Respondent: Yeah, I think you have to be careful first and I did touch on that, if somebody ever comes to me to make allegations, I always say put it in writing. But obviously you can't do that with children. So, I think the first thing to do is, to take in mental notes. I don't think you can make promises, but I think whatever you advise the cadet, you'd sort of say right, I will come back to you on it. I think then you'd need to go and look at who the person in charge of that cadet is and start the process there. [Participant 4h]

As is described in more detail elsewhere in this Report (see "Denial and Avoidance of Responsibility and Accountability" at Chapter 6), when the possibility that some members were still defaulting to chain-of-command reporting structures was raised with senior members of SJAI during interview, some of these participants denied the issue, and blamed the individual members for failing to take "personal responsibility":

> "We have documents with simple-to-follow rules, but we've got a more in-depth child protection policy document and that is available to everybody to use and all officers must, should know, like if you're in charge, you're supposed to know the rules and exercise them with a degree of accuracy and good sense, and if you're not sure yourself, you've got an officer above you to discuss it with, and in this issue, you don't even, in child protection documents, you don't even discuss it with that officer, you immediately … Child Protection Officers is the person you go to and step in". [Participant 6z]

The Review believes this response to be inadequate, as it fails to take account of SJAI's responsibility to ensure compliance among its membership with its child protection policies.

Some participants noted an increased emphasis on improving the child protection system in SJAI over the past two years, with the introduction of Traumasoft software and improved vetting. Some of these participants credit this renewed effort with the pressure on the organisation due to public controversy over abuse disclosures, and the work of the Review itself.

The Review notes that significant improvement has been made with regard to child protection policies and practices in SJAI over the past number of years. However, despite policy improvements, the Review was presented with little evidence with regard to child protection compliance management systems within SJAI. The few participants who were in a position to comment on this, described compliance management in this area as being in its infancy. As many changes and improvements to child protection in SJAI have been undertaken relatively recently, this is perhaps understandable. The voluntary nature of SJAI's membership—including its child protection team—may also explain the pace of development of compliance management systems.

The Review believes that while child protection policies have evolved to a significant positive degree, there remain outstanding areas of development in terms of compliance management. The Review recommends that SJAI undertakes ongoing compliance review with rigorous and routine unannounced inspection and monitoring.

3.6.12 Child Safety Culture

As noted above, questions regarding child protection policies and practices generated a significant volume of responses from all interview participants. An important theme to emerge from this field of inquiry relates to the organisational culture dimensions of child protection in SJAI; what this Review terms child safety culture.

As with other themes emerging from the Interview Phase of the Review, responses from participants broke down along different lines. In particular, as is described throughout this Report, there is a significant divide between those who had a positive view of child safety culture in SJAI throughout its history, and those who believed SJAI operated under a culture that was not safe for children at the time.

The former category of responses, which had a favourable view of SJAI's child safety culture, were, on the whole, drawn from leadership tiers of the organisation. These participants also had significant faith in both the "common sense" approach to child protection that was predominant in the pre-2013 period, and in the inherent capacity of SJAI's culture of discipline to address any safeguarding concerns. As is discussed in greater detail elsewhere in the Report (Chapter 6), the Review has reservations and doubts about both these general positions.

The latter category of responses, which had a negative view of SJAI's child safety culture, constituted the majority of responses. These participants believed that child safety was not an organisational priority before 2000, and many claimed this did not meaningfully change until 2011. These participants believed that the prioritising of "common sense" and discipline was wholly inadequate as these approaches to child protection were premised on a very high degree of trust in senior members who were subject to little meaningful scrutiny. These ideas of safety also, they explained, failed to root out practices that obviously posed risks to children. These participants, many of whom work as healthcare professionals, negatively compared the progress the organisation made between 2000–2011 to other frontline healthcare providers in the State.

These participant responses noted a sea-change in child protection practices and policies post-2011. Nearly all of these participants believed the SJAI organisation had, since 2011, grown into an organisation that was much safer for children.

The Review believes this latter category of responses to be the most compelling. The Review believes that SJAI operated under an inadequate child safety culture in the pre-2011 period. The Review believes that significant improvements have been made since 2011. However, the Review qualifies this positive assessment by noting some concerning cultural features within significant parts of the organisation's hierarchy regarding child safety, in particular, a pervasive denial about past failures and complacency regarding ongoing vulnerabilities.

3.7 Summary of Development of Policies

SJAI was not alone among organisations in failing to have adequate guidance, either to children and their families or to its own members to safeguard children against abuse. The development of its Child Protection Policies from 2000 to 2022 tracks the development and strengthening of national guidance, in successive publications of *Children First* from 1999 to 2019.

However, one area in which there was a deficiency in SJAI policy relative to *Children First* was that the first edition of the policy did not include any provision on retrospective reporting. This same edition also had the deficiency of being a handbook for its own members only, on how to deal with reports or suspicion of abuse, without giving guidance to children or their families on the procedures they could use to report abuse. For example, it lacked a complaints procedure. Subsequent editions are more generalised in their audience. There were instances of failing to keep track of legislative developments, such as the omission of a reference to the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 in the 2013 Policy.

In correspondence seen in the Documentary Review Phase, it was noted by the Review that Tusla wrote to SJAI on 21 September 2020 in relation to the child protection policy in place at that time. This correspondence noted that the:

> "[2020 version] of the Child Protection policy on the [SJAI] website is referencing documents [which are] out of date and obsolete (Children First 2011 and Duty to Care) and it is acknowledging input from Children First Information and Advice Officers who were not involved in this latest version of the policy … It is imperative that all Safeguarding documents are in line with Children First guidance and legislation".

The letter concluded by inviting SJAI to have its policies reviewed by the Children First Information and Advice Service.

The mandatory nature of *Children First* since 2017 places obligations on an organisation such as SJAI.

Along with SJAI's lack of development of child protection policies and practices for most of its early existence, this chapter has also highlighted some of the deeper cultural dynamics in play around these questions throughout most of its existence. This chapter has identified a number of clear cultural weaknesses within the organisation, some of which appear to persist in parts of the organisation to the present day.

Chapter 4

Participant Experience of Time in St John Ambulance Ireland

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Participant Experience of Time in SJAI

The Review sought to understand each interview participant's background and relationship with the SJAI organisation. An important theme to emerge from this line of questioning centred around the participant's experience with SJAI. The Review felt it was important to note that for many participants in the Interview Phase of the Review, their time with SJAI was, and in many cases remains, a valuable and positive experience. This was so even in circumstances where many of those participants were critical of the organisation's responses to risk, threats, wrongdoing and victimisation. In this chapter, some of these experiences are set out.

4.1 Reasons for Joining SJAI

The primary reason given by participants for joining SJAI centred on familial connections to the organisation. Many interview participants originally joined SJAI as cadets because of a parent who was a member of the organisation.

Nearly all participants interviewed by the Review had joined as cadets, most being in their early teens when they joined. This reinforced the views of many participants that the cadet divisions remain an important source of recruitment for the organisation, and will likely remain essential to the future survival, growth and flourishing of SJAI. This is a sentiment with which the Review agrees.

All interview participants described their pathway through the organisation, including promotion and the attainment of various ranks. Pathways of progression and promotion were a major part of participants' experiences of the organisation, and it is clear that many aspects of the organisation also endeavoured to teach and motivate young people to be ambitious and confident in their professional lives, as well as their voluntary lives.

Interview participants had a wide range of years of service. None had less than three years' service, with a number having been members of the organisation for several decades.

4.2 A Positive Experience

For most participants their time within the SJAI organisation was a very positive experience. Many participants spoke in particular of the deep sense of solidarity and belonging that they enjoyed during their time as cadets in SJAI. One such interviewee stated:

> "[Membership in SJAI] creates a certain camaraderie, it creates a certain esprit de corps". [Participant 8q]

SJAI appears to have been very successful in cultivating this sense of belonging among their cadet ranks, in part, by undertaking annual camping holidays, imitating the practices of scouting organisations:

> "[W]e used to have 7–10 day training camps in the summer under canvas, seven man Icelandic tents, great big yokes, a huge marquee for the event, all great fun, sports and swimming and you know long hikes and you would go visiting things and you would be up at seven o'clock in the morning and doing PE and then washing and going into breakfast, so very regimental and I mean essentially a sort of military barracks under canvas. We all enjoyed it, it was great fun". [Participant 8q]

Many participants were also keen to emphasise the valuable practical skills they learned through membership and undertaking training within SJAI. For example, one participant shared the profound impact that training had on him from a young age, when he was called upon to use his basic first aid training to save another child's life.

Similarly, other participants described the leadership skills and lifelong confidence SJAI instilled in them, which carried over into their professional life beyond the organisation. For the following interview participant, those positive experiences were part of the reason he was motivated to engage with the Review; a desire shared by a number of participants to help "right" the organisation which had done so much good for them and their peers:

> "I mean part of the reason I suppose why I was so concerned about this whole thing [child sexual abuse] was that St John was a hugely positive experience for me. I got to work with some great people, got to develop a lot of my personal skills, I was standing up in front of groups at 16 and 17 and that is something that has carried me through to my career and in fact I was presenting yesterday and probably using skills I would have learned in St John's. So, generally very positive". [Participant 1p]

Indeed, some of the victim-survivors who participated in the Interview Phase of the Review also described their time in SJAI as a positive experience, despite their victimisation:

Respondent: I enjoyed my time in [SJAI] … I mean you were disciplined, you were educated.

Interviewer: You had a positive experience.

Respondent: [I] learned quite a lot […] from the aspects of the John's Ambulance itself. I had a positive experience. [Participant 6g]

The Review also notes how many participants had, because of their experiences in SJAI, gone on to work in healthcare and other frontline essential services in Ireland and abroad. The well-established career pathway in healthcare that SJAI membership offered was also a point of pride for many long-standing and senior-ranking members of the organisation who participated in the Interview Phase of the Review.

A number of participants, including victim-survivors, also emphasised how the SJAI organisation's symbolic authority—with its uniforms, equipment and hierarchical structure——was appealing to them when they were considering joining. The potential to access concerts and other major public events was also a key motivation for many young people to become cadets in SJAI. One participant stated:

> "We were [visiting relatives] and on the way home my mother was telling me about [X] who was involved in [Y] and how she was getting in to see concerts and football matches and all of this and everything. And I thought to myself … that sounds pretty cool getting in to see all the stuff for free. So when I came home, over the few days I thought about it and I said yeah, I think I'll give this a go see if it's any good. It wasn't to do with first aid, it was the thoughts of getting into concerts and football matches and everything else that appealed to me first of all". [Participant 9x]

SJAI membership provided some status to many young people, through training, social events and getting access to work at these events. In this way, the organisation was reportedly a source of empowerment and pride for many of its cadets and younger members. However, this also meant the organisation was attractive to vulnerable young people seeking some form of legitimation and validation. This evidently put the SJAI organisation in a powerful position to influence young people at a developmentally significant stage in their lives, and put senior-ranking members of SJAI in a particularly sensitive and significant position, particularly if they had responsibility for cadets.

As is discussed in greater detail below, it appears that awareness of the power that the organisation exercised over its younger members was sometimes absent in the senior ranks of SJAI.

4.3 Progression from Cadet to Adult Member of SJAI

Some participants contrasted their positive experience as a cadet—which they felt was well-coordinated and organised—with problematic aspects of the organisation once they transitioned into adult membership and involvement. One such participant noted:

> "[F]rom my perspective growing up, you know, I thought it gave a very good grounding for young people's development, that kind of thing, and the volunteers that I came into contact with, and those adult volunteers who were responsible for running the cadet divisions or were involved with the cadets, you know, did a good job, and you know, they, from what I remember, it was run quite well, it was well organised, you know, I don't recall kind of having concerns at the time about how it was [run].
>
> As an adult member, I suppose I thought that because of ... the longevity within the post that the hierarchy were there for, you know, there was that kind of un-willingness to change and to perhaps take on board, you know, communication is a two-way street, like I said, you know, filtering down to the shop floor, you know, comms need to go up to the management if you like as well and there just seemed to be no interest in listening to other people's views". [Participant 11s]

This apparent cultural resistance to change within the adult division of SJAI—particularly by senior management—was highlighted repeatedly by a number of participants. This is a key theme identified by the Review, and is explored in detail in the following two chapters.

4.4 Conclusions

The large majority of interview participants described their time as cadets in positive terms.

It is clear that SJAI's cadet programme provided a valuable sense of community for its young members, while building self-confidence and leadership qualities through its structure, training, and routine activities. For many, this positive and valuable experience continued as they transitioned into adult SJAI membership. This appears to have been a key reason for the organisation's ability to retain members despite the significant commitment membership demanded in terms of time and training. However, this aspect of SJAI's structure, authority and influence over younger members also had problematic dimensions. How the organisation's structure and culture informed child protection culture and practices is the focus of the following two chapters.

SJAI also provided pathways to stable professional employment: a very valuable organisational feature during the 1980s and 1990s when many participants were cadets.

A number of participants were less enthusiastic about their experience as adults in the organisation. A partial reason for this is apparently rooted in the general culture and hierarchical structure of the organisation.

For a smaller number of participants, their view on the adult organisation was shaped by either experiencing victimisation, and/or observing how the organisation responded to evidence and complaints of sexual abuse and exploitation. These issues are dealt with in the following chapters.

Chapter 5

St John Ambulance Ireland Organisational Structure

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SJAI Organisational Structure

Among the most significant themes to emerge from the Interview Phase of the Review centred around the SJAI organisational structure. All participants highlighted and emphasised the issue of formal and informal structure when discussing their understanding and knowledge of child protection culture and practices in SJAI.

The Review sought out information on the structure of the SJAI organisation from multiple sources, including direct requests to SJAI. Interview participants were able to provide the most insights and understanding of structure. As a result, this chapter's account of SJAI structure is derived, in large part, from interviews with multiple stakeholders.

In this chapter, the structural features of the SJAI organisation that are relevant to child protection practices and culture are outlined and analysed. Many of these themes echo and overlap with SJAI organisational culture, which is the focus of Chapter 6. Themes in this section are explored in order of the importance attributed to them by the interview participants.

Understanding the structure of the organisation is essential to identify and understand how child protection risks were identified and responded to by SJAI. Most notably for the purposes of the Review is the quasi-military, hierarchical form that the organisation appears to have consciously cultivated and perpetuated over many decades.

This chapter examines the distinct themes of hierarchy, militarism, and accountability, that constituted the significant majority of participant contributions on the question of organisational structure.

5.1 The SJAI Hierarchy

Among the most dominant themes to emerge from the Interview Phase of the Review is the driving force of SJAI's distinctive hierarchical structure. This theme also manifested itself in many related themes, such as descriptions of the quasi-military, command-and-control governance practices and culture of the organisation. It was also evident from descriptions of the power and dominance of SJAI's senior-ranking members, and in the central importance of promotion, advancement and rank status to the organisation's ethos and values. Overall, participants to the Review described an organisation governed by a rigid and centralised hierarchy, which demanded deference and compliance.

The Review believes that SJAI operated under a rigid hierarchical structure, which placed a high value on deference and compliance. The Review believes that many aspects of that structure persist within SJAI.

SJAI's structure is highly relevant to how suspicions and complaints of child abuse were handled by the organisation, and how child protection practices were implemented more generally. In particular, the distinctive hierarchical nature of SJAI may have unwittingly facilitated predatory activities within the organisation, and insulated those activities from effective intervention and accountability within the organisation.

Many participants in the Interview Phase described SJAI as tightly organised around a strict and rigidly enforced hierarchy. This hierarchy itself was understood by these participants as inflexible, and slow to react to the changing circumstances both within the organisational and national contexts. For example, a number of participants noted how slow SJAI had been to take child protection seriously—as evidenced by its late development of formal and meaningful rules, guidelines and practices. Despite early work on child protection from 2000, SJAI's development of meaningful child protection practices occurred around 2011, many years after child protection had become a major public policy concern in the aftermath of the clerical and institutional abuse scandals.

The Review believes that SJAI's hierarchical structure struggled with significant organisational reform in areas such as child protection policies and practices.

A number of interview participants described the current centralised command-and-control features of the SJAI hierarchy as damaging to its organisational culture. A number of currently serving members noted how some members of leadership within SJAI lacked diversity and management skills. They described how SJAI's structures eroded the autonomy and dynamism

of motivated and well-meaning individuals in SJAI's junior membership. One participant stated as follows:

> "I think again we have got so many people in the organisation again with qualities that they could certainly bring about changes you know from their personal professional lives, they could make a big difference to the organisation … I think if we were to broaden the pool of people at the top table or broaden the group of people involved in the various departments. But again you have these heads of departments who just, if your idea doesn't fit that's it.
>
> And don't get me wrong, I know that that goes on in every organisation". [Participant 3t]

Various interview participants also described structural detachment between the general SJAI leadership and the rest of the organisation's membership. A number of participants characterised these divisions as partially based on class differences. Another participant stated:

> "[M]y impressions back in those days was [aspects of SJAI were] lofty. There were some times where especially … the old-time people, that they were superior than everyone else. We were all barrel scrapings to them, I suppose there was them and us. There was no person you could have told or spoke to, you are a kid, you are just standard uniform and you stand to attention, saluting and all that sort of stuff. You are seen as … very military". [Participant 2D]

Indeed, a number of participants described the SJAI hierarchy—and the culture within it—as being segregated and governed along socio-economic class lines. These participants believed the organisation placed significant prestige and importance in having members who were drawn from the medical profession occupying the most senior positions in the organisation, without having to follow the normal promotion pathways. This account of the organisation was confirmed by participants who were in leadership positions; though, on their account, this was a historical, rather than contemporary feature of SJAI. Some participants described significant resentment among parts of the SJAI membership towards these class divisions, and the high degree of deference expected towards individuals who were grandfathered into senior roles due to their professional background.

The hierarchical structure of SJAI manifested itself in other ways, with a large number of interview participants describing a dominant cultural norm within the organisation to unquestioning deference to those in positions of authority:

> "There was a time when you would say to somebody, 'do this!'. You'd say to someone 'jump!' and they would say 'how high?'". [Participant 5n]

These hierarchical features of the SJAI organisation appear, for whatever reasons, to have been designed and enforced in such a way to replicate military authority structures. Within this particular structure, decision-making by those in positions of authority suffered from a lack of clarity; "ordinary" members were expected to know their place, defer to the hierarchy, and not ask questions.

The following participant's description captures these accounts well; outlining SJAI's model of governance, and how it contrasted with the values promoted by the organisation:

> "Like, you knew your position, you knew your place, officers had their place. Meetings went on and decisions were made, that you wouldn't have a part, you wouldn't know. Like it's funny when you look at the brigade's own model it's supposed to be open, it's supposed to be transparent, there's supposed to be nothing hidden. Everyone is supposed to be basically equal in ways ...
>
> ... the board was always a secretive organisation, you met them twice a year maybe. But you couldn't really go up and talk to them. They weren't that sort of person that you could go and talk to. You knew who they were, it's on paper but you couldn't approach them. Same with the commissioner, like you wouldn't be able to go up and you know have a chin wag with him at an event or something, that didn't happen. You had your place and that was it.
>
> So you could go up to a certain level of talking to people. But, in general those at the top were above you being able to speak to. It's not as such a secretive organisation but more of they did what they want and you just obeyed. There was no collaborative process as such". [Participant 7k]

The Review believes that SJAI operates under a highly formalised and quasi-military structure. This structure, and the culture which informs it, places a high value on obedience to rank, and a low value on autonomy.

Another distinctive feature of the SJAI hierarchy to emerge from interview participants' accounts of the organisation is the intense emphasis on the rules of the organisation—specifically the 1947 Rules and Regulations—as both a guide to, and reason for, the hierarchical structure. A number of participants criticised aspects of this rule-centric approach, which manifested itself in a rigid adherence to the wearing of outdated, unpopular and highly gendered uniforms. For the following participant, this rigidity reflected a conservatism within aspects of SJAI, which opposed modest reform, and prioritised a traditional form over substantive operational best practice:

> "[T]here was a very backward looking tendency in senior staff and sort of senior management structure so that we were going around in … adult members were going around in tunics and shirts and ties long after other [pre-hospital] organisations had recognised you needed a more practical style of uniform for those kinds of events. We were still going around in great coats when what you needed was a bomber jacket that allowed freedom of movement and so on". [Participant 8q]

For some participants it appears the 1947 Rules and Regulations, and the rank system inherent within them, were prioritised above other considerations:

> "[T]here are people within the organisation who have been in the organisation for quite a number of years who would feel rank structure outweighs the whole structure of somebody being given a position or a role within the organisation". [Participant 3w]

As hierarchy and rank were such a powerful organising norm in SJAI, the attainment of rank status could become an unhealthy ambition for some members seeking validation:

> "In an organisation that did have that very very top-down approach, the one person who could have and this was the thing, everybody at a lower level, once you were in the organisation a few years, everybody tended to be looking for promotion and you got nothing out of it except status, but you know that is a powerful thing too". [Participant 8q]

For others, the attainment of senior-ranking status was sought because of the high degree of autonomy it enabled: liberation from interference by the organisation's headquarters. As the following account describes however, this feature of the hierarchy could also create opportunities for abuse of power:

> "Some men used [their rank] very creatively to create a forward looking cell within the organisation, sort of active and developing and so on. Someone like [redacted] started more advanced training for his guys, he started all sorts of initiatives and because he was in that secure position, he could keep it going and sort of keep the organisation from interfering.
>
> It also did mean, you know, with a decent man like him you were okay, you were safe. But if there was somebody who was … a bit of a bully or a bit petty or anything like that, they were essentially not really answerable to anyone. There was very little effective oversight". [Participant 8q]

While, as the above quote illustrates, this status and autonomy could be—and was—put to positive use to achieve positive ends, it also placed individuals outside any accountability infrastructures SJAI had in place. This characterisation of accountability (or lack thereof) for senior figures in the organisation was verified by a significant number of other interview participants.

According to the accounts of a number of interview participants, some members in positions of authority revered this chain-of-command approach to governance in SJAI. The high value placed on obedience inevitably led to scenarios where the deep power imbalances created by the organisation's hierarchy were exploited and abused by some:

> "I suppose [with the] hierarchical, militaristic, kind of authoritarian style, you just got on with it. I think I mentioned that there were some people who took that militaristic authoritarian approach perhaps a bit too far and were too shouty, you know, what would probably be considered to be bullying today but that was just the atmosphere or the situation at the time and I think there weren't, you know, almost the idea of raising a complaint on something like that is almost unthinkable. It just wasn't something, that wasn't on anyone's agenda". [Participant 8q]

However, it is not clear if this particular quality of rigidly enforced hierarchy was the norm for the entire SJAI organisation. Some participants noted substantial differences between the approaches in one particular geographical area of SJAI and in another particular geographical area of SJAI:

> "[I]n [one geographical area of SJAI people were] all first name terms where[as] in [another geographical area of SJAI] it was 'Mr This' and 'Mrs That', and all the senior officers, you would not address them by their first name in [one geographical area of SJAI]. It was 'Mr', and if you did [use first names], it was like frowned upon". [Participant 8x]

Indeed, some participants expressed sentiments which reflect a cultural orientation towards military-style discipline. For example, the following participant's use of the term "loyalties" in the context of describing the behaviour of youth members of a volunteer ambulance service, is illustrative of the continuing expectation of loyalty to hierarchy among many within SJAI:

> "I had to stand down a few [cadets] over the years, because I just found their loyalties were wrong, their loyalties were within the cadet group". [Participant 4h]

The reported reverence attaching to rank and a rigid enforcement of the chain-of-command also heavily informed the approaches to accountability used by SJAI. Accountability for wrongdoing within SJAI was centrally governed by senior-ranking staff, who adopted procedures and formalities to reflect their status and importance. As will be described later in this chapter, it appears that the policing of rank and status in the organisation seems to have often undermined achieving materially good outcomes from accountability processes:

> "[Complainants] were allowed to bring somebody with them [to a Court of Inquiry], but the person was told 'you are not allowed open your mouth'. That was the kind of discipline [expected] if somebody raised issues, and, again, very militaristic. They would all sit at a top table—senior officers—and determine what to do". [Participant 8x]

The Review believes that the SJAI hierarchy generated competition for rank status within the organisation, and created often unhealthy centres of unaccountable power.

In the next part of this section on SJAI structure, the quasi-military features of the organisation are examined in greater detail.

5.2 Quasi-Military Features of SJAI

The military or quasi-military form of the SJAI hierarchy was among the most consistent themes to emerge from the interview process. While this structure is provided for under SJAI's 1947 Rules and Regulations, numerous participants described an organisational culture that had embraced and embedded military symbolism, values and logics within it. These military procedures, symbols and values were among the first things cadet recruits were required to learn and perform:

> "[O]rdinarily, when you join[ed] as a cadet you are given basic first aid training, in those days you were given a certain amount of training in sort of foot drill and things, it was … it was a self-described semi-military organisation that used military style rank structure, uniform … what I call a robust system of discipline". [Participant 8q]

Most participants who discussed it were critical of SJAI's military structure. While a handful of interview participants defended its value in historical contexts, none articulated a view that it was an appropriate model for the current era. A number of participants highlighted how SJAI's sister organisation in the UK has long since abandoned the military model in favour of an emphasis on professionalism and best practice. Others noted that prioritising values of volunteerism and hierarchy over professionalism and role-specific competence, left the organisation with substantial weaknesses, including with regard to protecting vulnerable individuals:

> "There was no clear way to protect a person who was vulnerable or who was being groomed or who was being harmed. To be honest, I think, the fundamental is the organisation, the voluntary spirit, the willingness to give, those are all very healthy things but they need to be channelled in a professional sensible direction". [Participant 8q]

A number of participants drew a direct connection between the military structures and culture that SJAI embraced, and what they believed was the instinctively defensive stance the organisation took in response to complaints:

> "The organisation is an incredibly proud organisation. It has a great heritage and a rich history to be fair. But I think we need to put that behind us and put the welfare of young people before that, not the other way around. Again the organisation as I said to you it's a hierarchical kind of organisation, military style organisation and

> it's all about protecting St John. And I don't think that the organisation is great at putting its hand up and acknowledging any kind of wrongdoing for those reasons around heritage and pride". [Participant 3t]

In another account of their experiences with SJAI's internal accountability systems, the following participant described the "Court of Inquiry" procedure; a distinctly military process that has been appropriated for use in SJAI:

> "a meeting was scheduled in headquarters. And the meeting was kind of arranged in the format of what they would call a court of inquiry. They kind of would use these semi-military type terms". [Participant 7u]

Many participants were at pains to highlight their belief that this "military-style" discipline was routinely prioritised over what they believed were more important values, such as operational best practice, and the needs and well-being of individual members. A common example noted by participants was an enthusiastic enforcement by some leadership figures of the organisation's uniform regulations over best practice in healthcare management, or member well-being.

While it is clear that this quasi-military structure was a powerful driving force within SJAI, there was some minor disagreement as to whether these norms, values and performative practices have persisted within the organisation. While it appears that some of the rigid enforcement of these norms has dissipated significantly, the core quasi-military structure and many of its cultural norms remain.

The Review believes that the core military structures of SJAI remain. The Review believes these structures informed and shaped the hierarchical structure of SJAI, and the accountability structures within the organisation. The Review believes that these military structures are not appropriate for a healthy child protection and safeguarding culture.

The Review recommends SJAI reforms all remaining military structures and cultural norms.

5.3 Participant Attitudes Towards Leadership and Governance

Concerns and complaints around how SJAI is governed were prominent themes that emerged from a number of interviews with both serving and former members. Many participant contributions on this theme were generally focused towards how the organisation's hierarchical structures of power operated. All participants who discussed this theme, noted that these cultural problems were a significant obstacle to the effective implementation and operation of appropriate child protection systems and practices.

The most common complaint regarding SJAI's governance culture and practices centred around a general absence of transparency about how key decisions were made by the organisation's hierarchy. Two participants described SJAI's culture as "sclerotic", or rigid, in its approach to governance. Many focused on the perceived lack of turnover or revitalisation of personnel within SJAI leadership.

Other participants criticised the instinctive conservatism of the organisation, and a lack of decisiveness. The following quote identifies persistent corporate governance issues within the organisation:

> "[T]here [are] a few changes that need to be made definitely and I think it's just it needs to start at the very top, you know? ... another thing is we're lacking a massive amount of skills in the senior management of the organisation.
>
> Why doesn't St John do an audit on the amount of skills they have in the Executive, you know? ... So, we're lacking skills there and we're lacking youth". [Participant 2q]

The consensus among most interviewees who addressed this question was that the SJAI leadership was dominated by members who were wedded to the seemingly dysfunctional hierarchical structures and practices described above. This has left the organisation in a governance silo; disconnected from the bulk of the membership, and incapable of acting to adequately address many of the structural and cultural problems of the organisation, because it lacks the insights and skills to break with outdated and inadequate procedures and values.

More than one participant felt that some of SJAI's governance problems were rooted in the difficulty of running a very large, complex, emergency healthcare-providing organisation using volunteers. While all participants who discussed the issue had a positive attitude towards the

volunteer ethic of SJAI, some felt the way SJAI approached its commitment to volunteerism tended to also undermine competing and necessary efforts to professionalise, and maintain best practice standards.

The Review believes that some members of SJAI perceive some of its governance culture and practices to be dysfunctional.

The Review recommends that SJAI undertakes a broad re-examination of its internal governance, transparency and accountability mechanisms. The Review also recommends as part of this process that SJAI examines the potential for putting certain key roles on a professional basis within the organisation to support and facilitate a more dynamic and responsive approach to volunteerism.

5.4 Cadet Divisions in SJAI

The nature and operational features of cadet divisions within SJAI were clearly within the Terms of Reference to this Review. As a result, the Review's enquiries sought as much information as possible about how cadet divisions were organised, and what their relationship was to the rest of the organisation.

It is clear from interviews with participants that cadets are an essential and important part of the SJAI structure. The cadet divisions provide an opportunity for the organisation to recruit and train young people, with the hope of retaining those members as adults. In this way, the cadet divisions provide security for the future of the SJAI organisation, as well as revitalising it with a constant inflow of emerging new generations.

The cadet experience was also described by nearly all participants to have been a very positive experience. This included some of the victim-survivors who felt that many aspects of their cadet experience were positive. On these accounts, SJAI's cadet divisions provided, and continue to provide, a valuable opportunity for young people to acquire beneficial new skills, while contributing in an important civic institution. Membership of the SJAI cadets also enabled participants to access an alternative route to validation and socialisation other than the traditional routes of sport and academic success that often dominate validation pathways in Ireland.

The Review believes that the SJAI cadets are, in principle, a positive component of the organisation.

The Review recommends that the cadets should be maintained as a core component of SJAI.

However, the Review's investigations have identified a number of problematic features in the organisation and management of cadet divisions within SJAI. For example, it does not appear that SJAI has an effective membership management system for its cadets. It was not clear during the Review's inquiries if the SJAI organisation was in a position to confidently provide accurate figures for how many cadets are members of the organisation, though this is being remedied. One interview participant, when asked about cadet numbers in SJAI, gave the following troubling response:

> "Nobody will give you a straight answer to that. I believe from my memory there would probably be about 600 or 700 cadets in the organisation.
>
> There is no member management system, there will be …
>
> The only records we have are what they call the BF1, which is an annual return a superintendent will make to headquarters, and should detail out every member that's in their care.
>
> The BF1 is the greatest piece of fiction that was ever created, because the BF1 serves a purpose. If you want to obtain promotion within the organisation you have to have a certain amount of members. So in order to get promoted you'll make sure you'll have the members, whether you actually have them in a physical presence or not". [Participant 4h]

The potential misuse, by more senior members, of the cadet system for promotion purposes was, it should be noted, consistent with other accounts received by the Review. A number of interview participants explained how important cadet divisions were for those seeking promotion and advancement in SJAI.

The ongoing apparent lack of transparency and accountability for the cadet divisions in SJAI is concerning. Similarly, the Review notes this feature of the SJAI structure highlights a deeply problematic intersection between the military/hierarchical features of the SJAI structure, and risk of unsafe child protection practices.

The Review believes that some issues remain with regard to the governance and management of SJAI's cadet system.

The Review recommends that SJAI invests appropriate resources to resolve outstanding issues with regard to the membership information and management systems.

5.5 Z27 Division

Early on in the Review, a number of interview participants (including, but not exclusively, victim-survivors), drew the Review's attention to what they believed were unusual features of the "Z27 Division" (i.e. unnamed division) of SJAI. This division is of central importance to the work of the Review, and the Review therefore endeavoured to examine claims made about its particular structure, and the division's relationship to the rest of the SJAI hierarchy.

A number of interview participants claimed the Z27 Division did not have an official cadet division, though it appears a number of cadets were based at that division. From questions that were put by the Review to leadership figures of the organisation, it appears it was unusual for cadets to be based in an adult-only division:

> **Interviewer**: [W]ould it have been appropriate or considered inappropriate for an adult-only division to have had cadets attending?
>
> **Respondent**: Well, no, that would be a decision for the senior officers of the day. That's my way of thinking, and it's slightly off what we're talking about, but to my way of thinking, the way to establish a division is to go into a neighbourhood and establish a cadet division. And then what you get is, you'll get a number of boys or girls or the mixed divisions, and you'll get the makings of your new senior division, and there will be, from day one, they won't be challenging. [Participant 6z]

Some interview participants claimed the Z27 Division was not permitted by SJAI to have an official cadet division. This claim alleged that SJAI was aware of child protection risks in the Z27 Division, and took some protective action to manage those risks. However, the organisation was, according to this claim, unwilling to take more decisive action in the form of completely removing known threats.

When asked about these allegations, some in SJAI leadership denied any knowledge of the specifics of these allegations. When asked in more general terms about setting up cadet divisions, such as the ease or difficulty of setting up a cadet division, there were mixed responses from these participants. For example, one suggested setting up cadet divisions in SJAI during the 1980s and 1990s was a relatively easy process, while another suggested it was a more onerous process.

Other interview participants described a period of rapid expansion of cadet divisions in SJAI during the 1980s, including in a variety of locations in close proximity to one another. This suggests that it was, at that time, relatively easy to establish cadet divisions during this period. It also suggests that it would have been unusual for the Z27 Division not to have a cadet division, especially as it appears to have had a number of cadets who were part of that division.

One participant believed that the Z27 Division did have a cadet division during this period, but that it was removed for reasons they were not aware of.

Victim-survivors who were cadets in the Z27 Division, described various attempts by the senior officer in charge of the Z27 Division to encourage cadets to create a formal cadet division. The Review was unable to discover if a formal attempt at creating a cadet division was ever brought forward to an official application; or if it was, how such an application was dealt with by SJAI. As discussed elsewhere in this Report, the Documentary Review Phase of this Review found the organisation's document and data retention practices to be inadequate. The Review asked numerous questions relevant to this in interviews with SJAI leadership. These interviewees claimed not to have any knowledge of how the Z27 Division was managed.

A number of interview participants described the Z27 Division as having access to unusually good equipment, and that its members were given the opportunity to undertake a variety of specialist training that was not easily accessible to members and cadets in other divisions. This was noted to be unusual, and problematic, as it enticed cadets away from official cadet divisions in neighbouring areas. One participant described the position as follows:

> "Many a time officers, especially the likes of [redacted] and all of that, would be giving out about what we're doing. We were the first division at the time, St John Ambulance was very old school and you had to wear a tunic and you had to wear your officer hat and all of this. And whereas … we could relax that, we were wearing jumpers, we were wearing hi-vis jackets, which is all the normal now. But at the time it wasn't the case. Even the first aid bag, they used them like everyone wore a white first aid bag and it would go across your uniform tunic like that. But we weren't using anything like that, we were using proper trauma bags and everything else like this. And everybody resented us in the organisation". [Participant 9x]

This claim was echoed by other participants who were not members of the Z27 Division:

> "So what had developed after a while was that, [the Z27 Division] started to poach cadets from [other divisions] ... And there were a number of issues there because at the time [the Z27 Division] didn't have a cadet division so they were transferring to a division that didn't have a cadet division, which made no sense. Everybody knew about this ... and we knew it wasn't appropriate, it wasn't an appropriate place to go". [Participant 7U]

Some other features of the Z27 Division were also described by participants as unusual. In particular, it seems that the Z27 Division was, in effect, run by an individual occupying the rank of district officer. Various interview participants described this state of affairs as highly unusual, as district officers are typically responsible for a number of divisions. It was not usual for an individual of such a rank to undertake the day-to-day management of a single division for so long.

One interview participant described three other unusual features of the Z27 Division. First, this participant claimed that it remained a male-only division after gender segregation had ended in SJAI. Second, that the Z27 Division was operated as a private ambulance service; and third that the division was branded in a distinctive way to entice cadets into joining.

A number of other participants echoed these claims that the Z27 Division was a male-only division.

Finally, a very large proportion of interview participants described a culture of impunity from accountability in the Z27 Division. Participants who were members of SJAI both inside and outside the Z27 Division described various scenarios where cadets from that division were disruptive at events or duties, or breached the SJAI code of discipline (particularly respect for more senior ranks), but such behaviour did not result in a disciplinary response.

The claims and allegations regarding the operation and oversight of the Z27 Division go to the very core of the Review's Terms of Reference. These claims, in summary, allege that the Z27 Division operated with a high degree of autonomy and very little oversight from SJAI. This, it is alleged, extended to a failure of the SJAI organisation to intervene to prevent movement of children into a division that was widely understood to pose risks to children.

Given the seriousness of the various allegations made with regard to the Z27 Division, the Review must note its disappointment at the wholly inadequate documentary evidence that was made available to it by SJAI in respect of this division.

SJAI's failures to manage its documents and files are described and discussed in Chapter 8 of this Report. However, that failure has made it extremely difficult for the Review to investigate allegations regarding the governance and oversight of the Z27 Division. This has been made more challenging by the passage of several decades and the deaths of some in leadership positions during the relevant time period.

The Review believes that the Z27 Division operated with an unusually high degree of autonomy and there was a resulting lack of accountability within SJAI.

The Review believes that cadets were permitted to transfer to the Z27 Division, despite the absence of a co-located cadet division. The Review believes that this was a highly unusual state of affairs.

5.6 Differences Between One Geographical Region of SJAI and Other Geographical Regions of SJAI

A number of interview participants from both SJAI in one geographical area of SJAI and other geographical areas claimed there were substantial differences between these different divisions. For example, participants described a substantial degree of operational autonomy for the organisation's presence in two particular geographical areas of SJAI. A number of participants also suggested from experience that one particular geographical area of SJAI was more wedded to policing and enforcing the military and hierarchical features of the SJAI structure.

The Review interviewed a number of individuals based in one geographical area of SJAI. These interviewees were at pains to highlight what they felt were significant differences in how the organisation was managed in the different regions.

The Review believes that the structural and cultural issues with SJAI were primarily confined to one geographical area of SJAI.

5.7 Accountability Structures within SJAI

A key focus of this Review has centred on the systems of accountability within SJAI. This issue is among the most important flowing from the Terms of Reference for the independent Review, as understanding the accountability infrastructure within SJAI is essential to understand how and why SJAI responded as it did to complaints of victimisation and abuse, including child abuse. Interview participants were asked specifically about their understanding of systems of accountability within SJAI.

5.7.1 Formal Grievance Procedures

Most interview participants responded in interviews that they were never made aware of any formal grievance procedures within SJAI. A number believed that no such system existed. Others, who had some experience of attempting to raise grievances within SJAI, claimed that what did exist was largely informal, defaulting to the organisation's hierarchical basic norm: the chain-of-command. For example, the following participant described dysfunctional procedures which were, they felt, largely designed to place a superficial veil of accountability over a known area of weakness:

> **Interviewer**: [A]re you aware of any formal processes within St John Ambulance Ireland at the time for making complaints or raising grievances about other members of St John Ambulance Ireland?
>
> **Respondent**: At that time no, but soon after [allegations of child abuse within the organisation] came out a policy was put in place. It wasn't a great policy. It was basically you have to report through your right structure, there was no confidentiality there you know? And like, if anybody had any issues everybody knew and, you know, it was kind of brushed under the carpet if it was just considered minor, you know that way? So, it's very [clear] there was no proper guidance, there was no training, there was nothing. Absolutely nothing. [Participant 2q]

Other participants described their own difficulties in having their complaints of misconduct by another member dealt with. Their experiences illustrated the prioritising of informal and ultimately inadequate grievance processes over formal and transparent systems of accountability.

That SJAI appears to have routinely dealt with complaints of serious misconduct using highly informal accountability pathways stands in stark contrast to the organisation's strong adherence to formal rules of conduct and discipline. This leads the Review to find that discipline within SJAI was often seemingly superficial: focusing on materially insignificant matters such as compliance with the uniform regulations, while ignoring or avoiding substantively serious matters. The desire to manage complaints informally was felt by some participants to be rooted in a deeper cultural antipathy towards change and reform among parts of the organisation's leadership, and a general suspicion of external standards of accountability and best practice. Others felt this was also partly driven by the pride in the organisation's continuity, and the length of its operational history:

Respondent: Oh yeah, they [leadership] didn't want anybody [outside the organisation] involved no, no, no.

But that was across the board in every aspect of their stuff like. They were also quite narrow minded and sort of backwards thinking.

Like it took them a long time to sort of actually move forward like where the other organisations … they were like even down to something like vehicles and stuff like that. You know, what you should have in your vehicle, that type of stuff.

It was all, you know, 'oh we're good we have this and this is the way we've been doing it for like 60 or 90 years or 100 years' or whatever the case may be. [Participant 5k]

As might be expected given the quasi-military and hierarchical structure of SJAI, outlined above, what systems of accountability did exist, seem to have defaulted to the SJAI chain-of-command. Many participants explained that the chain-of-command operated as the sole accountability mechanism. A number noted that this accountability mechanism appeared to them to not account for the possibility that senior officers may be the source of misconduct and/or wrongdoing.

The Review believes that until recently, for child protection, the primary accountability mechanism in SJAI was the chain-of-command. The Review believes this was a wholly inappropriate accountability approach from a child protection perspective. The Review believes that this approach to accountability also failed to account for the possibility that individuals in that chain-of-command hierarchy may be implicated in victimisation. The Review believes that SJAI's accountability system was generally structured around the assumption that wrongdoing is committed by lower-ranking members.

Defaulting to the chain-of-command instead of more formal grievance procedures imported the same problematic features of the organisation's hierarchy and deference to rank. In particular, it replicated the unwillingness of the organisation to consider the interests of lower-ranking members of the organisation. The following interview participant insightfully characterised these dysfunctionalities in terms of information and communication pathways:

> "And as I say, … from my point of view … from my experience, the sense that I always got was that … on any issue that the membership had no way of passing information up, they had no way of expressing concerns up, it was a very, very top down organisation …

> [T]heoretically you could pass things up the chain-of-command, you could complain to your officer in charge, your divisional superintendent who could bring it on to the Brigade Headquarters … But the disconnect [was] between the senior people [and junior-ranking members]". [Participant 8q]

Ultimately, it appears that SJAI's approach to accountability for most of its existence was governed exclusively by rank and hierarchy, without any clear guidance or norms around which such accountability functions were to operate. Instead, the values of the hierarchy, such as deference to rank and other quasi-military features of the organisation, came to operate as the guidance norms for internal accountability.

The Review believes that defaulting to the chain-of-command as the principal accountability mechanism imports other problematic features of the SJAI organisation's hierarchical and quasi-military structure and culture.

The Review recommends that SJAI develops formal guidelines to deal with grievances and complaints.

5.7.2 The Court of Inquiry

A number of interview participants spoke of their experiences with a formal accountability procedure that appeared to be provided for under SJAI's 1947 Rules and Regulations: the Court of Inquiry. All participants who described their personal Court of Inquiry experience, did so in distinctly negative terms. The process was perceived to be highly opaque, and to manifest the most problematic features of the SJAI hierarchy. In particular, participants described a process they believed was designed to evade proper accountability by intimidating junior members seeking an appropriate organisational response to claims of wrongdoing. There were troubling accounts of young lower-ranking members of SJAI being humiliated by senior officers, with little or no recognition or respect for constitutional requirements of natural justice.

A common theme that emerged from the Review should also be noted: accountability systems were designed for junior members, not senior-ranking members. The following participant characterised this mechanism in the following, negative light:

> **Respondent**: [T]hey used to have courts of inquiry. So, if somebody, a junior person, had done something wrong, they used to have these courts of inquiry, we used to call them Kangaroo Courts … They were allowed to bring somebody with them, but the person was told you are not allowed

> open your mouth. That was the kind of disciplinary, if somebody raised issues and again, very militaristic, they would all sit at a top table, senior officers and determine what to do …
>
> To me, I think, no I think a lot of [Courts of Inquiry] would be very minor insubordination. This sort of, breaking silly rules or …
>
> **Interviewer**: You don't recall any examples of things that …
>
> **Respondent**: I know two people who would have been fairly young, and I don't know the exact reason why the two of them ended up before this … And they said it was the worst experience of their lives. They came out crying, these are 18/19 year olds. Over silly things, you know to me, very minor infringements. [Participant 8x]

During the Documentary Review, the Review was unable to find evidence or notes from any Court of Inquiry process, other than one handwritten note which was produced as part of the Supplemental Disclosure in July 2022, following a question raised by the review team. It appears that contemporaneous notes of these procedures were either not routinely taken, or were not securely stored. This is, to say the least, unfortunate.

The Review believes that the Court of Inquiry process within SJAI lacks adequate transparency, and that the leadership of the organisation has failed to explain to membership what its processes and functions are. The Review also believes that the Court of Inquiry process was primarily used to discipline junior members of the organisation. This in turn reinforced, in punitive terms, the structural and cultural features of SJAI that prioritised hierarchy and rank. The Review believes that the Court of Inquiry process contains many concerning features which fail to respect individuals' constitutional rights to natural justice.

The Review recommends that the Court of Inquiry process in SJAI be significantly reformed.

5.7.3 Accountability of SJAI Leadership

Taking all interview participant contributions on the topic of accountability together, it appears that whatever accountability procedures were in place, they were primarily directed towards more junior members of the organisation. Whether by design or oversight, SJAI was structurally inhibited from holding senior-ranking members to account for wrongdoing. The effect of this in the past was to permit a high degree of impunity from accountability for persons within higher ranks in the organisation.

For example, one of the victim-survivors made clear that internal accountability processes within SJAI were designed exclusively with discipline among junior-ranking officers in mind:

> "Because … that person would have been considered a superior officer and, for an ordinary member or a junior officer, you could be suspended, you could be thrown out of the organisation very simply but for somebody of his status, it was actually quite difficult if you read the rules and regulations to actually get rid of somebody". [Participant 8x]

A number of interview participants explained that SJAI's inability to provide high-level accountability was rooted in a deep culture of pride in the organisation, and the desire to protect its reputation. This intransigence and/or ineffectiveness in dealing with serious complaints—which this Review describes as response paralysis—apparently resulted in organisational dysfunctionality in the management of suspected or known risks.

The Review believes that the structural and cultural features of SJAI's hierarchy and chain-of-command inhibited accountability for senior-ranking members. The Review believes that this led to impunity for more senior-ranking members of the organisation from scrutiny or accountability across a wide range of areas, and response paralysis of SJAI in the face of known or suspected threats and wrongdoing.

The Review recommends a reconsideration of the hierarchical structure and culture of SJAI. The Review recommends the creation of robust internal accountability frameworks which are transparent and apply equally to all ranks of the organisation.

5.7.4 Organisational Capacity to Deal with Wrongdoing

Another reason behind SJAI's earlier apparent inability to provide meaningful responses to wrongdoing at a systemic level appears to lie in the organisation's capacity and resources. The Review was told by a significant number of participants that SJAI relied, to an excessive and problematic degree, on much older members in senior roles.

The reason for this over-reliance on older members appears, on these accounts, to be rooted within the structural prioritising of rank and hierarchy by SJAI. As attaining higher ranks appears to have required years of commitment, it is understandable that some senior roles would be occupied by older members. However, participants described an organisational feature of SJAI whereby members attained high-ranking positions, and then remained *in situ* for many years. The effect

of having many senior management roles within the organisation occupied by older members, combined with the hierarchical structure of the organisation, was to hand extremely important governance roles to people on the basis of rank, not expertise or competence.

An additional point here is that existing accountability structures for serious wrongdoing—such as they were—relied on a system of hierarchy to which senior officers owed their status. The past failure of the organisation to seek external assistance, expertise or guidance on how to manage such complaints reinforced an existing dynamic that strongly militated against "rocking the boat".

5.8 Conclusion: Organisational Structure

The Review has heard compelling evidence from a large number of participants about SJAI's organisational structure. The Review has, on the basis of these contributions, found that the SJAI hierarchy, its military structure which prioritised rank status, and the emergence of factionalism within the organisation, have all contributed significantly to dysfunctionality within aspects of the operation and governance of the organisation. The Review also believes that, in the past, these dysfunctionalities extended to systems of oversight and accountability within the organisation, impacting on the capacity of SJAI to operate a safe and responsive organisation for all its members, including children.

Chapter 6

Organisational Culture

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Organisational Culture

A key area of evaluation in order to meet the Terms of Reference for this independent Review has centred on SJAI's organisational culture, particularly how organisational culture plays out in the arena of child protection and safeguarding. As with the organisational structure, understanding SJAI's organisational culture helps explain whether, how, and why SJAI failed to protect children in a specific number of instances. Understanding SJAI's organisational culture also helps identify and explain potential weaknesses and vulnerabilities in SJAI's child protection systems and practices. This part of the independent Review sought to identify and examine features of SJAI organisational culture that left or might leave SJAI vulnerable to mismanagement of child protection risks, threats, and failures.

During the Interview Phase of the Review, interview participants were asked about their views on SJAI's culture, with particular attention on both child protection culture and governance culture more generally in the organisation. The specific child safety culture conclusions are addressed in Chapter 7. This chapter deals instead with the general organisational culture of SJAI, building our understanding on how the general culture within SJAI informed child protection and safety culture.

This chapter describes and outlines the most distinctive features of the SJAI culture according to interview participants. Some of the key themes on organisational culture include deference, discipline, resistance to change, transparency, and professionalism. The order of themes described in this chapter generally follows the frequency with which they were mentioned by participants, and the importance those participants placed on those themes.

6.1 Deference and Discipline

> "Like, you knew your position, you knew your place, officers had their place". [Participant 7k]

Deference and discipline were the two most significant themes to emerge from the discussion of organisational culture in the Interview Phase. This broadly mirrors the significance participants placed on these themes when discussing organisational structure, particularly the quasi-military

and hierarchical structure of the organisation. This chapter describes how that hierarchical and quasi-militaristic structure engendered a dominant culture of deference to rank and status.

Interview participants described a culture of deference that was routinely policed by senior-ranking members of SJAI. Senior members were, according to a large number of participants, very concerned that their senior status within the organisation be respected. Indeed, the Review observed and noted such cultural features in its own engagement with SJAI, including interviews with many of the organisation's leadership.

Interview participants also described a cultural expectation that junior members would observe obedience to senior members by virtue of rank alone. This, the Review notes, is a distinctly superficial form of discipline; namely, discipline as obedience, rather than discipline as a goal-oriented form of organisation, progress and efficiency:

> "So I found it was very disorganised. But at the same time the discipline in terms of saluting and standing to attention and back in the early days you called officers Ms. or Miss, or Mrs. So you had the older members who demanded respect but at the same time that's all they demanded or that's all they contributed to the organisation". [Participant 7u]

> "The command structure was very much, I suppose, in respect of the command structure was very much military, … you gave [officers] the respect that their rank should command regardless of whether you liked them personally or impersonally or whatever way, you always made sure that you did whatever your superiors told you to do … you had a command structure and you respected the command, and one thing you were always taught in there was, you know, *respect the rank not the person*". [Participant 1a] [emphasis added]

As noted in the previous chapter, SJAI's structure was tightly organised around a rigid and quasi-military hierarchy. These structural features appear, from the accounts provided by many of the interview participants, to have permeated into the deeper fibres of the organisation's culture. Nearly all interview participants for the Review described SJAI as being an organisation concerned with deference to rank.

Many participants who are, or were, members of SJAI described a rigidly enforced culture of deference. Obedience to rank was highly valued and demanded careful adherence to the organisation's formal rituals of hierarchy. For example, it appears that until very recently, many senior members in SJAI expected members—particularly junior-ranking members—to refer to

senior officers by their rank and surname. Interactions between the hierarchy and rank-and-file were governed by other rigid formalities, such as military-style salutations and standing to attention. The following participant drew an insightful connection between the conservative gender norms of SJAI and the more general culture of deference to rank, though they conceded there has been progress in this regard in recent years:

> "I know there was a, in the last 10 years or so, there was a willingness to sit down and look at the rules and update the rules because even women have a lower place in the rules because they go back to 1947, which we know in this day and age, we all know is absolutely ridiculous but they do need to seriously update the rules and regulations to bring them up into modern day era. I think even the subservience is probably gone now too, to a certain extent when you are dealing with people". [Participant 5n]

Deference to the rank was also described by a number of participants as having significant negative implications for the proper functioning of internal accountability or disciplinary processes within the organisation. According to these accounts, deference combined with the structural weaknesses in internal accountability systems in SJAI, could operate to effectively shield individuals who were suspected of serious wrongdoing. This shielding could also be extended to more junior officers under the protection of a senior-ranking officer. Indeed, there was a perception that some senior-ranking members could exploit the culture of deference to enable others to avoid basic disciplinary accountability.

Many interview participants described how the culture of deference also had significant negative impacts on the organisation's practices around reporting and managing concerns of risks to children and other vulnerable members. In the absence of sophisticated reporting practices, this deferential culture reinforced the structural default of reporting through the chain-of-command. Interview participants described a number of different examples of this. Indeed, a handful of interview participants answered the situational child protection questions posed by the Review in a manner which suggested this default pattern has not been fully addressed despite efforts by SJAI to do so.

Some participants interviewed voiced their confidence in the chain-of-command as an effective and appropriate means of dealing with serious grievances, while at the same time describing their perplexed surprise that there was abuse within the organisation. The following quote illustrates the confident belief that respecting hierarchy and chain-of-command could provide adequate accountability and safety:

> "Until this [child abuse within SJAI] became an issue, until this raised its head, the rules were quite clear; you reported to your next in line ... you'd report to your Superintendent, and if that person [the Superintendent] was involved, you would bring it further [up the hierarchy]. But you had a chain-of-command that would investigate any sort of overdoing the rules, and that's as much as we'd expect, we would never have expected this sort of thing". [Participant 6z]

The effect of this culture of deference to rank status was to prioritise rank over safety. This cultural feature assumed the organisation's hierarchy could achieve accountability by virtue of it being a hierarchy. It also encouraged deference to senior-ranking officers who were often ill-equipped, poorly trained, and lacking in the necessary insights and understanding to deal with suspected risks to children from within the organisation. By prioritising and policing deference to rank as a high cultural norm in the organisation, SJAI reinforced the existing structural weaknesses in the organisation to address risks and threats emanating from within the organisation's senior ranks.

The following quote helpfully illustrates this point:

> "[T]his complicated mix of the military structure, deference to the hierarchy ... would I say it was high risk [to children]? Potentially due to the low knowledge base as opposed to ... I don't want to overstate the military ranking piece ... potentially there were cultural barriers to ... child protection practices". [Participant 3r]

The same interview participant also noted overlaps between the culture of deference to rank and the older age and gender profile of those in the hierarchy; specifically, that the older male members of the organisation's hierarchy could be more conservative, and less open to accountability and safeguarding practices that might seek to subvert or challenge existing authority structures. This participant also noted a cultural disinclination within the organisation towards respecting and trusting younger and more junior members with skills and responsibility. This participant also observed that the culture of deference in SJAI had created information and skills silos.

Many participants described a distinct generational approach to the cultural expectation of deference, with younger members questioning the appropriateness and legitimacy of such a cultural norm in an organisation such as SJAI. For example, the following interview participant

described tension between the implementation of new child protection reporting structures and safeguarding mechanisms, and the existing hierarchical structures and the deference culture attaching to it:

> "[I]t's definitely the older generation of the organisation who struggle with the fact that they're not part of every element of the organisation, they're not aware of everything that's ongoing, and there's no need for them to be aware of everything". [Participant 3w]

Indeed, the Review observed other aspects of this culture of deference during interviews, where some participants spoke in reverential terms of other members because of their status in the medical profession.

A large number of interview participants were, however, highly critical of this tendency within SJAI towards glorifying such professional status, which they argued fell clearly along socio-economic class lines. These and other participants also described how this form of deference militated strongly against dynamism and creativity within the organisation:

> "[I]t was very disorganised. It was very much living off the glories of past days. So as I said a lot of the senior officers that were running things or were charged with certain responsibilities were just not able to do it. But because they had a senior rank they were just given something to do, even if they didn't do it. So I found it was very disorganised". [Participant 7u]

Other accounts and examples of the culture of deference provided by participants included descriptions of grievances being greeted with suspicion, and having obstacles raised to block effective accountability. For example, a number of participants recounted their attempts to bring formal grievances through the official Court of Inquiry system, and being greeted with hostility by some leadership figures in the organisation. The aim, these participants felt, of such obstructive responses, was to deliberately intimidate in order to disrupt the complaints process. These accounts illustrated some of the most disruptive features of deference, leading to institutional defensiveness, and attempts to manage, control and "cover up" complaints to minimise the threat to the organisation, as described by these participants.

The Review believes that SJAI placed a high cultural value on deference to rank and seniority. The Review believes that the effect of this deference to rank inhibited the development of robust and effective accountability mechanisms within the organisation. The Review believes that SJAI's culture of deference conflated rank and status within the organisation, and in other discrete pro-

fessions as equivalent to the skill, knowledge and integrity appropriate for their role. The Review believes that deference informed and inhibited SJAI's development of internal accountability systems. The Review believes that this included the directing of disciplinary measures towards more junior ranks and away from senior ranks, facilitating a culture and practice that lacked accountability. The Review believes that this culture of deference posed a threat to the implementation of robust and effective child protection systems and practices.

6.2 Resistance to Change

One of the most common and important themes to emerge from the interview process centred around SJAI's capacity and inclination towards change and reform of practices and values. While this issue also emerged under the theme of "organisational structure"—specifically around the updating of the organisation's rules and regulations—the question of change was much more significant under the theme of organisational culture.

A large majority of interview participants outlined the view that the SJAI organisation was deeply resistant to change. This culture of resistance to change was reported to be, in part, related—if not rooted—in the structural themes of hierarchy and militarism in SJAI; and the cultural theme of deference to rank and status. For others, the wider culture of the organisation was distinctly conservative during their period of membership:

> "[T]here was a very backward looking tendency in senior staff and sort of senior management structure". [Participant 8q]

Only a handful of participants suggested the organisation is culturally open to change. Most of these participants were in leadership positions.

It is notable that the majority of interview participants, who felt the organisation was resistant to change, described SJAI's leadership as the dominant source of that resistance. The Review heard from a number of current and former members that the central governing structures of the organisation resisted change using strategies of direct obstruction, or indirect avoidance.

Others described indirect resistance to organisational change, facilitated by SJAI's hierarchical structures and culture, which strongly militated against autonomy and dynamism. Some participants contrasted this with SJAI's sister organisation in England, where many interview participants had, through emigration, volunteered or come into contact through cross-organisational engagements. Indeed, the Review's attention was directed towards the English organisation on multiple occasions by participants, as a compelling example of what SJAI could achieve if it was

so inclined. Notable differences highlighted included how the English organisation has paid staff, who exhibit a highly professional culture, and best practices training. Interview participants explained the Irish organisation has not closely followed major changes in organisational culture and structure in England, despite the close proximity of the two organisations, the overlap in membership, and the symbolic connections between them.

A number of interview participants explained how they hoped the Review would disrupt the settled consensus in SJAI, and force the organisation to embrace change. Some of these members believed the organisation would only respond to and learn from having organisational failures and weaknesses aired in public.

For a number of interview participants, the cultural resistance to change was the overriding reason for their having left the organisation; in all cases after many years of service in an organisation they were deeply committed to.

The Review believes that there is a long-standing and persistent cultural antipathy towards change within some aspects of SJAI. The Review believes that this culture of resistance to change poses an ongoing risk to the implementation of robust and effective child protection systems and practices.

6.3 Conservatism

Another important sub-theme that emerged with regard to SJAI's culture of resistance to change centred on the conservatism of SJAI. Interview participants from many ranks described a strong disinclination towards progressive changes in the organisation. This disinclination was directed at both mundane and radical proposals around organisational practices.

Others described how this kind of conservatism of the organisation—rooted in part by the hierarchical structure and deference to rank—alienated younger members seeking to bring about change:

> "[B]ut you had a situation where people in senior positions simply carried on and on until they passed away and then they were replaced in turn by other people but the people who were coming in tended to have very strong views about how things should be done and didn't have very … they weren't really willing to listen to feedback from below so that was something that applied across every aspect of the organisation.

> The things that we tended to be unhappy about, uniform, equipment, training, you know future direction, we could see St John was becoming less and less relevant in its chosen field and that's the sort of thing that exercised us but there was no clear passing of information up and passing and explanations of decisions back down". [Participant 8q]

Some interview participants described a deeper social conservatism within the organisation, at least as recently as the early 2000s. For example, one participant described an early attempt at child protection training in SJAI that was provided by a non-expert, and was woven-through with explicitly homophobic and inaccurate claims:

> "He was basically equating gay people with paedophiles, and that the whole child protection policy is about keeping the gays out.
>
> And then he was making references to the public toilets … being closed because of them and all this stuff, at the top of a whole room of people. And it was outrageous, just laughing because it was just so outrageous. But I think it was more about the age and the era of these people running the organisation". [Participant 7u]

This claim regarding the social conservatism within the organisation was echoed by other participants, and was confirmed by currently serving members of the SJAI leadership. Though, it should be noted, a number of currently serving members explained that these features of the organisation are in decline.

Others sought to defend the organisation, by claiming such homophobic views were commonplace in the late 1990s and early 2000s. While the Review accepts that homophobic views were commonplace in the late 1990s and early 2000s, it rejects that this can be used to justify such expressions of view.

The Review believes that there was a culture of conservatism within SJAI, that may have incorporated homophobic myths into its early child protection training. The Review believes that was likely to have significantly undermined SJAI's initial attempts to develop a formal child protection system in the late 1990s and early 2000s. The Review rejects the contention that such a position can be defended by reference to supposed cultural norms of that time.

6.4 Organisational Change

Substantial organisational reform and change experienced from the mid-2000s onwards was a significant theme that emerged during many interviews. This period was described in universally positive terms by participants who were members during that time. It is clear that for many members of SJAI—particularly younger and more junior members—this period continues to represent a symbol of reform, modernisation, professionalisation and progression. A number of participants described an immediate change in the relationship between leadership and rank-and-file membership. These participants perceived leadership in this period as particularly responsive and open to the needs of the membership at that time:

> "All of a sudden there was a general meeting of the brigade, concerns were being listened to, things were being mooted … you know I remember one female officer pointed out that she had no support and no assistance to keep her division going, she ran a cadet division because she was having a baby … exactly the sort of circumstances that the rest of society had caught up and St John still hadn't … that really started things moving very very significantly". [Participant 8q]

The Review believes the 2011–2022 period was one of concerted reform and change within SJAI. The Review also believes that this period saw the first meaningful attempts by SJAI to develop and implement a robust and effective child protection system.

6.5 Transparency

The issue of cultures of transparency or secrecy goes to the heart of accountability culture within an organisation. Whether SJAI is or was culturally capable of being transparent, both internally with its membership and externally with non-members, is very significant for understanding how and why SJAI responded to complaints of serious misconduct and abuse by members. All interview participants were therefore asked whether they felt SJAI is a transparent or secretive organisation.

Transparency is relevant to two distinct governance contexts in SJAI. The first context is the branch or divisional level: did ordinary members active in their local branch perceive the branch to be managed in a transparent and open way? The second context is within the hierarchy and leadership level: did members perceive that the governing hierarchy/leadership was managing the SJAI organisation as a whole in a transparent and open way?

At the level of the individual SJAI branch, interview participants who spoke of transparency did so in generally positive terms. For example, the following participant felt the management within his division was done in a transparent way:

Interviewer: Was St John Ambulance Ireland an open and transparent organisation?

Respondent: When I was in the adult division ... it definitely seemed, I mean as a cadet you are told nothing. There's no reason, you're a kid. And as an adult I would say it was definitely a lot more open. We definitely were included more. And even tried to be more professional as well because obviously we were really the front facing, the people that dealt with the public. [Participant 72p]

The latter of these two contexts is of most relevance to the Review's enquiries. The question of organisational responses to misconduct and abuse in a highly centralised and hierarchical organisation such as SJAI, will necessarily focus on how that centralised hierarchy responded. Indeed, this particular context occupied by far the greatest concern for interview participants who spoke to the Review.

A very large majority of interview participants believed that the SJAI hierarchy was not transparent. Many of these participants described the hierarchy as secretive, offering a variety of views on what drove such organisational secrecy. Some participants provided sophisticated observations that connected the cultural ambivalence towards openness to the deeper structures of centralised and insular decision-making in SJAI's leadership. As noted already, many interview participants described a governance culture in SJAI where leadership figures sought to centralise decision-making powers. This was also broadly consistent with the culture of deference to rank status. In that light, secrecy in leadership's decision-making was used to police the organisation's hierarchy and enforce deferential norms.

Many participants believed that SJAI's ambivalence towards transparency was rooted in a deeper desire to protect the reputation of SJAI:

Interviewer: Would you describe it as an open and transparent organisation?

Respondent: No, I wouldn't say it's open. And not transparent. Again I think pride would come before all of that. I think ... I don't think they would want to do damage to the organisation's name and that's kind of always been a concern with the organisation. [Participant 3t]

Indeed, the following victim-survivor was, remarkably, understanding of the defensive desire to control information when faced with reputational threats:

Interviewer: And how would you describe the culture within the organisation, would you describe it as a secretive organisation? A learning organisation?

Respondent: I wouldn't say it was secretive. I can understand at the moment how much they're trying to protect themselves [as] anybody would in this scenario but no I wouldn't say it was secretive. I enjoyed my time in the [organisation]. [Participant 6g]

Poor record keeping—an issue explored in Chapter 8—was also identified as a factor working against organisational transparency in SJAI. Some credited this with a general disorganisation in many parts of the organisation, while others felt this was mis-governance by design.

Other participants described more obvious examples of secrecy, including routine avoidance or inhibiting of transparency on mundane issues. According to these accounts, this was reflective of the deep discomfort within the SJAI organisation with transparency. Others felt the organisation was not necessarily secretive but that its hierarchical structures and culture militated against transparency and openness:

> "Like, you knew your position, you knew your place, officers had their place. Meetings went on and decisions were made, that you wouldn't have a part, you wouldn't know. Like it's funny when you look at the brigade's own model it's supposed to be open, it's supposed to be transparent everything else, there's supposed to be nothing hidden. Everyone is supposed to be basically equal in ways. And have the respect of everybody else and all that, that's all written in there. But you will find that within the organisation there was always lots of secrets, there was lots of little things said as well… But the board was always a secretive organisation, you met them twice a year maybe. But you couldn't really go up and talk to them. They weren't that sort of person that you could go and talk to. You knew who they were, it's on paper but you couldn't approach them". [Participant 7k]

Numerous examples of such "anti-transparency" support other observations by participants that information was kept in silos that were carefully guarded by the organisation. A number of participants drew connections between this culture of secrecy with the quasi-military structure and culture of SJAI. Another participant described a culture of "cloak and dagger" factionalism

among the organisation, which actively militated against transparency. Some believed this tendency against transparency was a feature of the older members in the organisation, but were optimistic that younger members were more culturally inclined to transparency:

> "It's becoming more open, but it's still very kind of protecting each other, do you know? But, it is getting better as new people arrive, you know? But certainly, the more senior Officers, it was very kind of close the doors and tell nobody, you know?" [Participant 2q]

The only interview participants who answered that they believed SJAI is a transparent organisation were leadership figures. However, even these responses tended to concede that the organisation had historically kept information contained in isolated hierarchical silos:

Interviewer: Do you think SJAI is an open and transparent organisation?

Respondent: Traditionally, we weren't. In the view that, and again I'm not talking about safeguarding, I'm talking about generally as an organisation, we would have been probably, as with most organisations of the period, and I'd be going back to the 70s, 80s and 90s, there was very much a view that information stayed in certain pockets or certain areas. That has gone in the last twenty years and we have moved much more towards an open and transparent organisation. [Participant 9c]

The Review believes that SJAI did not operate in a transparent manner towards its membership. The Review believes that this lack of openness has, in the past, manifested itself as a perceived culture of secrecy. The Review believes this culture of secrecy was intimately linked to dysfunctional accountability structures and practices within SJAI. The Review also believes that this culture of secrecy inhibited the effective functioning of child protection practices within SJAI.

6.6 Denial and Avoidance of Responsibility and Accountability

The robustness and effectiveness of internal accountability mechanisms, and the organisation's willingness to admit responsibility and fault are key indicators of healthy organisational governance. These issues are all essential to understanding how and why SJAI responded to complaints of serious misconduct and abuse by members. A large number of interview participants described their anger, disappointment and frustration at what they perceived as SJAI's ongoing failure to accept responsibility for past wrongdoing by the organisation. Participants believed this failure manifested itself in multiple forms. These participants characterised this as part of a broader unwillingness of SJAI to engage with, or accept responsibility for, past wrongs and harms. More significantly, victim-survivors who spoke to the Review described their profound hurt and trauma caused by the perceived failure by SJAI to adequately acknowledge their victimisation within the organisation.

A number of participants also articulated deep frustration and disenchantment with SJAI for what they perceived were repeated denials by some within the organisation that serious wrongdoing and child abuse had taken place in the organisation. They believed that the refusal to publicly accept responsibility again reinforced the sense that SJAI was not equipped to be run in a safe and responsive manner.

A number of participants also described their observations of the culture of denial as it played out on the SJAI social media platforms.

Despite these frustrations, one interview participant felt that the discussions on social media about past wrongdoing had also encouraged this culture of denial to slowly disintegrate as more people have gone public about their experiences.

The interviews with some SJAI leadership figures encountered some hostility to suggestions that SJAI's child safeguarding practices may have vulnerabilities or weaknesses. These responses indicated a significant over-confidence in the ability of training alone to overcome the kinds of cultural issues identified here, and a lack of appreciation of the importance of compliance management in organisational learning and change. In the following quote, for example, the Interviewer indicated that the Review had found evidence of continuing confusion about SJAI's reporting processes for child protection risks. This suggestion was met with a defensive denial:

Interviewer: … can you understand why people might be slightly confused as to the [child protection] reporting procedure if in fact the rules suggest that you report up the line to the next most superior officer?

Respondent: No, no not at this stage.

Everybody has had child protection training, everybody knows what the line of communication is. And everybody in the brigade at this stage, or in St John has to have it and up to date.

Interviewer: I'm conscious of all the progress that has been made on child protection. So it's not in any way to take away from that. It's more to focus on really what could be done in terms of flagging it for people. I just wonder whether a prominent notice on the website would be something that would be worthwhile?

Respondent: I think it's been flagged, I think it has been flagged and people need to take a responsibility themselves, a co-responsibility to make sure that they are educated in how it works. I think that St John has done everything in its power to make sure that people are aware of the child protection to make sure that people are up to date and have the relevant information. [Participant 4X]

The interviews undertaken reveal what appears to be a continued culture of denial and avoidance of responsibility by some within SJAI, particularly in certain areas of the organisation.

6.7 Professionalism

Interview participants were asked whether they believed SJAI is a professional organisation. Similar to the relevance of organisational transparency and accountability to the Terms of Reference, this is relevant to whether SJAI has the cultural capacity to identify and address past wrongdoing and victimisation. Perhaps more importantly, this theme explores whether SJAI is capable of learning from its past failures, and taking up and embracing new norms and practices that reflect current best practice in areas such as child safeguarding.

Participants' responses here were, on the whole, highly sophisticated and offered an impressively nuanced appreciation of the meaning of professionalism in the organisational context. The dominant impression of interview participants—particularly those with current or recent experience volunteering within SJAI—was that it is an organisation pursuing meaningful efforts to positively improve its structures and practices in a professional manner. This view concedes that the organisation was not previously professional, but the current SJAI has improved significantly:

Interviewer: Do you think that SJAI is a professional organisation?

Respondent: In how we do things, how we approach things? Yes, we are.

Are we always 100% right? No, no organisation is. There are, I'm sure, gaps in things that we do. But where we find a gap, at whatever level, there is a very strong push, particularly in the last number of years to try and identify gaps and to try and close gaps across all issues, safeguarding is obviously one, but we would have loads of patient issues, paperwork issues, all of that is compliance issues, all of that sort of area, and we've really been working hard as most voluntary organisations have to do.

You've got to work really hard, because you're not a professional, you're a professional organisation but you are not a paid professional organisation and therefore some of the resources aren't always there, so what you've really got to do is you've got to work extra hard to try and make sure that you cover all of those issues. [Participant 9c]

Most participants who remain members of SJAI, believed the organisation continues to fall short of where they believed it should be, despite the organisation's efforts to realise better professionalism:

Interviewer: Is [SJAI] a professional organisation?

Respondent: In what context? Professional in the sense of a private company who would be out to make money and portray a professional image? Or? Organisation with … Professionally run?

Interviewer: Professionally run with robust procedures?

Respondent: No, I believe it tries to do its best and its intentions are always the right intentions. But I don't believe it's as professional as it should be. [Participant 4h]

Participants who were no longer members, but who all had many years of experience, were consistent in their view that the organisation was not professional. This is broadly consistent with other more positive assessments, all of which conceded the organisation was historically exclusively voluntary. It is interesting to note here that the vast majority of participants recognised that the strict quasi-military norms and structures, that had traditionally governed the organisation, are

distinct from the question of professionalism. In other words, robust discipline is not synonymous with professionalism. Some contributions again connected resistance to improved professionalism to the cultural dynamics within SJAI.

A number of interview participants emphasised the enthusiasm of many within the organisation for professionalism, while observing that this enthusiasm did not always materialise in substantive changes. One participant believed that this was because a significant number of members in SJAI were not themselves healthcare professionals. This view suggests that professionalism in SJAI can often be determined more by how professional the members are in their working lives, rather than any distinct efforts by SJAI itself:

Interviewer: Would you describe St John Ambulance Ireland as a professional organisation?

Respondent: They certainly attempt to be professional, they do try hard. I think the problem is we have so many people who are not involved in pre-hospital care on an ongoing basis that it does become harder sometimes to be fully professional. [Participant 5n]

The voluntarist ethic of the organisation was routinely held out by participants as an obstacle to professionalism within SJAI. Some members observed an inherent tension between the voluntary nature of SJAI and the highly regulated medical field in which the organisation provides services and training:

> "Is it professional? I would say it's a community organisation I would see it as. And maybe I'm being unfair to them there. Certainly it's a very different experience working in an organisation like that versus when you are working with professionals in the delivery of health and social care elsewhere.
>
> So in a sense it is this community grass roots organisation that has taken on this military ranking style. And is delivering health and social care. And are very committed to that and they deliver it. But is it the healthiest culture, are there other cultures, are there other organisational models that they could be using in 2021, 2022? Without a doubt. But I suppose for them it goes back to that volunteer base and how difficult it is to attract and keep volunteers". [Participant 3r]

Similar to the voluntarist ethic of the organisation, other participants observed the tight community quasi-familial nature of the organisation as a constraint on what they believed was appropriate professionalism.

Other participants expressed a desire for greater professionalism in the organisation along corporate lines, while acknowledging the impressive level of organisational management in SJAI despite its voluntarist foundations. The following participant highlighted the need for improved corporate governance considering the significant finances generated by SJAI:

Interviewer: Do you think St John Ambulance Ireland is a professional organisation?

Respondent: I'd love to see a chief executive. And don't tell me we can't afford it, we could. Because we generate business, we run first aid courses, we run operations. So we can, we can bring in a million pounds, we can bring in a million and a half pounds with no problem. So I'd love to have either a general secretary or a chief executive. We are running the organisation and very well, on a voluntary basis, we shouldn't be. There should be professional people running the organisation and people like us supporting that structure. [Participant 27q]

Some participants insightfully observed the need for an organisation such as SJAI—which, through its work, inevitably carried a high risk profile—to operate on a professional basis in order to ensure adequate levels of safeguarding and risk management:

> "Technically we are very professional, we have got the highest standards, we are linking with the ambulance services, we are happy, we are top of our game, I think.
>
> The commercial side of it, due to Covid we have fallen a little bit flat on our face …
>
> [However with regard to child safeguarding] I don't think we can do, we have what 700 cadets, 600, 700 cadets, and it's the knock on effects of those. You can't do it, I think you can't do it on a voluntary basis, absolutely. And you might say, people like my other colleague, well we can't afford it, we cannot afford it, we have to do it. Because and there's examples of [other comparable voluntary organisations] they are all looking and looking at best practices and they're all going down that way. And we have to follow". [Participant 27q]

A handful of particularly perceptive contributions differentiated between a cultural enthusiasm for professionalism and best practice, and the organisational capacity to ensure compliance with

high professional standards. These participants felt that the cultural enthusiasm was currently quite strong throughout the organisation. That said, they held that this was not mirrored by the compliance culture and practices needed to realise such ambitions for the organisation:

Interviewer: Would you describe St John Ambulance Ireland as a professional organisation?

Respondent: That's a difficult one …

[Would it meet the standards required in comparable public sector organisations?] No. Most definitely not.

Do I feel there's a progress towards professionalism? Most definitely. And an understanding of the professionalism behind it …

So, do I feel that we're at the best standard? No. Do I feel we're getting there? Yes.

Is there a pathway to it that has to progress? Most definitely. And are there still gaps? Most definitely, and we just have to work towards ensuring that the organisation has a full organic understanding of how compliance grows and changes and there's continuous improvement. [Participant 3w]

Once again, in contrast to the generally nuanced responses from interview participants outside the leadership, participants from within the leadership were unequivocally positive about the current level of professionalism within the SJAI organisation. Beyond these assessments, no senior-ranking members elaborated further on the question of professionalism:

Interviewer: Would you describe the organisation as a professional organisation?

Respondent: Yes it is now. [Participant 4X]

In contrast to the generally positive responses on this aspect of SJAI culture, some of those interviewed described the organisational culture as the antithesis of professionalism:

Interviewer: Yes and just going on the issue, how would you describe the culture or environment in St John Ambulance, would you describe St John Ambulance as a professional organisation?

Respondent: Professional? … No, I wouldn't say it's professional no, I couldn't say it's professional. [Participant 3t]

As already noted, many interview participants who had volunteered in the English organisation saw gaps in SJAI's practices and culture much more clearly than those who had never volunteered outside Ireland.

The Review believes that beyond pre-hospital best practices, SJAI lacks professionalism in some of its operative culture. The Review believes that this lack of professionalism has the potential to undermine the implementation of robust and effective child protection systems.

6.8 Socio-Economic Class in SJAI

Finally, a number of interview participants raised the complex issue of socio-economic class as an unspoken organising norm of SJAI in both structural and cultural terms. In particular, some participants—specifically some of the victim-survivors—believed that victimisation tracked along socio-economic class.

More broadly, a number of participants observed that the organisation was organised along socio-economic class lines, with leadership roles traditionally being dominated by people drawn from privileged backgrounds. Notably, this feature of SJAI's past was confirmed by a number of leadership figures interviewed by the Review:

Interviewer: You are describing that there was a big class divide in the organisation? Could you elaborate on that?

Respondent: Yeah, it was a socio-economic thing, like all the officers, like you wouldn't see a working-class officer get to a particularly high rank. They might become like a District Officer or an officer within their local division … [Participant 9j]

Indeed, as already noted in this Report, some interviews with senior-ranking members supported the claim of a deferential culture towards medical professionals. It is suggested here that this great esteem for medical status also reflected the class biases of the organisation.

Chapter 7

Accounts of Abuse And Response To Abuse In St John Ambulance Ireland

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Accounts of Abuse And Response To Abuse In SJAI

This chapter deals with the components of the Terms of Reference for this independent Review that relate to how SJAI responded to complaints or concerns about abuse or grooming of children in the past.

The first part of this chapter summarises the testimony shared with the Review by victim-survivors that described incidents of grooming, sexual abuse and other forms of victimisation. It also includes the testimony of other interview participants that referred to similar incidents. This part of the chapter describes the different forms of harm and trauma spoken about by victim-survivors and also sets out the testimony given which describes actions within SJAI that would be regarded in the child protection area as strategies to facilitate abuse and avoid accountability. Finally, the first part of the chapter also examines the question of what, if any, level of institutional knowledge of potential abuse existed within SJAI.

The second part of this chapter explores the different responses by SJAI to the abuse reported by victim-survivors to the SJAI. This part includes an examination of any investigations undertaken by SJAI into complaints of wrongdoing within the organisation, and any attempts by the organisation to identify and address risks to children and vulnerable people.

7.1 Accounts of Abuse within SJAI

During the Interview Phase of this Review, the Review heard accounts of serious child sexual abuse and grooming from a number of victim-survivors. Some of these people had disclosed these accounts to SJAI ahead of engaging with the Review.

A number of victim-survivors made disclosures to the Review who had not previously made a complaint to SJAI.

The Review understands that some of these individuals had not previously disclosed their experiences to any state agency. A number had previously made a complaint to An Garda Síochána, but not to SJAI. In their testimony, these participants described experiences of grooming and child

sexual abuse. Other victim-survivors stated that they had made complaints within SJAI about abuse, to include sexual harassment, although they did not describe themselves as victims of abuse.

Finally, one other individual came forward to the Review and disclosed a non-recent serious sexual assault. However, the context of that assault was outside of the Terms of Reference for this Review. As a result, this individual's account was not included in the Review, but an appropriate referral was made by the Review to the statutory agencies, An Garda Síochána and the Child and Family Agency/Tusla.

All victim-survivors who came forward were referred to the relevant statutory agencies and were encouraged to make disclosures to them, unless those individuals had already made such disclosures.

During the Interview Phase, the Review also heard descriptions of harassment and bullying within the organisation. These accounts were determined to be within the Terms of Reference for the independent Review, as the response by SJAI to this kind of wrongdoing is relevant to understanding the specific responses by SJAI to reports of sexual abuse and grooming.

The Terms of Reference preclude the Review from making determinations about the merits of specific complaints. This, as has already been stated, is a matter exclusively for determination by the statutory agencies. That said, the question of whether allegations of abuse were properly handled by SJAI is directly relevant to the question of how the organisation responded to child protection risks, threats or complaints.

The testimony of a number of victim-survivors was consistent in describing abuse within the SJAI organisation. Some testimony received contained references to incidents outside the SJAI context. However, this testimony also described SJAI as the key institutional context that facilitated the incidents described.

Testimony from victim-survivors described various actions which would generally be regarded by child protection specialists as strategies of grooming and abuse. These included: actions which were not officially sanctioned by SJAI but which would appear to have been facilitated by the connection of those involved with SJAI, such as bringing children on unofficial weekend trips, and providing children with paid work opportunities outside SJAI. This highlights the necessity for organisations to be aware of how a position of authority within an organisation like SJAI can facilitate potential grooming or abuse outside the strict parameters of organisational activities, and to address that risk in their policies and child protection measures.

Other testimony referred to activities directly within the remit of SJAI. For example, a number of victim-survivors described being routinely sexually assaulted during SJAI branch and cadet meetings, and during public duties.

The accounts of victim-survivors who spoke to the Review described predatory and abusive behaviour over a number of decades in SJAI. The testimony, taken as a whole, covered a period from the early 1970s until the late 1990s.

7.2 Nature of Abuse Described

Some victim-survivors described the manipulation of other children into being part of the cycle of grooming and abuse. Other participants described lengthy campaigns of sexual harassment and sexual assault. These allegations included harassment and assault of older male cadets.

7.3 Strategies for Access

A number of victim-survivors and other participants described the use and exploitation of SJAI rank status to gain access to areas with young members. These accounts of victim-survivors and other participants suggest that the particular structural and cultural features of SJAI's hierarchy, in particular the chain-of-command and deference to rank status, were sufficiently inadequate that they presented a serious risk of facilitating grooming and sexual abuse.

7.4 Grooming Strategies

Most victim-survivors described conduct beginning immediately upon their joining SJAI as cadets that would be regarded from a child protection perspective as a potential grooming strategy. These accounts all described how training and mentorship roles—first aid training being a fundamental part of SJAI's work—were used to gain access to potential victims, and as a shield against potential scrutiny.

A number of participants discussed an incident in which an adult was discovered in a locked ambulance with some male cadets. The adult claimed that he was undertaking training exercises with cadets, but this excuse was widely dismissed as not credible:

> "When the ambulance door was open that morning, there was three or four kids sitting on one side of an ambulance and he was sitting on another side and it

> looked like they were just talking, and it looked reasonably innocent, but at the same time because the door had been locked that is what set the alarm bells off". [Participant 5n]

According to this participant, and a significant number of other participants, there was widespread awareness and knowledge of this incident within SJAI.

Other activities described by victim-survivors, which would be regarded as having the potential to facilitate grooming or abuse, included force or threats of force, humiliation and intimidation, or other forms of abuse of power. The potential risks to children from such behaviour could have been exacerbated by the obstacles to accountability generated by SJAI's preoccupation with rank and status in the organisation's hierarchy.

Testimony from victim-survivors also described inappropriate means of developing bonds or connection with children, such as generosity; the attempted manipulation of sexual identity; or the purchase and provision of alcohol to victim-survivors to help establish a bond. Alcohol also presents the additional risk of making a child more vulnerable to grooming or abuse due to their intoxication.

Other actions described by both victim-survivors and other participants that would generally be regarded as potential grooming involved protecting cadets from accountability for breaches of discipline.

Such behaviour would have relied heavily on SJAI's deference to rank and weak accountability structures. A number of other participants from the SJAI leadership noted how cadets who appeared disruptive were protected from accountability. While the Review believes this behaviour should have been the subject of scrutiny and investigation, no effort appears to have been made to do so.

Rank status in the SJAI hierarchy and the authority it conferred were, according to victim-survivors and participants, used to create fiefdoms where the already weak accountability mechanisms were ineffective. This enabled the arbitrary and opportunistic exercise of power.

The ability to use power in this way within an organisation that was both structurally and culturally inclined to deference created many opportunities for the grooming and abuse of vulnerable children.

The Review believes SJAI's structure and culture facilitated forms of behaviour which would, from a child protection perspective, generally be regarded as potential grooming strategies. The Review believes SJAI's accountability systems failed to intervene or investigate despite evidence of potential risks.

7.5 Ongoing Trauma

A number of victim-survivors stated that grooming and sexual abuse had immediately negatively impacted aspects of their familial, professional and sexual lives. They told the Review that the trauma remains with many of the victim-survivors to this day, and that they found it difficult to discuss these matters during interviews with the Review:

> "And then just my general appearance, even now like you know, I find it hard at times just to even go up the stairs and have a shower or you know … change … just tidy myself up or whatever, I just have this in my head, well if I am unclean or whatever like … you know … nobody is going to come near me or want to come near". [Participant 59y]

The Review would like to again commend the victim-survivors for their bravery and dignity in telling their story.

Victim-survivors also spoke about the profoundly damaging impact which they believed the abuse had on their sexuality and sexual experience.

Some victim-survivors explained that they wanted anonymity and identity protection from the Review because of their fears about the potential impact if their families were aware of their stories.

It is important to note that most of the victim-survivors criticised the response of SJAI to their abuse as being a significant source of what they regarded as re-victimisation and traumatisation. The perceived inadequate responses of SJAI described by victim-survivors included the failure to protect people despite awareness of the risk, the failure to monitor potential victims, and the failure to respond to complaints.

It should be noted that some participants who described what would be regarded as instances of abuse in their testimony—specifically those who had experienced sexual harassment, rather than grooming or serious sexual abuse—did not perceive themselves to have been seriously victimised or traumatised. Indeed, these participants did not consider themselves to be "victims" or "survivors" of abuse. These participants perceived such matters as less serious: e.g. brief, opportunistic groping. However, it should be noted that some of the experiences they described involved prolonged campaigns of sexual harassment and sexual assault. These participants sought to engage with the Review as they understood their experiences were relevant to the Review's Terms of Reference. While the Review accepts that these individuals may not have been seriously

victimised or traumatised, the nature of the events that they described to the Review means that it is important that they be dealt with in the same section as the similar alleged matters described to the Review by other victim-survivors.

7.6 Knowledge of Potential Abuse within SJAI

The question of whether knowledge or awareness of abuse, or risks of abuse, was present in SJAI during the relevant period is among the most important to be considered by the Review. The failure of SJAI to address known or suspected threats of harm to children arguably constitutes a failure of child protection policy.

The Review heard from multiple sources—including victim-survivors and other participants—that there was, at the very least, a substantial degree of awareness in SJAI that a significant threat to the safety of children existed. Most of these sources were unequivocal that, over several decades, many in SJAI were fully aware of specific risks to children. These claims were put to senior management in the SJAI executive. All denied any personal knowledge or suspicions.

On balance, the Review believes the claims by numerous participants that there were widely held suspicions about a threat to children which many believed at the time to be credible. This view, or material consistent with it, was expressed by a large number of participants, including currently serving members of SJAI.

The Review believes that there were significant suspicions that one division of SJAI posed potential serious threats to children within SJAI.

7.7 Rumours

The most consistent accounts by participants and victim-survivors of organisational knowledge or awareness of the risk to children concerned rumours.

A large number of participants also described routine informal warnings about specific threats to their safety from an individual in the organisation. The Review heard identical accounts of these informal warnings from multiple participants.

Most participants described having heard rumours of a specific threat to children at some point during their time in SJAI. A number of participants explained that these rumours were widely

known among cadets in SJAI due to the informal warnings that were routinely given (see below "Informal warnings").

These participants firmly believed that SJAI was aware of these rumours. For example, numerous participants described alterations made to a camp song book used by cadets while on SJAI-organised camping weekends. These particular alterations reflected rumours of serious sexual misconduct and exploitation with cadets. These participants argued this was strong evidence of organisational knowledge of the risk posed to children.

This account of an altered song book was repeatedly confirmed by a number of participants throughout the Interview Phase.

The nature of these rumours—what kinds of suspicions were widely held in SJAI—was slightly less consistent between participants. A number of participants described an awareness that some cadets had been, or were being, sexually abused and exploited. However, awareness of the nature or seriousness of that victimisation was less clear-cut.

Beyond knowledge of specific examples of victimisation, most interview participants believed that there was some potential risk to the welfare and safety of children:

> "I think that's fair to say there were red flags. People in general knew that the children may have been at risk". [Participant 5n]

This general awareness of child protection risks emerged in a significant number of interviews where participants consistently described the routine informal warning of cadets.

Some participants described participating in conversations with others in SJAI about how to address the specific threat, and the failure of the organisation to take meaningful action. Indeed, one participant echoed a common view among participants, that despite some knowledge of risk, SJAI feared litigation and damage to the organisation's reputation if some intervention was undertaken to address those suspicions.

A number of participants voiced their surprise and anger at what they described as denial by SJAI about any organisational awareness of there being more than one victim.

It appears from multiple accounts from participants that there were widely discussed rumours of a specific threat to children in SJAI.

7.8 Informal Warnings

The most frequently described example of SJAI responses involved informal warnings given to cadets about a specific threat to child safety. Most interview participants described either having received such a warning, or being aware that such warnings were routinely given. These accounts were echoed by the majority of other interview participants from SJAI.

The Review notes that these informal warnings were often largely inadequate. The Review observes that predatory individuals seeking to groom young male cadets could have easily exploited informal warnings from other males in positions of authority, as teenage males may be inclined to ignore such warnings, or not treat them as serious. This sentiment was echoed in a number of accounts provided by participants and victim-survivors.

Nearly all the leadership figures who participated in the Interview Phase denied any knowledge of such warnings. Two did concede giving such warnings. However, these were explained merely because the subject of the warning was an "unpleasant individual".

The Review believes that informal warnings were routinely given to young male cadets about a specific child protection threat. The Review believes that these warnings were given by both peers and senior-ranking members, and reflected a deep organisational awareness of the potential risk present in SJAI.

7.9 Knowledge from When?

The Review found it difficult to identify exact time periods during which such rumours became well-known in one geographical area of SJAI. Some participants and one victim-survivor believed rumours were circulating as early as the late 1960s/early 1970s. The most consistent dating was from the mid-1980s.

It seems clear from the majority of interview participants that rumours were well established by the early to mid-1990s.

The Review believes that awareness of specific threats to child safety in the SJAI organisation was well-established by the early to mid-1990s.

7.10 SJAI Response to Risks and Potential Abuse

SJAI's response to known or suspected child protection risks or threats—particularly risks of grooming and child sexual abuse—is one of the questions under the Terms of Reference for the independent Review to consider. Assessing this question was a complex process for the Review and required careful weighing of a diversity of accounts regarding the performance of both individuals and groups within the organisation. The conclusions in this part of the Report are closely connected to the conclusions on SJAI's organisational structure and culture, particularly the features of the organisation that the Review concludes left SJAI members vulnerable to child grooming and abuse.

This section begins by examining what, if any, investigations were undertaken by SJAI. Here the Review concludes that in most cases there was never a formal investigation into widely held suspicions of child grooming and abuse within SJAI. Indeed, the Review has been unable to find documentary evidence relating to any formal investigation into the question of child abuse, even where a formal disclosure of abuse was made. It appears from the evidence gathered that the SJAI organisation failed to intervene to address known or suspected threats to child safety because of a fear of litigation until it received a formal complaint in the late 1990s when it took action. The Review also believes that SJAI felt powerless to act to address known or suspected threats because of misguided beliefs about the necessary evidential thresholds for their own interventions.

This section then describes how SJAI, at various points, sought to avoid responsibility for any wrongdoing within the organisation. The Review has heard numerous accounts that SJAI as a corporate entity sought to avoid formal acknowledgement of wrongdoing within the organisation. It appears from the evidence gathered that this avoidance of responsibility was primarily due to a desire to protect the reputation of the organisation.

The Review believes that responses to wrongdoing more generally in SJAI were inadequate and were designed to serve the interests of the organisation rather than its ordinary members.

7.11 Investigations

In the case of the disclosures made by the various victim-survivors, the Review was unable to find any evidence of any investigation undertaken by SJAI. Indeed, in all the evidence provided during the Interview Phase, no participant from SJAI leadership mentioned or described an investigation into wrongdoing. This absence of evidence of investigation was noted by one victim-survivor. In their case, the only records provided to the Review were short notes of contact relating to the disclosure.

The Review was unable to find any additional evidence of an investigation undertaken by SJAI to examine any complaints of abuse in 1999/2000. No such documentary evidence was made available by SJAI.

Some of the accounts given by participants and victim-survivors about SJAI's response to serious complaints, described significant delays in the organisation undertaking any substantive response. For example, one interview participant, who had raised a significant grievance with respect to their senior-ranking officer, described a lengthy delay by the organisation in pursuing any meaningful response. This response did not appear to include any transparent intervention. The participant described merely a finding in his favour. This participant suggested the reason for this delayed response primarily lay in the absence of meaningful accountability for senior-ranking members in the organisation. This participant believed an investigation had taken place into his complaint, but the secretive nature of the SJAI hierarchy meant that he was never informed about what it involved.

The Review believes, on balance, that SJAI failed in the past to undertake any meaningful investigation into known or suspected threats to children. The Review believes that this failure to investigate is part of the broader weak accountability mechanisms within SJAI.

7.12 Courts of Inquiry

The only evidence of SJAI undertaking formal investigations following complaints by members involved Courts of Inquiry. In other cases, it appeared from the review of files made available for inspection that investigations were undertaken through meetings, telephone calls and/or other conversations which, in many instances, do not appear to have been properly recorded or noted. Beyond the limited provision under section VIII of the SJAI Rules and Regulations 1994—which are exclusively concerned with the composition of Courts of Inquiry—the Review was not provided with any official guidance or rules governing the operation of this internal accountability mechanism. The Review was provided with no rules governing the operation of the Court of Inquiry process.

As has already been noted, the experiences recounted by interview participants of the Court of Inquiry process were exclusively negative. Participants described this process as intimidating and humiliating. Participants believed that Courts of Inquiry were not designed to investigate complaints, but instead functioned to deflect complaints through intimidation and neutralisation.

Along with intimidation, deflection and neutralisation of complaints, accounts of the Court of Inquiry process provided to the Review also reflect strongly the themes of hierarchy and obedience outlined earlier in this Report. In particular, some accounts suggest resentment on the part of some SJAI members when the Court of Inquiry system was used by a junior officer to pursue meaningful accountability. In one case, the participant and the supervising officer in their branch were allegedly threatened with disciplinary measures for questioning an arbitrary procedural direction from a senior officer.

Another participant's experience of the Court of Inquiry again described a process designed to intimidate, frustrate, and neutralise their grievance.

A further participant, again recounting their Court of Inquiry experience in negative terms, described a total absence of transparency around the rules and procedures of the court. On their account, their experience of the Court of Inquiry was of trial by ambush. The Court of Inquiry offered no transparency about its processes.

The Review believes that the Court of Inquiry process is wholly inadequate and fails to offer a meaningful or effective accountability mechanism. The Review also believes that the process is profoundly procedurally flawed, and poses a serious threat to the constitutional rights of SJAI members.

7.13 Inaction

> "[T]hey knew about this, they did nothing about it. And when it came out, they still did nothing about it, you know?" [Participant 2q]

Among the most common themes to emerge in the Interview Phase in relation to responses by SJAI to misconduct or abuse was inaction. As already noted, even after the first victim-survivor to disclose made those disclosures, there is no evidence that SJAI undertook a formal investigation in relation to that complaint. The Review was unable to find evidence that SJAI referred initial complaints to the relevant statutory agencies: An Garda Síochána or the local health board with responsibility for child protection. If that is correct, this suggests that SJAI failed to initiate any formal investigation following a full disclosure of alleged serious grooming and child sexual abuse. This would constitute a failure of SJAI's ethical duty of care to its membership, which included hundreds of cadets. SJAI has, on its part, said that as the victim-survivor had already reported the matter to the Gardaí, it cooperated with Garda investigations and appeared to believe that it, therefore, should not conduct a parallel investigation.

A more subtle form of inaction was evident from accounts provided by other participants to the Interview Phase of the Review. As already described, the Review believes that the evidence suggests there were widely held suspicions in SJAI about a specific threat to children. Some of these suspicions related to widely known rumours of specific incidents.

However, despite these widely held suspicions, and a number of other incidents of note, the Review found no evidence that SJAI ever initiated any formal investigation to examine these suspected risks to children.

A number of interview participants defended SJAI's failure to intervene due to a lack of "hard evidence" of wrongdoing. The Review believes, on balance, that some in SJAI failed to act on knowledge or suspicions of risk because of a misguided belief that a criminal standard of evidence had to be reached before their intervention was permitted. The Review considers it difficult to imagine how "hard evidence" could be found if there was no attempt to investigate suspicions properly.

Finally, it was suggested by a number of interview participants that a key factor in SJAI's inaction, in the face of known or suspected child protection risks, was due its fear of litigation.

The Review believes, on balance, that some in SJAI failed to act due to a fear of litigation arising from removal of threats or suspected threats to child safety. The Review has not found any evidence that SJAI sought independent legal advice on this matter.

7.14 Avoidance of Responsibility

The desire among many in SJAI to avoid being held responsible for any wrongdoing was a significant theme in the Interview Phase. Victim-survivors described their firm view that SJAI had actively sought at different times to minimise, deflect or deny any responsibility for wrongdoing within the organisation. As already noted, this avoidance of responsibility was a source of frustration, anger and trauma for those victim-survivors.

Other participants described their view that SJAI continued to actively seek to avoid organisational responsibility. Some believed this was due to a fear of ruinous financial consequences to the organisation, or the tarnishing of the organisation's reputation. Others identified a desire to protect status and reputation within SJAI as a key driver of the response by SJAI to complaints and disclosures of abuse.

7.15 SJAI's Reaction to Information Regarding Child Protection Risks

The Review has heard accounts in interviews of so-termed "cover-up" on the part of individuals or groups within the SJAI organisation to attempt to suppress the spread of information about risks or disclosures of grooming or child sexual abuse beyond the small groups who were described by participants as having relevant knowledge. These attempts could include—but are not limited to—the payment of money to secure secrecy about sexual grooming and abuse, or non-disclosure of knowledge of abuse to relevant authorities, such as the statutory agencies, An Garda Síochána and the Child and Family Agency/Tusla.

Nearly all victim-survivors who spoke to the Review, and a number of other participants expressed the view that the actions and responses of SJAI to both the knowledge of child protection risks, and complaints and disclosures of grooming and child sexual abuse, amounted to a "cover-up". Some participants described the general culture of SJAI as being particularly prone to cover-ups of wrongdoing. For example, numerous accounts of experiences of SJAI's Court of Inquiry mechanism were described as functioning as a means of cover-up to achieve reputation protection.

A number of very serious allegations of cover-up were made by some victim-survivors and other participants in the Interview Phase of the Review. Many of these are extremely difficult to verify due to the poor record keeping of SJAI during the relevant time periods. One claim that the Review was able to partially corroborate relates to the attempted offer of informal cash compensation to

one of the victim-survivors after a formal complaint was made. While there is no documentary evidence in the SJAI records to verify this, a number of interview participants in leadership positions believed it was accurate.

In one interesting contribution, a participant initially denied there was a cover-up of wrongdoing in SJAI. However, the participant then went on to justify attempts to informally pay cash compensation for silence, and stated that this may have occurred to protect SJAI's reputation:

> "And that was … at the time privacy was privacy at that time and it was held private, it wasn't a cover-up. And I'm adamant about that, it was protection of the brigade's name let's say. It's not being regarded as a cover-up. But the thought of that getting out at that time would have been such a horrendous as turned out with all the institutions as it happens … but [it was] the protection of the brigade more than a cover-up". [Participant 8f]

It may be obvious to point out that cover-ups are very often motivated to protect an individual's or organisation's reputation.

The Review was unable to verify claims of an offer of a cash payment by SJAI to a victim in order to protect the organisation's reputation.

7.16 Legal Action Against SJAI

Rule 122 of the 1947 Rules and Regulations of SJAI (reprinted in 1994) states:

> "Legal action shall not be taken by an Officer or member against any other Officer or member of the Brigade as such, without the sanction of the Commissioner having been first obtained in writing".

The Review was directed towards rule 122 by an interview participant describing his experience of a Court of Inquiry. In that case, the participant described how individuals in SJAI threatened disciplinary action against a member who was considering seeking legal advice about how the Court of Inquiry was operating. That participant claimed that rule 122 is an unlawful rule. The Review believes that rule 122 of the 1947 Rules and Regulations of SJAI (reprinted in 1994) is problematic in that it seeks to constrain the constitutional rights of SJAI members.

The Review does not believe it is necessary to comment further on the legality of rule 122, beyond to reiterate that it has the potential to be a breach of members' constitutional rights for SJAI to seek to restrict the right to bring legal actions against other members of the organisation. The Review strongly recommends that rule 122 be reviewed.

On the more general relevance of rule 122 to SJAI's response to child protection risks and disclosures of grooming and child sexual abuse, the Review found no evidence that this rule directly impacted on the manner in which SJAI responded. However, the Review suggests rule 122 expressly reflects the hierarchical nature of the organisation, and a desire by that hierarchy to control and manage accountability in a manner consistent with its own interests.

7.17 Reputation Protection

The principal explanation for SJAI's responses to child protection risks and disclosures of grooming and child sexual abuse was understood by victim-survivors and other participants to be the desire to protect the organisation's reputation. As noted at various points already in this Report, reputation protection was also a key theme in the Review's analysis of the Interview Phase of this Review:

> "The organisation is an incredibly proud organisation. It has a great heritage and a rich history to be fair. But I think we need to put that behind us and put the welfare of young people before that, not the other way around. Again the organisation as I said to you it's a hierarchical kind of organisation, military style organisation and it's all about protecting St John. And I don't think that the organisation is great at putting its hand up and acknowledging any kind of wrongdoing for those reasons around heritage and pride". [Participant 3t]

Interviewer: And why do you think St John Ambulance Ireland responded in the way that they did?

Respondent: Well I suppose then, I think they just … you know … these things didn't happen back then so you didn't … you know … you didn't talk about it and I suppose now they just didn't want the bad publicity, they didn't want you know their name out there in, you know with other organisations or whatever that would have been through similar situations I suppose so I think they were just protecting themselves rather than their members. [Participant 59y]

As noted above, a number of participants—including one victim-survivor—defended any potential inadequacies in the response by SJAI on the basis that it was done to protect SJAI's reputation; in their view a legitimate goal. Indeed, a number of interview participants appeared, during interviews, to be more concerned by the damage to SJAI's reputation than about the alleged serious victimisation that took place within the organisation, and the inadequate responses to safeguard children by that organisation.

The Review believes that reputation protection has been a strong driving force in SJAI's response to complaints or suspicions of grooming and abuse within the organisation.

7.18 Paralysis by Evidential Threshold

A number of interview participants expressed their belief that SJAI needed to have "hard evidence" of serious misconduct before the organisation could respond. The Review believes that many members of SJAI appeared paralysed by a sense that they needed an evidential "smoking gun" before they could intervene in any way to assess or address potential child protection risks.

As noted elsewhere in this Report, this sense of paralysis was based on misunderstandings about the law, in particular, an incorrect belief that evidential thresholds of a criminal trial standard were necessary for protective or investigative efforts by SJAI to begin. More fundamentally, the Review believes that this position by some within SJAI reflected a clear lack of awareness of the ethical duty of the organisation to protect the interests of its many vulnerable members. The SJAI could have, and should have, investigated suspicions and complaints of serious misconduct and victimisation.

7.19 Reaction by SJAI Reflective of Culture of the Time

Some interview participants attempted to explain various failures by SJAI to intervene in the face of knowledge or suspicion of child protection risks, by reference to the cultures of abuse, shame, secrecy and cover-up pervasive in Ireland during the relevant decades. In particular, a number of participants drew parallels between the reaction of SJAI and that of the Roman Catholic Church and Irish swimming to grooming and child sexual abuse by its priests, nuns and instructors. A number of participants also referred to the recent controversies around grooming and child sexual abuse in Scouting Ireland.

A small number of interview participants offered highly nuanced and insightful comments on how the general culture of secrecy about sexual violence may have affected SJAI's response. The following interview participant made clear that while standards in Irish society may have been different, this did not excuse inaction, as they saw it.

> "I said the structures were different the channel of communication, the chain-of-command was very different. Now, I'm not for one moment condoning because I think whatever happened, something happened, I reckon had to be investigated … But at the same time it's very hard to explain to young people today, because they have a different. But I feel for [young members], because [they're] the future of the organisation and there's a lot of new members, they are kind of, what's going on here. And they feel tarnished by the past". [Participant 4h]

7.20 Conflating Sexual Orientation with Predatory Sexual Grooming and Abuse

The Review also wishes to highlight a concern regarding the relevance of sexual orientation in some participants' accounts of their awareness of risk to child safety. In particular, a number of participants described awareness or suspicion that a named individual was homosexual.

It appears that some with suspicions or concerns about a threat to child safety conflated sexual orientation with predatory child grooming and abuse. Conflating homosexuality with paedophilia is a long-established and pervasive homophobic myth. Some of the accounts given by interview participants about their suspicions suggest that some in SJAI may have conflated homosexuality with paedophilia. The Review suggests that these participants may have individually failed to act on suspicions of threats to children because they were not interested in interrogating sexual orientation, which they conflated with paedophilic tendencies.

7.21 Apology, Compensation and Communication with and Support for Victims

The Review notes that there has been some attempt by SJAI to apologise to one of the victim-survivors of abuse. In particular, the Review has seen evidence that a senior official in SJAI wrote to apologise to one victim-survivor who had formally made a complaint of grooming and abuse to the organisation.

One victim-survivor told the Review that he was informally offered cash compensation by a person within SJAI. The victim-survivor told the Review that he rejected this offer, as he desired greater transparency and accountability around what had occurred in SJAI.

This same victim-survivor also described a single offer of counselling support made by SJAI following his initial disclosure of abuse. However, he explained that this offer never materialised, and no subsequent offers or support were made by SJAI until the commencement of this independent Review.

The Review recommends that SJAI puts in place appropriate therapeutic support for those who came forward to speak with the Review. The Review understands that to date SJAI has offered one consultation plus six counselling sessions for victim-survivors.

7.22 Adequacy of SJAI's Response

Interview participants and victim-survivors were asked their view on the response of SJAI to wrongdoing and abuse in the organisation. All who answered characterised this in negative and critical terms. As already discussed, SJAI suffered from numerous structural and cultural features that disinclined and disempowered members from bringing formal complaints to the organisation. Yet, even when members overcame those hurdles and did succeed in making formal complaints, those complaints were managed and responded to in problematic and inadequate ways.

Responses to this question were principally concerned with participants' views on inadequate responses by SJAI to child protection risks in the 1980s and 1990s. However, a number of participants observed that, even in the aftermath of the significant disclosures of grooming and child sexual abuse in the early 2000s, SJAI continued for a time to manage disclosures and complaints of misconduct poorly.

For example, one participant described following the chain-of-command reporting procedures as they then were. The details of this complaint were subsequently disclosed to the subject of the complaint, who then angrily confronted the participant about their complaint. It was unclear from the Review's enquiries whether this disclosure of the complaint was made formally or informally. This example suggests that there was little procedural protection for those who brought complaints within SJAI. Examples such as this, where the absence of procedural protections led to an improper disclosure, could serve to disincentivise future legitimate complainants from coming forward for fear of victimisation. Current SJAI policies and procedures appear to address this shortcoming.

Even where senior-ranking officers wanted to try to address complaints properly, SJAI provided no guidance to its members with such responsibilities on how to carry out investigations and intervene in productive and sensitive ways. SJAI's sole provision in the past in this regard was to bring complaints further up the chain-of-command, or to attempt to bring about a Court of Inquiry.

Other participants and victim-survivors also described inadequate communication procedures for people who bring complaints or grievances. A number of participants and victim-survivors explained that they received little or no feedback on their complaints, and were rarely informed what, if any, action was taken by SJAI to address those complaints. Although this reticence may have been an over-rigid application of confidentiality, the Review suggests the cause of this inadequacy may be at least partially rooted in the absence of a transparency and accountability culture within the SJAI hierarchy. This approach to accountability mechanisms within SJAI is unsatisfactory in terms of the interests of complainants, and other members of the organisation.

The Review recommends enhanced ongoing communications processes for those who make complaints, and that complaints processes are managed with a greater emphasis on transparency and institutional confidence-building for the membership.

Chapter 8

Review of Files and Documentation

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Review of Files and Documentation

8.1 Terms of Reference

As outlined in Chapter 2 above, the review of all relevant files and documentation constituted an important phase of the Review. The review of documentation was undertaken in accordance with the Terms of Reference for the Review dated 7 March 2021. The terminology used in this chapter is also in line with the Terms of Reference.

8.2 History of Child Protection in SJAI as Seen in Documentary Review

The first reference to "child protection" in the files made available for inspection in May 2022 was seen in correspondence dated 7 September 2011 from a senior official within SJAI.

In this letter, the senior official wrote that he had:

> "made arrangements to set up a Child Protection Committee. The role of this committee will be to assist and support the Child Protection Officer in developing and promulgating a suitable Child Protection policy for the Brigade … One of the main aims will be to ensure that every member of the St John Ambulance Brigade of Ireland is trained in the recognition of potential risks to children and the appropriate response to such risk. A training programme will be developed and rolled out to members. It will be based on the HSE Children First Guidelines".

At that time (2011), it was noted in this letter that the children in SJAI numbered approximately 450. The Review requested current membership figures in the course of this Review. This information was provided in the Supplemental Disclosure and SJAI advised that this number remains almost the same, being 451 cadet members, as at July 2022.

The senior official subsequently wrote to all staff officers and senior officials to advise that he had established a "Child Protection Committee to redraft and strengthen our Child Protection policy, procedures and training".

This letter referred to having a gender balance on the committee and proposed a term of three years on the committee. It further noted that:

> "the designated Child Protection Officer or Deputy, if they consider that a child at risk should more properly be reported directly to the HSE or to An Garda Síochána is empowered and professionally required to do so".

A social worker was appointed as the first child protection officer at this time. The Review was impressed by her notes and correspondence in the files made available for inspection, in addition to those of her successors.

In the redacted minutes of a further meeting of the Executive in October 2012, produced in the Supplemental Disclosure, the Review noted a reference to child protection being identified as a "critical issue" for SJAI.

In the redacted minutes of a more recent meeting of the Executive in October 2019, produced in the Supplemental Disclosure, the Review noted that a division had been:

> "suspended due to risks presenting in relation to full implementation of our safe-guarding policies. No particular risk has been realised but … cannot permit the Division to resume activities until … assured that our safeguarding policies will be implemented rigorously as they are in our other Divisions by this Division's Lead-ership team".

8.3 SJAI Files Relating to the Historical Child Protection Matter

The Review was advised that no files had been kept in relation to this historical child protection matter, other than two statements which had been made to An Garda Síochána.

The Review inspected two typed statements which the Review understands were made by a senior official within the organisation to An Garda Síochána. One statement is undated and it is not clear who made the statement.

This Statement contains the following information:

> "So far as I am aware, [SJAI] has not had any other reports of this nature about [the person] previously, although there have been innuendos relating to him from time to time".

The Review has seen on the files made available for inspection an email dated 2011 from a senior official in SJAI, by way of apology to one of the victim-survivors.

The senior official explained that he became aware of the matter after taking up his role in the organisation. Referring to difficulties in prosecuting such matters, the email stated:

> "Nevertheless, the suspicion itself should be sufficient to make the organisation intervene and prevent further damage".

In this case, stating that the former volunteer had been "persuaded to resign", the email continued:

> "I can understand that this was not a very satisfactory conclusion, but am equally satisfied that it was a (sadly belated) attempt to protect vulnerable children".

The email offered an apology on behalf of SJAI in the following terms:

> "I am only too prepared to apologise on behalf of St John Ambulance for the hurt you have suffered".

The email concluded:

> "On a personal basis, I am very sorry that your life has been so difficult. Once again, on behalf of [SJAI], I apologise for ANYTHING we did, or did not do, as an organisation, to contribute to your difficulties".

In contrast to the position as reported to Tusla by SJAI in a meeting which took place in September 2020, that it was understood that the former volunteer had been "spoken to and asked to step aside from [their] role", the Review inspected an extract of undated minutes (but which appeared on detailed examination to date from 2001) which differed from this account. The majority of the text in the minutes was redacted from the document made available for inspection. When this was queried by the Review, SJAI advised that:

> "[T]hese relate to Minutes [of] a meeting of the [SJAI] Executive and the redactions relate to other business matters of the meeting wholly unrelated to Child Protection/Safeguarding".

Following a request made by the Review, a complete copy of these minutes was provided by SJAI with the Supplemental Disclosure. These confirmed that the minutes related to a meeting of the Executive held in 2001.

Under "Any Other Business", the minutes referred to "the present investigation", which the Review understands to refer to an investigation of the historical child protection matter by An Garda Síochána, noting that the named senior official in SJAI:

> "thought it best to wait and see the outcome of this meeting and stated that [the person who was the subject of the child protection allegation] may be suspended from [SJAI] eventually".

These minutes also stated that it had been brought to the attention of a senior SJAI official that the person who was the subject of the child protection allegation:

> "who is on leave of absence from the Brigade had been seen in uniform—this could not be definitely confirmed and, therefore, no action could be taken at the moment".

Minutes of a meeting of the Executive dated 1 October 2013 were also produced in the Supplemental Disclosure. While much of the text again was redacted, the Review was interested to note the following:

> "Concern for exposure of organisation to claims from members which might not be covered by our indemnity, given the historical nature of the issue. Old paperwork sought—if any available … Concerned for possibility of other people coming to light at this time … Clear that we must have clear protection, consent, approval process etc. for areas of risk, such as Cadet camps".

A handwritten note from a senior official in SJAI which we understand was dated 2013/2014 notes a "failure to act on time", but there is no further information on this page.

A further note which was undated and unsigned contained the following information:

> "Preliminary Actions: [Former Volunteer] stood aside.
>
> Final Actions: [Former Volunteer] gone since 2002 for certain".

In its replies to queries provided with the Supplemental Disclosure, SJAI confirmed that records had not been retained from that time, either by the organisation or SJAI officials involved in the matter. This is a matter of concern in the opinion of the Review, given the seriousness attaching to the matter.

In correspondence seen by the Review in a separate matter in 2006, a senior official in SJAI wrote to another senior official to "formally ... request sight of the investigation and resolution in regard to [an] issue raised under the Child Protection policy". It is the view of the Review that this may suggest the creation of relevant records in that case. However, the retention of such documentation is in issue.

8.4 Correspondence to Tusla in 2013

The files made available for inspection by the review team in May 2022 contained a letter from SJAI to Child and Family Services dated 12 August 2013. This letter referred to a retrospective allegation of sexual abuse by a former member of SJAI. The letter stated that the allegation related to sexual assault in childhood (early teenage years) by a former senior member of SJAI. The letter also noted the allegation that other former members had been sexually assaulted by the same individual; however it stated that such members had not made contact with the writer at that time.

This letter further records that the complainant was "very unhappy with the response from the [named official] in [SJAI] at the time of his original report".

The letter of 12 August 2013 continued to state that:

> "From historic records within [SJAI], it is unclear whether a report was made to Child Protection social work services at that time via either the Gardaí or the Child Protection team in [SJAI]".

Prior to the date of this letter, a senior official in SJAI had written to another senior official asking to "see the old file".

8.5 Correspondence from Tusla in 2020

The files made available for inspection contained a letter from Tusla dated 29 July 2020 with regard to a: "Historical Child Protection report made to Tusla Child and Family Agency". This letter made reference to the report first made by SJAI in 2013 of an allegation of "sexual abuse perpetrated by a former member" of SJAI. In this letter, Tusla indicated that it:

> "would like to meet with SJAI to share some of the findings of the investigation, but also to enquire as to whether there are any further historical allegations that we may need to review. In addition, we would like to confirm the Child Safeguarding processes you have in place currently".

When the files were first made available by SJAI to the Review for inspection in May 2022, the first page only of this letter was made available. It was apparent both from the content of this page and a staple mark on the page that this did not constitute the entire letter and that one or more pages had not been provided.

A query was raised by the Review in this regard and a complete copy of the letter was provided by SJAI with the Supplemental Disclosure in July 2022. SJAI responded that: "Page two was the request to confirm the meeting date and sign off".

A meeting between members of SJAI and Tusla took place on 9 September 2020 and the Review has inspected a file note of this meeting which was prepared by Tusla.

With regard to the historical allegation, Tusla advised the meeting that an assessment had been undertaken in line with Tusla's "*Policy and Procedures for Responding to Allegations of Child Abuse and Neglect*" (September 2014).

It stated that:

> "[T]he outcome of the Tusla assessment is that the allegation of child sexual abuse is Founded and that on the balance of probability, Tusla has reached a determination that the abuse took place as described".

The file note further provided that:

> "[T]here was a second complainant who was a child at the time of the alleged abuse and the assessment of their allegation has reached the same outcome. A complaint was received by a third person, however, as they were an adult at the time of the alleged abuse, this was outside the remit of Tusla to assess".

The letter further noted that SJAI was fully aware of the allegation, as well as the identities of the person subject to the abuse allegation and the three complainants. The letter also noted that there was a civil case ongoing and that: "[SJAI] is offering counselling and pastoral care to the complainants".

The note of the meeting also refers to the historical management of the allegation by SJAI in the following terms. It stated that when the allegation was initially reported to SJAI, the person subject to the abuse allegation was:

> "spoken to and asked to step aside from [their] role. [This person] never returned to the organisation … As there was an investigation underway by An Garda Síochána, [SJAI] deferred to the statutory authorities and did not investigate this independently. Neither of the other two complainants made direct reports to [SJAI]".

As to the circumstances of making the historical referral, the file note provided as follows:

> "In 2013, during a review of Child Protection Policy and Procedures and when a new Safeguarding Officer had taken up [their] post, a decision was made to send a reference to Tusla (then HSE) [with regard to] the allegation".

The note continues: "An assessment of the allegation was commenced by Tusla in 2017".

The file note stated that SJAI had advised Tusla that the three identified complainants were the only known complainants. It further stated that:

> "[SJAI] had removed the [person who was the subject of the Child Protection allegation] from an active role in the organisation as soon as the allegation was reported … they have no information that other members were aware of any risk [this person] posed and failed to act. They have cooperated fully with Tusla and An Garda Síochána".

In correspondence from Tusla to SJAI dated 21 September 2020, following the above meeting, reference was made to previous contact between SJAI and the Tusla Child Safeguarding Compliance Unit in 2019 with regard to SJAI's Child Safeguarding Statement. It noted that:

> "[T]his Unit identified specified procedures that were absent initially and through work on this Statement, by way of a number of communications with regard to these procedures, the Child Safeguarding Statement had met the requirement under the Children First Act 2015".

This letter, however, noted that the:

> "[2020 version] of the Child Protection policy on the [SJAI] website is referencing documents [which are] out of date and obsolete (Children First 2011 and Duty to Care) and it is acknowledging input from Children First Information and Advice Officers who were not involved in this latest version of the policy ... It is imperative that all Safeguarding documents are in line with Children First guidance and legislation".

The writer concluded by inviting SJAI to have its policies reviewed by the Children First Information and Advice Service, remarking: "I know you hold safeguarding and child protection as a priority for your organisation".

A query was raised by the Review as to the current status of this matter. In its reply received with the Supplemental Disclosure, SJAI wrote that:

> "[that] process was completed on 2 March 2022 with a confirmation letter received to say that our Safeguarding statement was compliant ... A full review of the safeguarding policy document was completed by ... [Children] First Information and Advice ... guidance provided, and amendments made to meet advice".

While the Review was advised by SJAI that the draft safeguarding policy is now at an advanced stage, having been approved by the Board of SJAI as of June 2022, it is difficult to form a view in relation to the draft documentation supplied, which is not in final form at the time of writing this Report.

The letter from Tusla to SJAI dated 21 September 2020 further referred to the report of historical abuse made by SJAI and the writer noted:

> "from our meeting with you, [we do not] have any concerns regarding the management of the allegation discussed or any concern that child abuse was systemic within your organisation, or that there was any failure to act on the part of [SJAI]. We don't plan to meet with you again unless further matters arise".

Notwithstanding this letter, the Review was also provided by SJAI with further correspondence from Tusla dated 12 November 2020 which appeared to show a change of approach. In this letter, Tusla recommended that SJAI "engage an independent review" of allegations previously made, with the stated purpose of the review being that SJAI "seek assurances that there were no further concerns, allegations being raised during this time frame" (said timeframe not specified in the letter).

8.6 Correspondence with Tusla in 2021

The files made available for inspection contain a letter from Tusla to SJAI dated 22 February 2021 with regard to a retrospective abuse allegation made against a named individual. In its letter, Tusla wrote that its role in cases of retrospective disclosure of child sexual abuse by adults is "to establish whether there is any current risk to any child who may be in contact with the alleged abuser revealed in such disclosures," pursuant to *Children First* (2017). This letter further stated that "the alleged abuser identified above is already known to Tusla and has been through [an] assessment process". The letter also noted that since the person reporting the abuse did not wish to identify themselves, Tusla would be unable to contact them and that the case would be closed as a result.

The said letter from Tusla to SJAI, dated 22 February 2021, referred to receipt of recent correspondence from SJAI. As this correspondence did not appear to be with the files made available for inspection by the Review, a request for such correspondence was made. While the response received from SJAI with the Supplemental Disclosure stated that such correspondence had been attached, it was not, and the Review, therefore, has not had sight of this correspondence.

8.7 Child Protection Concerns Arising from Documentary Review

A number of child protection issues arose from the review of the files made available for inspection.

Notes were provided on numerous cases where child protection issues had arisen or concerns were raised.

Concerns were raised, for example, when a senior official was made aware of an allegation that a cadet, then aged over 18 years of age, had asked two other cadets to perform oral sex, while at an SJAI camp. This was not the only reported instance of inappropriate behaviour and lack of supervision in the context of SJAI camps. A separate concern in relation to SJAI camps in 2013 noted that a male cadet and a female cadet had been found alone in a male changing room at the camp.

The Review raised a concern with SJAI with regard to the level and adequacy of supervision at SJAI camps. SJAI replied to this query by providing the current "Out and About" Permission form and a draft "Out and About" policy which the Review was advised "is being finalised by the Cadet and Youth Development Team", together with a draft "Day Trips Statement of Practice".

SJAI advised in this regard that:

> "the policies are close to sign-off at Cadet Management Team level and are expected to be submitted shortly for final approval by the Commissioner. These policies should be read alongside the Child Protection Policy".

It is difficult for the Review to form a view in relation to the draft documentation supplied, which is clearly not in final form at the time of writing this Report.

SJAI further advised that:

> "[T]he Permission Form regime has been in place for approximately 2 years and the forms are processed by the Director of Cadets and the Activities and Pursuits Officer. Information on the forms is shared with the Business Manager and the Child Protection Officer for comment before approval is issued".

As to what the practice was prior to two years ago, SJAI wrote that:

> "Past practice is, perhaps, best captured in the attached copy of what we called the 'black book' in the 1980s and 1990s among those Cadet Divisions that would regularly go camping".

This is an older document and no references are made to child protection. The Review noted one rule which provides that "Cadets must not enter other cadets' tents without permission".

A further complaint concerned a member who had allegedly performed oral sex on a minor cadet and had sent inappropriate text messages to another minor cadet. The file states that the alleged perpetrator was suspended from all SJAI activities, pending the outcome of an investigation. It also notes that a support person in SJAI should be appointed to support the alleged perpetrator, "to accompany him to meetings, provide emotional support and keep [him] updated on progress". However, again, the specific actions taken and outcome in the case were not contained in the files made available for inspection.

In response to the query raised by the Review for clarification on this matter, SJAI advised that the person "left SJAI thereafter and never sought to resume membership". It appeared from the file that An Garda Síochána were aware of the matter and SJAI made a formal notification to the HSE. The Review was concerned to learn that the alleged perpetrator was known by two possible names on the organisation's records, which did not appear to have been clarified. In one file, it was noted that "[his] Garda vetting form went in last November and has not been returned yet [April]". Indeed, the response received from SJAI with the Supplemental Disclosure still appeared to refer to two possible names for this individual.

It is interesting to read the 2013 SJAI Child Protection Policy in the light of this, which provides, in relation to safe recruitment procedures for members, as follows:

> "Identification: St John Ambulance will ensure that the identity of the applicant is confirmed against some documentation (ID card, driving licence, age card or passport) which gives his or her full name, address together with a signature or photograph. This should be compared with the written application".[75]

This information deficit is attributable in part to poor record keeping on the part of SJAI. In another case, a complaint was raised about an adult member who allegedly made contact with a cadet outside SJAI time and attended at that cadet's home. A concern was also raised where an adult

75 SJAI Child Protection Policy (2013) page 15.

officer was discovered buying cigarettes for a cadet member. Unfortunately, the details recorded on file were unclear and some notes were handwritten. A senior official noted the following in a handwritten note at the time:

> "Concerns with the running of cadet division. Need to clarify what adults work with cadets".

A subsequent handwritten note provided that "Both [Named Division 1] and [Named Division 2] need better supervision".

8.8 Supervision and Cadets

In one of the files made available to the Review for inspection, a concern was raised about the lack of an adult female to supervise in a named division of SJAI, noting that concerns had been raised by parents in this regard.

A separate file noted the advice of a senior SJAI official that the "best practice" would require a "gender balance of adults". This note also recorded the senior official's view that there should "ideally" be three adults working with 27 cadets. However, it was further noted that one named division had only one male adult in charge.

The Review has also seen a file relating to a different division where it appeared that two junior cadets had been on duty, with no adult present to supervise. While a senior official noted on this file that this was "not acceptable", the Review was concerned to further read on this file that "this is not the first issue to arise with cadet supervision … need to consider further action".

As a result, a query was raised by the Review as to supervision of cadets and whether any ratios or any other criteria are applied in practice.

The response of SJAI was to direct the Review to the 6th edition of the SJAI Child Protection and Safeguarding Policy (2022), which the Review was also advised is still in draft form and has not been finalised. As outlined above, it is difficult for the Review to form a view in relation to the draft documentation supplied which is not in final form at the time of writing this Report.

With regard to ratios of supervision, the following information was supplied by SJAI:

> "At a high level, the following are the ratios:
>
> - At least 2 adults per Cadet Division with a 1:10 ratio + 1 – i.e., a Division [with] 15 cadets should have 3 adults
> - For trips we reduce that ratio to 1:8 + 1
> - For mixed gender groups, we endeavour to have mixed adult leaderships
> - On any duty, Cadets must always be paired at a minimum
> - No adult is allowed [to] drive cadets home from an event without a second adult present but the norm is for cadets to make their own way home or for parents to collect them when an event has a late finish (e.g., a concert)".

In the redacted minutes of a meeting of the Executive in May 2013, produced in the Supplemental Disclosure following queries having been raised by the review team, the Review noted the following:

> "We have identified weaknesses within the Cadet structure and have now put corrections in place to ensure that all meetings are supervised by at least two adults of both genders".

The Review has also seen correspondence from a senior official in SJAI to officers and members in charge dated 21 March 2014. This letter refers to an "important change" in practice requiring all correspondence from SJAI regarding cadets to be sent to their parents and not directly to cadets.

This letter also states that:

> "All adult members are reminded that they should only have contact with cadets during designated [SJAI] activities and are strictly prohibited from having contact with children outside of designated [SJAI] business. No under 18-year-old should be admitted to the Senior Divisions".

In a separate child protection matter among the files made available for inspection, the Review has seen correspondence dated 12 January 2015 from a senior official in SJAI stating that "[i]t is imperative that a female leader is sought for [named division] cadets".

In response to the Review's query as to whether such change was effected, SJAI advised that a decision had been taken to suspend that division.

The Review has seen correspondence between two senior officials in SJAI dated 11 April 2018 referring to the need for a "National Youth Leader" and a proposal to appoint a "Cadet and Youth Development Officer". A query was raised by the Review as to the status of such proposals.

The following reply was received from SJAI:

> "A Director of our Cadet and Youth Development Department was appointed to the position in summer 2018. Prior to that, another senior officer held the role of Officer-in-Charge of cadets. The Director, ([a] volunteer) has assembled a Management Team of the more senior Cadet Superintendents to assist [them] in this role".

8.9 Referrals to Tusla

From the review of the files made available for inspection, it appeared to the Review that referrals to Tusla were not made in every case where a child protection issue arose or such an allegation was made. A query was raised by the Review as to the basis for making such a referral and whether any guidelines exist as to when a referral should be made.

The response received from SJAI was in the following terms:

> "Where reports are made to the Safeguarding team, a full consideration of the report is undertaken. Where we are unsure if a report is needed, we have informal conversations with Tusla on advice on how to proceed and at that stage we are advised if Tusla can take any actions. Where no action is required, the organisation provides any supports needed. These engagements are all handled by the Safeguarding team [who have] absolute discretion [in this regard]. In essence, a referral is made where the issue is clear cut. Where the issue is more nebulous, the Safeguarding team still consult Tusla as to whether a report is appropriate".

The Review was advised that the "Safeguarding Team" currently comprises the safeguarding officer, the deputy safeguarding officer and the Commissioner of SJAI.

8.10 Child Protection Training

It is the view of the Review that considerable importance should attach to child protection training within SJAI.

The Review was, therefore, concerned to read a note on a file from 2016 which stated that a person who was the subject of a child protection matter had not attended any child protection training, despite having been a member for four years. The file notes that that member believed that the training course was "too long", being four hours in duration.

Reference was also noted by the Review in extract minutes of a meeting of the executive officers from 2015 (provided to the Review as part of the Supplemental Disclosure) that a senior official had "urged that any members of the Executive who have yet to undertake Child Protection training do so as a demonstration of leadership on the key issue".

8.11 Social Media Cases

The files made available for inspection contained a number of cases where child protection concerns had arisen through the use of social media. It is clear from interviews with victim-survivors that these technologies were used by individuals in ways that present new and additional risks to children. These represent clear and present dangers to child protection that cannot be ignored.

A number of linked cases concerned the alleged creation by a member of a false social media profile purporting to be a 13-year-old fictitious member of SJAI. The Review understands that this was denied by the member. The Review further understands that, although no such person existed, the account appeared to have a good working knowledge of matters relating to a particular cadet division. The file stated that the social media account had 440 contacts, many of whom were children. Several abusive messages were sent from this account, which also sent messages involving child pornography and cyber bullying.

In a note on file seen by the Review, a senior SJAI official recorded that:

> "[W]hilst the usual process would be to proceed to a Court of Inquiry under Brigade Regulation No 128, [it was] decided that this matter was too complex and potentially dangerous for [SJAI] to investigate and opted to await the outcome of the HSE investigation before making any further decisions".

The Review understands that the HSE and An Garda Síochána were involved in these related cases.

A handwritten note on file states that this case was "closed off once An Garda Síochána confirmed that no action had been taken by them or HSE/Tusla".

The Review also inspected documentation relating to a member of SJAI who was engaged in inappropriate social media conversations with a minor cadet member of SJAI over a number of weeks and often in the early hours of the morning. It was of concern to learn that this member had a role in child protection within SJAI, although it is acknowledged that there did not appear to be any awareness of this conduct at that time. It appears from the file that the member was immediately suspended from all SJAI activity, to include "step[ping] down" from any child protection work pending the outcome of the investigation.

A senior official in SJAI wrote to the member in the following terms:

> "I hope that this matter can be dealt with expeditiously, and in privacy, for the good of this child, all children in [SJAI], [SJAI] as an organisation and you, the member accused of inappropriate behaviour, in that descending order".

A senior SJAI official subsequently met with the alleged perpetrator in person and reported as follows:

> "I do not feel that [named person] has the skills required to have responsibility for young people in our organisation given his repeated use of poor judg[e]ment in his dealings with [named child]".

The Review has seen further correspondence from a senior official that he was:

> "not convinced we have to bar [him] from dealing with children entirely—just always in a group and only indirectly … [he] should not attend Cadet-only occasions".

Following meetings between senior members of SJAI and the alleged perpetrator, a decision appears to have been made that he would be "reinstated as an adult member with no cadet contact and/or supervision and no attendance at cadet functions". This decision was met with dissatisfaction on the part of the minor's parent.

Unfortunately, the file was unclear as to any particular action or actions which were ultimately taken in this case, to include any consequences for the alleged perpetrator and any support provided to the cadet member and their parents, if any support was so provided. Regrettably, this gap in the information provided is representative of many of the files made available for inspection and made the task of a documentary review extremely challenging.

A query was raised by the Review as to the outcome in this matter. In its reply dated 18 July 2022, SJAI confirmed that the individual had "resigned from SJAI". No further information was provided.

Inappropriate interactions between adult members of SJAI and cadets through social media such as the examples outlined above seem to have also occurred through SJAI-provided technology. The Review examined a file involving content of concern which was held on an SJAI laptop and tablet. When a senior SJAI official gained access to this equipment, they wrote as follows:

> "My main concerns arising from what I viewed are … interactions with cadets via social media, emails to cadets about divisional nights, buying gifts for cadets and [a] cadet's rapid rise to [a specific rank] even though not enrolled (query why this has happened)".

This case also involved an allegation that an adult member had asked a cadet to sleep with him, when staying in the house of another cadet member. The senior SJAI official who reviewed the social media noted the following concerns in this regard:

> "The reported incidents of him and other adults staying over for the night, arranging and meeting cadets outside of division and these interactions and the concerns and welfare of the cadets involved and their fears on the report".

Proper reporting procedures were observed by SJAI in this matter.

Another file involving technology and social media concerns included the case of a member who had sent inappropriate messages and pictures to other members, some of whom were very young teenagers at the time. It appears that this continued over a number of years.

A further file was reviewed by the Review where a member was suspended for inappropriate contact with a cadet. This case involved text message exchanges with the cadet and an invitation to the cadet to meet with the adult member outside of SJAI activities. Correspondence on file from a senior SJAI official to the adult member notes that the adult member was:

> "aware that [they] were breaching policy and knowingly did so ... [they] encouraged a child to keep a secret from [SJAI], [their] parents and friends ... this behaviour is entirely unacceptable".

Queries were raised by the Review as to whether SJAI has any policies relating to internet safety and cyber bullying. No such documentation or information was contained in the files originally made available for inspection. It is the view of the Review that internet safety and social media are critically important areas for all organisations where children are involved. The Review has no doubt from the testimony received that these technologies present new and additional risks to children. It is critical that organisations ensure that they have policies in place that address these risks. The internet and social media involve clear and present dangers to child protection that cannot be ignored.

In response to the Review's query to SJAI to provide further information in relation to any policies in place to deal with social media communications and/or internet safety and/or IT security, the following response was received:

> "Social media etc is specifically referenced in our latest Safeguarding Policy. We also have a standalone Social Media Policy as attached".

This document entitled "Communications Policy", which is undated, was provided to the Review as part of the Supplemental Disclosure. This policy provides that "it is not appropriate to use personal email to conduct Organisational business".

Under the heading "Social Media", the document provides that:

> "[M]embers utilising social media in the name of the organisation must ensure to only allow appropriate material or comments".

Under the heading "Acceptable Use Policy", the text provides that:

> "[I]t is the responsibility of every member to ensure that organisation provided Internet access or organisation devices (phone, laptop, computers etc) are not used to access or download offensive, lewd, inappropriate or illegal material or images".

It further provides that:

> "[M]embers utilising social media in the name of the organisation must ensure to only allow appropriate material or comment … Members should not mention the organisation in a negative manner on private or public social media sites".

As stated above, it is difficult for the Review to form a view in relation to the draft Safeguarding Policy supplied, which is not in final form at the time of writing this Report.

It was also noted on one of the files made available for inspection that an internet safety education session was held by SJAI in one division in or around 2013, involving both parents and cadets and An Garda Síochána. It is the view of the Review that such education and training sessions should be provided to all members and divisions within SJAI.

Correspondence was also reviewed as between two senior SJAI officials at the time to propose holding a parents' evening and to plan a child protection information session with cadets, leaders and parents. No information was furnished as to whether these took place.

8.12 Dignity and Respect and Anti-Bullying

In response to a query to SJAI to provide further information in relation to any policies in place to deal with dignity and respect and anti-bullying, the following response was received:

> "These policies are reflected in our Code of Behaviour, Rules and Regulations and the Safeguarding Policy Document. Further policies have been constructed as part of our quality assurance measures and are uploaded to our website".

The Review has seen one file where an allegation of bullying was made in relation to a child with additional needs. The file as shared with the Review contains very little information, stating that it is "not an active Child Protection issue".

The file also noted that the child's parent was happy with the support and liaisons put in place by SJAI.

8.13 Garda Vetting

The Review raised a query with regard to Garda vetting and procedures in SJAI.

The reply from SJAI was in the following terms:

> "Our Garda Vetting procedures follow National Vetting Bureau regulations. Applicant members complete the initial Garda Vetting application and then post their application with their two forms of ID to the SJAI Garda Vetting Team. This is then reviewed and an email containing a link is emailed to members to complete the remaining process online. The online form is then processed and submitted to the National Vetting Bureau. Once they complete the process, they return their finding to our Vetting team. Members receive an email to say a declaration has been made to National Organisation and if there are no red flags in that declaration then SJAI issues Garda Vetting clearance to the member. Any red flags raised in [the] declaration are raised with the Commissioner and Child Protection team to see if they impact one becoming or continuing to be a member of SJAI.
>
> New members are only issued their Personal Identification Number if they have cleared Garda Vetting and have completed all aspects of Child Protection/Safeguarding Training.

Re-issue of Garda Vetting is only done provided members are Safeguarding compliant as above.

The issue date for Membership ID cards is now aligned with the member's Garda Vetting completion date and the Child Protection Training date.

Membership ID lapses if Garda Vetting is not renewed by its expiry date".

8.14 Suspension of Members and Communication

Actions on foot of a child protection concern are unclear from a review of the files. In some cases, the alleged perpetrator appears to be suspended pending the outcome of an internal investigation.

In other cases, they are asked to "step back" or "step aside" from the organisation pending investigation.

The manner in which investigations are undertaken also appears to be unclear and appears to vary from case to case.

In one file seen by the Review, a letter from a senior SJAI official advised a member that they are to have no contact with cadets and "step back from any kind of involvement with cadets". It appears from the file that this member attended a cadet division some weeks later, following which an email is on file stating that he was then "suspended from all [SJAI] activities until further notice". Again, the outcome in this matter did not appear in the files made available for inspection.

On a review of the files made available for inspection, it appears to the Review that difficulties have arisen with regard to communication in the past.

In some cases, it appears that a decision to suspend a member, or ask them to "step aside" pending the outcome of an investigation, is communicated in writing. In other cases, it appears to be communicated by telephone call. However, many instances on the files made available for inspection do not make this clear.

The Review has seen one file where a difficulty arose in this regard. On a review of the file in question, a dispute appears to have arisen as to whether a suspension had been communicated properly or at all. The person who had been suspended, according to the files, appeared to have no knowledge of this. Indeed, in correspondence on the file, this person stated that they had continued their activities with cadets "with the consent" of senior-named officials and that this

matter had caused them "stress and upset". It also appeared that the suspension had followed the making of a child protection report by that person against a more senior member. The file noted that the outcome of that complaint had been "no case to answer". The files made available for inspection were incomplete in this matter and so the Review is unable to infer any connection between these two events.

A query was raised by the Review as to current practice and procedure with regard to suspensions and communications in this regard. The following response was received from SJAI on this matter:

> "Any decision to suspend is taken by the Commissioner but the Safeguarding Policy provides that a person [the] subject of a complaint can take a leave of absence. In either case they can only resume volunteering with the approval of the Commissioner. A member would ordinarily be informed in writing but in an emergency situation (e.g., when an allegation of abuse has been made) that decision may be conveyed over the phone and then followed up by written communication. The procedures are set out in the Safeguarding Policy".

It is the view of the Review that any decision to suspend a member should be clearly and unambiguously recorded in writing and provided to the relevant member in accordance with fair procedures.

When a decision has been made by SJAI to restrict adult or cadet involvement in the organisation following suspension or other action taken, the Review raised a query as to what supervision, if any, is put in place to ensure that this occurs. This query was raised in the light of two instances seen on the files made available for inspection where members who had been suspended and/or asked not to make contact with cadets continued to endeavour to make such contact.

The Review also read in a separate file relating to a different allegation of misconduct that it had been brought to the attention of a senior official that an alleged perpetrator had made contact with a parent seeking information about SJAI camp activities, even though they had been suspended at that time. The parent had divulged this information, unaware that the person had been suspended by SJAI.

The following reply to the query having regard to supervision post-suspension was received from SJAI with the Supplemental Disclosure:

> "Such decisions would be monitored by the Child Protection/Safeguarding Team and the Commissioner to ensure compliance. In practice, such restrictions have been very limited as most cases where we have tackled a Child Protection-Safeguarding concern have ultimately resulted in the person against whom a complaint has been made leaving the organisation".

In all the files made available for inspection, the Review noted only one file where a follow-up or review appears to have taken place, following a suspension. In this case, the senior SJAI official who had originally dealt with the matter undertook a review after six months and reported accordingly.

8.15 Poor Record Keeping

It is the view of the Review that it was difficult, if not impossible, to understand what had happened in many cases, as many files contained incomplete information. Information relating to different individuals often appeared together in one file or, indeed, duplicated in different files. On many occasions, events were recorded in handwritten notes which were very difficult to read and understand. In most cases, it was not clear who had written these notes or when they were written.

There was a clear inconsistency in note taking from file to file, some with handwritten notes and sparse detail and others with more detailed, typed notes. However, the files also contained some typed notes which did not contain details of who wrote the notes or when they were written. As a result, it was necessary for the Review in many instances to endeavour to gather information by reading through chains of email or other correspondence.

It is the view of the Review that, given the utmost importance attaching to child protection matters, all notes on file should be typed and dated and should clearly set out all relevant information in a consistent and readily accessible manner. It is the view of the Review that all documentation should contain these basic facts at a minimum and as good practice of accurate record keeping and to substantiate the actions taken in each individual case.

The Review was advised by SJAI that there are currently 476 adult members and 451 cadet members in SJAI, as at July 2022. As a result, the provision of four folders of documentation pertaining to all child protection and other matters arising within the Terms of Reference appears particularly

inadequate. The paucity of documentation on particular complaints was especially noted by the Review.

In the entirety of the documentation and files made available for inspection by the Review in May 2022, it was noted that only extract (redacted) minutes or notes from one meeting had been provided. A query was, therefore, raised by the Review as to whether minutes are or were routinely taken of meetings or other discussions, as would be standard practice.

The following reply was received to this query:

> "All notes etc that we have on Child Protection/Safeguarding cases/complaints were made available for the inspection. A small number of references to Child Protection generally [as] discussed by the Executive and/or Council is attached".

The Review also examined the notes provided with the Supplemental Disclosure, which contained copy correspondence and minutes of various Executive meetings, most of which were redacted. It is notable, however, that these were not contained within the files made available to the review team for inspection in May 2022.

In addition, the further file of documentation supplied to the Review as a result of the Supplemental Disclosure contained a handwritten note or Minute relating to a Court of Inquiry held in 1997 which dealt with child protection concerns, to include meeting with cadets outside of SJAI activities. This was the only note relating to a Court of Inquiry seen by the Review.

8.16 Retention of Documentation

The Review was greatly concerned by the inconsistent record keeping which appeared on its review of the files made available for inspection, in particular in relation to historical child protection matters.

8.17 Data Protection Concerns

The Review was concerned to see the practice of files containing information and private personal data relating to a number of different individuals and entirely separate complaints. In some instances, records of child protection concerns were located in the same files as unrelated correspondence and ambulance reports of attendances at sporting and other duties.

The Review was also concerned to learn from SJAI and many participants in the Interview Phase of the Review that a practice had existed of keeping records, to include sensitive personal data and notes, in the homes of members and their workplaces. The Review was told by some participants that this practice had occurred in recent times. Regrettably, one of the participants, who advised the Review that they had kept sensitive documentation in their home or workplace, also advised the Review that they had subsequently been unable to locate this documentation. The participant advised the Review that they had kept notes:

> "locked in a drawer in the office where I worked … I have searched for those notes, I have, I can't find them at home … I cannot, I'm sorry, remember what I did with them, but I made them. The first time I was involved with the case, I don't think I made any notes".

The retention by SJAI members of highly sensitive documentation in homes and workplaces raises obvious and very significant data protection concerns and a query was raised in this regard by the Review.

SJAI replied with the Supplemental Disclosure that "no records are kept at personal residences and this practice ceased [in] 2022".

8.18 Contact Information

The Review has seen various instances of difficulties with maintaining contact details of members in the files made available for inspection.

In one case involving an inappropriate social media message sent to a number of people, one of whom was a child, the senior SJAI official dealing with the matter attempted to make contact with the alleged perpetrator. However, the file notes that, not alone was that person's mobile phone not working, their email address was also not working and there was no home address on file. As a result, considerable difficulties were encountered in making contact with this member in a timely

fashion. Of further concern to the Review was the number of people who had to be contacted by SJAI in an endeavour to locate the member's contact details.

The senior official wrote as follows:

> "All this highlights an information deficit in our organisation. All relevant personnel information should be on file, it should be readily available without having to jump through hoops. Also, what if we were asked by HSE for a home address? Issue to be dealt with. Even to get what we got, too many people have already been made aware that there is now a [child protection] issue in [named location] and the name of an individual involved in some way".

In another file involving an allegation of inappropriate contact with cadet members and contact outside of SJAI activities, the senior SJAI member dealing with the matter met with the relevant senior member in that division. Following this meeting, the SJAI member wrote:

> "I discussed my concerns for interactions of adults with the cadet division, also my concerns of contacts for parents … [He] doesn't have these to hand and told me that a full list is not available".

Further correspondence between senior officials seen by the Review noted that "[i]t is essential that clear records are kept for cadets' contact details".

It might be noted that the cases referenced here are from recent years, but the specific details of these cases have been omitted in the interests of privacy.

It is the view of the Review that difficulties in straightforward management of contacts are not satisfactory in the present day. An up-to-date database of contacts, to include all contact details, must be maintained and updated regularly.

The Review raised this query with SJAI and the following response was received with the Supplemental Disclosure:

> "Safeguarding team have [fully] documented processes to gather all this information, these are stored on the OneDrive aligned to each division and updated annually to capture all contact details and core member information including parent/guardian contact details".

8.19 Email Correspondence

In the course of the interviews, the Review became aware of the existence of an email account which had previously been used by a senior officer within SJAI, but which did not appear among the files and correspondence, including email correspondence, made available for inspection.

A query was, therefore, raised by the Review as to the current status of this email account and the present location of emails to and from this account.

The following reply was received from SJAI with the Supplemental Disclosure:

> "1. Our understanding is that there is no reliable e-record of any emails pre-2015. We attempted to migrate accounts from [named provider] to [named provider] and subsequently to [named provider], but most accounts were left to migrate themselves.
>
> 2. SJAI went from informal, self-managed emails/[named provider] to [named provider] before we moved to [named provider] in 2015 which is our current system. The reason [was] there was a 50 address limit on [named provider]. We had more on [named provider] but looking back at it, it was a poor move as the system was not easy to use at all according to … ICT support volunteers. There was an 'ask' to be in a position to provide email to members but at the time [named provider] did not have a corporate donation programme in Ireland and we had essentially unlimited addresses on [named provider] (albeit with tiny inbox limits). [Named provider] has been described … as a 'godsend' in that regard.
>
> 3. The [named provider] system used [named provider] as the programme to connect. Any SJAI [named provider] data would have been migrated to [named provider] and then on to [named provider]. We have no visibility on anything pre [named provider]. There may have been a system before that or perhaps business might even have been conducted through personal email … which … was the case.
>
> 4. Currently there is a [named provider] hosted … email addresses where the accounts are not personal and in the event of successors being appointed, SJAI would simply reset the password and send it to the successor so the account would stay alive.

5. Finally, a volunteer … having considerable ICT consultancy experience, has undertaken a root-and-branch review of [SJAI] ICT systems and is overseeing a re-booting of our systems.

Most files were an amalgam of printouts of emails and traditional letter correspondence".

8.20 Courts of Inquiry

A query was raised by the Review in relation to Courts of Inquiry in SJAI. The following reply was received from SJAI:

"Courts of Inquiry are only instituted when disputes between members cannot be resolved amicably. For all intents and purposes, they run in a similar, formal manner to a Labour Court hearing:

- The Commissioner would appoint three senior officers to the 'Court' or panel
- Each party is given an opportunity to both state its case and respond to the case made by the other party
- The Court then makes a report to the Commissioner.

The ultimate decision is the Commissioner's and where removal of the member is determined, that is ratified by the Board of SJAI (formerly the Council) before SJAI became a CLG [Company Limited by Guarantee].

In reality, Courts of Inquiry have not been convened [in recent times] as issues have been resolved by other less formal means. However, the procedure is still available should its invocation be requested by a complainant, person against whom a complaint is made, or the Commissioner.

For all the Child Protection/Safeguarding cases for which the Review reviewed files, no courts of inquiry took place".

8.21 Membership Structure

A query was raised by the Review as to the structure and other organisational arrangements within SJAI to assist our understanding in this regard.

A chart was provided by SJAI to the Review with the Supplemental Disclosure. This chart is set out at Appendix X to this Report.

The following explanation was also provided by SJAI by way of information:

> "The key element is that the rank structure follows similar lines to that of the Armed Forces or An Garda [Síochána] and is a hierarchy. Therefore, responsibilities move up and down a 'chain-of-command'. For most of the life of [SJAI], that hierarchy would be rigidly applied so if a member had a complaint, he/she would raise it, in the first instance, with an NCO [non-commissioned officer] and it would then go up the line, as appropriate, for dealing with. Often issues were/are successfully concluded within a Division but where they are not, they can be elevated up the ranks in HQ. Ultimately the Commissioner has the final say. However, when we first introduced Safeguarding in 2000 that hierarchy was set aside insofar as issues of Child Protection were concerned, whereby anyone could directly approach the Child Protection Officer and no reporting hierarchy obtained. The CPOs and the Commissioner would then deal with the matter thereafter respecting the utmost confidentialities".

As set out in Chapter 5 above, it was noted by the Review that this diverged from the information obtained in numerous interviews, including from some senior members of the organisation, that the "chain-of-command" approach continued to be used in all matters, or at least, that there appeared to be some confusion as to how complaints involving child protection matters should be addressed.

Chapter 9

Conclusions And Recommendations

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Conclusions And Recommendations

The Terms of Reference published on 7 March 2021 stated that:

> "SJAI is aware of a number of complaints of sexual abuse of members under the age of 18 years relating to one former volunteer member who ceased volunteering with SJAI circa 2000/1".

Under Part I of the Terms of Reference, the independent Review is required to undertake, among other things:

> "a review into the adequacy and effectiveness of
>
> - the manner in which the aforesaid complaints in relation to sexual abuse made to SJAI were dealt with when first made taking into account Government guidance and SJAI policies on child protection available at that time; the manner in which such complaints were dealt with when re-reported in 2013 taking into account Government guidance on child protection and SJAI policies available at that time ...
>
> - whether there were any other complaints (whether in writing or verbal to any person in a position of authority) regarding grooming or abuse in relation to the volunteer concerned over his period of involvement with SJAI; and
>
> - any other complaints (whether in writing or verbal to any person in a position of authority) relating to any other individual based on reports made to and/or records held by SJAI".

Under Part 2 of the Terms of Reference, the independent Review was required to undertake:

> "a review into the adequacy and effectiveness ... of the adequacy of arrangements now in place for the protection of children and vulnerable adults who may come into membership of SJAI ... all with a view to identifying learning and making recommendations for the organisation".

This chapter sets out the conclusions reached by the Review in relation to the above and related matters. It also sets out recommendations for SJAI to ensure that SJAI can continue to play an important role in Ireland's society as a charitable organisation, building on its legacy and its reputation. To do so, however, there must be structural and cultural changes, recognising that its organisation and patterns of behaviour in the past led to systemic failures in child protection and safeguarding.

The Review believes that SJAI can demonstrate its dedication to its aims and the commitment of its volunteers with a thorough review and reform of its practices, recognising the greater role it can play in the formation and personal development of its cadet members by working within a framework of robust and informed child safeguarding. The Review believes in this regard that there is a clear difference between SJAI in the past and the organisation today.

9.1 Apology

On the basis of the conclusions reached in this Review, it is recommended that SJAI should now offer an apology in comprehensive terms to victim-survivors and others. It is recommended that SJAI should look to other organisations who have been deficient in child safeguarding for assistance in this regard. In particular, the following wording employed by Scouting Ireland in their comprehensive apology is to be commended.

In 2020, Scouting Ireland made an apology (as reported by *The Irish Times* on 14 May 2020)[76]:

> "On behalf of Scouting Ireland, we unreservedly apologise to the victims and survivors of abuse in scouting who were failed.
>
> We are sorry that adults in scouting harmed you.
>
> We are sorry that you were not protected.
>
> We are sorry that you were not listened to or were unable to tell your story at that time.
>
> We are sorry for the hurt caused to you and the legacy of that hurt which many of you still live with today.
>
> We know we cannot take away that hurt. But we do want you to know that you have been heard.

76 See *https://www.irishtimes.com/news/social-affairs/full-text-scouting-ireland-apology-to-victims-of-sexual-abuse-1.4253456*.

> We want you to know that you are believed.
>
> We want you to know that we will support you.
>
> We are determined that there is no place in Scouting for anyone who, by design or by omission, harms a child, as you were. Cronyism, looking away and covering up are not victimless crimes. They are enabling actions.
>
> We pledge to adopt and deliver the Learnings and Recommendations of this Report. It is a light pointing into a very dark corner but it is also a beacon for the standards, culture and structures we must have, and which must be resourced to ensure that Scouting is a safe place for young people.
>
> You, by your bravery in speaking out, have helped to uncover the truth. Your legacy now is to have helped to make Scouting Ireland a safer place for young people; to have reminded us of why we exist – to support and cherish our young people through their scouting experience".

Scouting Ireland also issued a 27-page response,[77] which included the following apology:

> "Scouting Ireland apologises to all the [sic] who have been failed by scouting, those who have been subject to child sexual abuse, victims and survivors, to their parents who trusted us with their children, to the adults who tried to protect them and were ignored, to the youth members at the time whose development was not the focus, to our communities who supported us, to the funders who supported us and to our members today".

Scouting Ireland provided contact details for victims to report sexual abuse within a scouting organisation, with both a freephone number and an email. It also published an online video[78] with an apology.

SJAI should also provide appropriate counselling and therapeutic support to all those who came forward to speak to the Review and to any others who come forward in response to its publication to speak of similar harms done to them while in the care of SJAI.

77 See *https://assets.gov.ie/74307/9b9472a9ad414b28962313743043ceb.pdf*.
78 See *https://www.youtube.com/watch?v=at7eFZ6KLyQ&t=25s*.

9.2 Change in Ethos

A change in culture and ethos is needed within SJAI. It should abandon its military and hierarchical structures. These do not have a place in a modern volunteer organisation. In its cadet activities, the interests and views of younger members must be at the centre of how SJAI operates. Cadets should be considered as members who have a contribution to make. SJAI needs both a culture of safeguarding, and a practice of including, cadets within its structures.

The cadets within SJAI should be valued as an important function within the organisation. In activities where cadets take part, it is imperative that their needs as children and adolescents are pre-eminent. Activities should take place in an atmosphere and an environment that encourages growth and personal development, allowing cadets to build on their skills, whether those particular to the aims of SJAI, or of any voluntary organisation. This means providing them with roles appropriate to their skills, training, understanding and progress. SJAI should respect the individuality of each of their cadets, recognising that their needs will differ.

SJAI must ensure that all appropriate measures are in place to ensure the safety and well-being of cadets in its care at all times. The Review believes that this should include appropriate rules with regard to supervision and management, in particular when cadets are taking part in any offsite activities or overnight stays.

Rank and status in the hierarchy of SJAI should not be prioritised ahead of rewarding and acknowledging skill, knowledge and integrity. Even as the organisation remains a structured one, with layers built on experience, it should move to become a more open one. This change in ethos should mean a move away from a culture of impunity from accountability for more senior members of SJAI. Experienced members of SJAI must and in many cases will earn respect; this differs from deference considered due to them by virtue of rank or status.

SJAI must conduct its activities in a transparent manner. This means that its units must be inclusive in their governance, and where possible, include representatives of the voices of young people, whether through direct representation, safeguarding officers, or their parents and guardians. Members including cadets should feel open to question the structures and workings of the organisation, and should not operate within a chain-of-command structure.

There is a role for greater professionalism working within a model of volunteerism. To ensure accountability and standards, there are positions within the organisation which should be recruited to allow for applications from outside the organisation. In such cases, selection panels should include external members. Recruitment in this way will assist in finding staff and officers who are right for the roles of contemporary pre-hospital care.

Transparency and openness in recruitment and in elections to boards will assist in combatting the factionalism and cliques that can form in many organisations. A system of good governance requires frequent changes within committees and boards.

A culture of openness is also one that does not make excuses or contextualise its failings behind conservative ideas and prejudices. It is not acceptable to defend the failures at a systemic level that allowed children to be vulnerable by reference to culture of the time. Instead, SJAI should be honest about how its structures facilitated grooming and predatory behaviour. Warnings were ignored or not taken sufficiently seriously in the past, nor were reports made to the appropriate authorities. The failure to investigate known threats to the safety of children in the past was part of the broader weak accountability mechanisms within SJAI. The disciplinary structures within SJAI were not used when a threat presented itself. There was a failure to investigate, with excuses made about the degree of information available. This represented an ethical failure, when children's safety and welfare were at stake. The organisation formed an opinion that it could not act, even to investigate, without the degree of evidence that would secure a criminal conviction. It formed this opinion without seeking independent legal advice. A culture that did not investigate these suspicions also found it too easy to dismiss the gravity of allegations, and from there to deny or minimise that there was wrongdoing within the organisation. The culture of deference towards rank and status also led to the reputation of the organisation itself being prioritised over the safety and welfare of young people in the organisation.

9.3 Child Safeguarding Officers

The national safeguarding officer must be independent of SJAI. It should be a full-time role. However, it may be appropriate for this position to be held by an individual in conjunction with the same position for other organisations with similar aims and structures. Recruitment for the role should focus on experience with child welfare, rather than any experience of SJAI as an organisation, although experience with child welfare within a large organisation would be desirable.

Further to the appointment of a national safeguarding officer, each branch of SJAI should have a local safeguarding officer. This is not to suggest a hierarchy or chain-of-command when reporting. All safeguarding officers are mandated persons under the Children First Act 2015, and must be aware of their reporting duties, functions and responsibilities under this legislation.

SJAI and its local branches must provide details of the local safeguarding officer to all those working within and with SJAI, whether cadets, their parents or guardians, or officers. Any changes to this information should be communicated as early as possible, and this information must always be readily available.

All members of SJAI are to be required to undergo the SJAI safeguarding training course and the Children First e-learning Programme.

9.4 Complaints Procedure

There must be a robust complaints procedure, following the best practice and experience of other organisations.

Clarity is vital, both to any potential complainant, to know where to make a complaint, and to any child safeguarding officer, to know how to respond.

Fair procedures and constitutional rights must be given to those against whom accusations have been made. This should be provided for in a structure that recognises the best interests of any child in question and the young people generally under the supervision of SJAI. A priority must be the prevention of any potential further harm to children. The current system of Courts of Inquiry should be abolished or significantly reformed to ensure compliance with child protection regulations and national guidance.

The complaints procedure must be transparent and clear to all. Information on how to make a complaint should be structured in a manner which is age-appropriate and age-sensitive, so that any cadet can easily understand who they can speak to if they have a complaint.

The complaints procedure should provide alternates, to account for situations where the designated local child safeguarding officer is not someone the minor is comfortable addressing their particular complaint towards, or if they are absent for any reason.

All child safeguarding officers should know the relevant contacts in both the Child and Family Agency/Tusla and in An Garda Síochána for any complaints concerning the welfare and the safety of a child.

There should be no restriction within the organisation on a member or officer taking legal action against another member or officer, and it should be made clear to all members that the former such rule (rule 122 of the 1947 Rules and Regulations of SJAI) is amended or removed to reflect this position.

9.5 Garda Vetting

All adults within SJAI must receive vetting from the Garda National Vetting Bureau under the National Vetting Bureau (Children and Vulnerable Persons) Acts 2012–2016. This is a statutory obligation, under which a relevant organisation shall not permit any person to undertake relevant work or activities on behalf of the organisation, unless the organisation receives a vetting disclosure from the National Vetting Bureau in respect of that person. Applications for membership of SJAI must not be considered to be complete until the conclusion of Garda vetting.

National guidelines require Garda vetting to take place every three years. Within their third year, members must have completed Garda vetting, the Children First e-learning certificate, and SJAI safeguarding training.

Cadets who approach their 18th birthday must be vetted before joining the relevant adult division or branch.

9.6 Document Management and Data Privacy

SJAI should institute a system of typed and dated reports for each complainant and every incident or suspected incident affecting child protection or raising child safeguarding concerns.

Typed and dated notes about each meeting where any child protection concerns are considered must also be kept in hardcopy format. These must be accessible by the national safeguarding officer and by the relevant state agencies (Tusla and An Garda Síochána). All information should be kept securely in offices or premises of SJAI, and must not be taken to the residences of SJAI members or officers, or any other locations.

Membership officers in each branch should be aware of the renewal policy, including the requirements for regular re-training and re-vetting. Membership and contacts lists must be kept up to date and retained in line with data protection policies. This also ensures that past members who have not complied with the requirements of training and vetting will not receive information about events or meetings they are not entitled to be informed about.

In the immediate term, this will require investment in resources to resolve current issues with membership lists and management systems.

9.7 Regulations

SJAI has revised its child protection policies on an interim basis since their first publication in 2002. However, the general regulations of SJAI have remained largely unchanged since 1947. As part of good governance, these should be considered as a whole, ensuring that they comply with 21st century standards and regulations. This should include data protection and child safeguarding, as well as a general review of governance structures.

9.8 Implementation and Review

SJAI must maintain a culture of being proactive in child safeguarding. Best practice in safeguarding of children and regulations will continue to develop. SJAI must ensure that it does not lag behind in implementation of changes in practice and that it stays informed of changes to regulatory regimes. Guidance should be given having regard to *Children First* as it develops as well as further relevant publications of the Child and Family Agency/Tusla.

SJAI must also adopt practices of awareness of developments and changes in data protection and privacy, in conjunction with proper and accountable record keeping.

9.9 Conclusions and Recommendations

9.9.1 Abuse Claims and Threats to Child Safety

Relevant Learnings:

The Review believes that SJAI's structure and culture was, in the past, vulnerable to facilitating grooming of children for sexual abuse. The Review also believes the accountability systems failed to intervene or investigate despite evidence of potential child protection risks being highly visible within the organisation.

The Review believes it is important for SJAI and others to be very conscious of the fact that several victim-survivors reported that they suffer ongoing and persistent trauma as a consequence of the abuse described in their testimonies.

The Review believes that there was a significant degree of organisational awareness in SJAI of a persistent and serious threat to children within SJAI, including widely discussed rumours of a specific threat to children in SJAI. The Review believes that awareness of a potential threat to child safety in SJAI was well-established by the early to mid-1990s.

The Review believes, on balance, that SJAI failed to undertake any meaningful investigation into known or suspected threats to children when complaints were first made in the late 1990s. This failure to investigate was part of the broader weak accountability mechanisms within SJAI.

Regardless of whether the organisation was legally obliged to respond at the relevant time, the Review believes that SJAI's failure to initiate any formal investigation following a full disclosure of serious grooming and child sexual abuse in the late 1990s was a serious failure of SJAI's ethical duty of care to its membership, which included hundreds of cadets.

On balance, the Review believes that SJAI failed to act on knowledge or suspicions of risk because of a misguided belief that a criminal standard of evidence had to be reached before its intervention was permitted. The Review believes it difficult to imagine how "hard evidence" could be found if there was no attempt to investigate suspicions properly. The Review believes that many members of SJAI appeared paralysed by a sense that they needed an evidential "smoking gun" before they could intervene in any way to assess or address potential child protection risks. The Review believes that this position by some within SJAI reflected a lack of awareness of the ethical duty of the organisation to protect the interests of its many vulnerable members. The SJAI organisation could have, and should have, investigated suspicions and allegations of serious misconduct and victimisation.

The Review believes, on balance, that a key reason for SJAI's failure to act on suspicions of victimisation was due to fear of litigation arising. The Review has not found any evidence that SJAI sought independent legal advice on this matter.

The Review was unable to comprehensively verify claims of an offer of a cash payment by SJAI to a victim in order to protect the organisation's reputation.

The Review believes that reputation protection has been a strong driving force in SJAI's response to allegations of grooming and abuse within the organisation.

Relevant Recommendations:

The Review recommends that SJAI should now offer an apology in comprehensive terms to victim-survivors and others. It is recommended that SJAI should look to other organisations who have been deficient in child safeguarding for assistance in this regard.

The Review recommends that SJAI puts in place appropriate therapeutic support for those who came forward to speak with the Review. The Review understands that SJAI offered one consultation plus six counselling sessions for victim-survivors.

The Review recommends enhanced ongoing communications processes for those who make complaints, and that complaints processes are managed with a greater emphasis on transparency and institutional confidence building for the membership.

9.9.2 Structure of SJAI

Relevant Learnings:

The Review believes that SJAI operated under a rigid hierarchical structure, which placed a high value on deference and compliance. The Review believes that some aspects of that structure persist within SJAI; the core military structures remain. The Review characterises this structure as highly formalised and quasi-military, placing a high value on obedience to rank and a low value on autonomy. These structures have informed and shaped the hierarchical structure of SJAI, and the accountability structures within the organisation. The Review believes that these military structures are not appropriate for a healthy child protection and safeguarding culture.

The Review believes that SJAI placed a high cultural value on deference to rank and seniority. The effect of this deference was to inhibit the development of robust and effective accountability mechanisms within the organisation. The Review believes that SJAI's culture of deference conflated rank and status within the organisation, and in other discrete professions as equivalent to the skill, knowledge and integrity appropriate for their role. The Review believes that deference informed and inhibited SJAI's development of internal accountability systems. This included the directing of disciplinary measures towards more junior ranks and away from senior ranks, facilitating a culture and practice of impunity from scrutiny or accountability across a wide range of areas. The Review believes that this culture of deference poses an ongoing threat to the implementation of robust and effective child protection systems and practices.

The Review believes that SJAI's hierarchical structure impeded significant organisational reform in areas such as child protection policies and practices. It is also believed that SJAI's hierarchical structure facilitated predatory activity within the organisation, and insulated this activity from effective intervention and accountability.

The hierarchy, at least insofar as it operated in SJAI, generated competition for rank status within the organisation, and created often unhealthy centres of unaccountable power.

The Review believes that the structural and cultural features of SJAI's hierarchy and chain-of-command inhibited accountability for senior-ranking members. The Review believes this led to impunity for senior-ranking members of the organisation from scrutiny or accountability across a wide range of areas, and response paralysis of SJAI in the face of known or suspected threats and wrongdoing.

Relevant Recommendations:

The Review recommends that SJAI abandons all remaining military structures and cultural norms and that a reconsideration of the hierarchical structure and culture of SJAI is carried out.

The Review recommends the creation of robust internal accountability frameworks which are transparent and apply equally to all ranks of the organisation.

9.9.3 Governance

Relevant Learnings:

The Review believes that some members of SJAI perceive some of its governance culture and practices to be dysfunctional. These organisational dynamics have likely created some obstacles to the effective implementation and operation of appropriate child protection systems and practices.

The Review believes that the SJAI cadets are, in principle, a positive component of the organisation. However, it is clear that persistent issues remain with regard to the governance and management of SJAI's cadet system.

Relevant Recommendations:

The Review recommends SJAI undertakes a broad re-examination of its internal governance, transparency and accountability mechanisms. The Review also recommends as part of this process that SJAI examines the potential for putting certain key roles on a professional basis within SJAI to support and facilitate a more dynamic and responsive approach to volunteerism.

The Review recommends that the cadets should be maintained as a core component of SJAI.

The Review recommends that SJAI invests appropriate resources to resolve outstanding issues with regard to the membership information and management systems.

9.9.4 Discipline and Accountability

Relevant Learnings:

The Review believes that discipline within SJAI was often superficial: focusing on materially insignificant matters such as compliance with the uniform regulations, while ignoring or avoiding substantively serious matters.

The Review believes that the primary accountability mechanism in SJAI was, and remains, the chain-of-command. This was a wholly inappropriate accountability approach from a child protection perspective, although it does not apply under SJAI child protection policies today. The Review believes this approach to accountability also failed to account for the possibility that individuals in that chain-of-command hierarchy may have been implicated in victimisation. SJAI's accountability system appeared generally structured around the assumption that wrongdoing is committed by lower-ranking members.

The Review believes that the Court of Inquiry process within SJAI lacks adequate transparency. The Review was not furnished with any rules or procedures of the court. It seems that the Court of Inquiry process was primarily used to discipline junior members of the organisation. This in turn reinforced, in punitive terms, the structural and cultural features of SJAI that prioritised hierarchy and rank. The Review believes that the Court of Inquiry process contains many concerning features which fail to respect individuals' constitutional rights to natural justice. In this way it is profoundly procedurally flawed. It is wholly inadequate and fails to offer a meaningful or effective accountability mechanism.

The Review believes that rule 122 of the 1947 Rules and Regulations of SJAI (reprinted in 1994) is problematic in that it seeks to constrain the constitutional rights of SJAI members.

Relevant Recommendations:

The Review recommends SJAI develops formal guidelines to deal with grievances and complaints.

The Review recommends that the Court of Inquiry process in SJAI be significantly reformed to address these critical conclusions.

The Review strongly recommends that rule 122 be removed from the SJAI Rules and Regulations.

9.9.5 Culture

Relevant Learnings:

The Review believes that there is a long-standing and persistent cultural antipathy towards change within some aspects of SJAI. The Review believes that resistance to change poses an ongoing threat to the implementation of robust and effective child protection systems and practices.

Further, as discussed above, there was a culture of conservatism within SJAI, that incorporated homophobic myths into its early child protection training. The Review believes that this conservatism likely significantly undermined SJAI's initial attempts to develop a formal child protection system in the late 1990s and early 2000s. The Review rejects the contention that such a position can be defended by reference to supposed cultural norms of that time.

Relevant Recommendations:

The Review recommends a reconsideration of the hierarchical structure and culture of SJAI. The Review recommends the creation of robust internal accountability frameworks which are transparent and apply equally to all ranks of the organisation.

9.9.6 Professionalism

Relevant Learnings:

The Review believes that beyond pre-hospital best practices, SJAI lacks professionalism in some of its operative culture. This lack of professionalism poses a continuing threat to the implementation of robust and effective child protection systems.

Relevant Recommendations:

The Review recommends that SJAI takes steps to consider this lack of professionalism through the implementation of robust and effective child protection systems.

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Appendix I

Terms of Reference

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A1.1.1 Process as to how the Review will be conducted 239

A1.1 Terms of Reference for Review of Handling of Past Complaints of Abuse in St John Ambulance Ireland

St John Ambulance Ireland (SJAI) is aware of a number of complaints of sexual abuse of members under the age of 18 years relating to one former volunteer member who ceased volunteering with SJAI circa 2000/1. The Board of St John Ambulance Ireland has commissioned an independent review to undertake a review of the adequacy and effectiveness of:

PART 1

- the manner in which the aforesaid complaints in relation to sexual abuse made to the SJAI were dealt with when first made taking into account government guidance and SJAI policies on child protection available at that time (see Appendix I); the manner in which such complaints were dealt with when re-reported in 2013 taking into account government guidance on child protection and SJAI policies available at that time (see Appendix I);

- whether there were any other complaints (whether in writing or verbal to any person in a position of authority) regarding grooming or abuse in relation to the volunteer concerned over his period of involvement with SJAI, and

- any other complaints (whether in writing or verbal to any person in a position of authority) relating to any other individual based on reports made to and/or records held by SJAI: and

PART 2

- the adequacy of arrangements now in place for the protection of children and vulnerable adults who may come into membership of SJAI having regard to TUSLA's assessment in July 2019;

all with a view to identifying learning and making recommendations for the organisation.

The Report will be to the Board of SJAI.

Members of SJAI will offer full co-operation with the reviewer as she/he determines.

A1.1.1 Process as to how the Review will be conducted

The Review will consist of:

- A review of files held by SJAI on past Safeguarding complaints;
- An opportunity for complainants to meet confidentially with the Reviewer and to outline their experiences of making Safeguarding complaints to SJAI;
- An opportunity for the Reviewer to meet with any Member of SJAI with a view to understanding that person's roles and responsibilities in relation to any complaints he/she may have had reported to him/her in his/her time in SJAI;
- An opportunity for any Member of SJAI identified by a complainant as a recipient of a complaint to inform the Reviewer in relation to his/her actions on foot of his/her receipt of any such complaint;
- Former Members of SJAI are encouraged to assist the Reviewer by meeting him/her at his/her request to share any information or insights he/she may have on how past complaints were managed;
- The SJAI "point-of-contact" for the Review is the Commissioner supported by A/Commissioner P Corcoran.

David J Strahan,

Chairman of the Board of SJAI

John Hughes,

Commissioner, SJAI

7th March 2021

Appendix II

Data Protection

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DATA PROTECTION

A2.1 Legitimate Interest

A2.1.1 What is the Interest Pursued?

It is necessitated that as part of this Review, certain data would be processed which relates to the purpose of the Review, being the investigation of the response of SJAI to complaints of alleged child sexual abuse, as well as ensuring the adequacy of arrangements relating to the care and protection afforded to children historically and in the present day by SJAI. The Terms of Reference record that this Review is taking place with a view to identifying and making recommendations to SJAI. SJAI provides a "relevant service" under the Children First Act 2015.[1] As such, the Review serves the public interest of ensuring protection of children and vulnerable people into the future.

The Review is also concerned with investigating potential non-compliance with SJAI's statutory obligations under the Children First Act 2015, particularly section 10 which obliges providers of a relevant service to "ensure … that each child availing of the service … is safe from harm while availing of that service".

The interests and rights of third-party complainants are also being asserted through the Review. This is supported by section 7 of the Children First Act 2015 which provides that in performing a function under the Children First Act 2015, Tusla "shall … regard the best interests of the child as the paramount consideration".

By all measures, the Review concluded that the interests it was pursuing were important and compelling.

1 A list of what is considered a "relevant service" is contained in Schedule 1 of the Children First Act 2015. As a provider of a "relevant service", SJAI is obliged to ensure each child is safe from harm while availing of its services (section 10) and to undertake a risk assessment and prepare a "child safeguarding statement" (section 11).

A2.1.2 Is the Interest Clearly Articulated?

The purpose of the Review is set out in the Terms of Reference for this Review. In recommending the Review takes place, Tusla acted under its duty to promote the welfare of children who are not receiving adequate care or protection under section 3 of the Child Care Act 1991. Section 3(2) of the Child Care Act 1991 provides that Tusla shall:

> "take such steps as it considers requisite to identify children who are not receiving adequate care and protection and co-ordinate information from all relevant sources relating to children".

In *M.Q. v Gleeson*,[2] Barr J. stated that Tusla's obligations under section 3 are proactive in nature.

A2.1.3 Is the Interest Lawful?

As discussed, one aspect of the Review's purposes is to evaluate compliance by SJAI with its statutory obligations under the Children First Act 2015 and its predecessors. As detailed above, it is the lawful duty of Tusla to proactively ensure that all children within its remit receive adequate care and protection. It can, therefore, be said that the interest being pursued is lawful.

The Data Protection Commission ("DPC") published draft guidance on the processing of children's data (the "DPC Guidance").[3] A key passage is found at page 23 and is highly relevant to this legitimate interests assessment ("LIA"):

> "It is of fundamental importance to emphasise that the data protection rules in the GDPR and the 2018 Act [Data Protection Act 2018] (irrespective of whether children's or adults' personal data is at issue in any given situation) are not a barrier to safeguarding, and that it is in the best interests of children to be protected from violence, abuse or interference/control by any party".

2 *M.Q. v Gleeson* [1998] 4 I.R. 85, at pages 99–100, in relation to obligations of the health boards (statutory predecessors of Tusla): "I have no doubt that in the exercise of their statutory function to promote the welfare of children, health boards are not confined to acting in the interest of specific identified or identifiable children who are already at risk of abuse and require immediate care and protection, but that their duty extends also to children not yet identifiable who may be at risk in the future by reason of a specific potential hazard to them which a board reasonably suspects may come about in the future".

3 Data Protection Commissioner, *Children Front and Centre: Fundamentals for a Child-Oriented Approach to Data Processing*, (December 2020); available at: https://www.dataprotection.ie/sites/default/files/uploads/2020-12/Fundamentals%20for%20a%20Child-Oriented%20Approach%20to%20Data%20Processing_Draft%20Version%20for%20Consultation_EN.pdf. The consultation period ended on 31 March 2021, with the final guidance published in December 2021.

Insofar as Part 2 of the Review examines the adequacy of the current child protection measures of SJAI, it was likely that children's data would be processed. In this regard, the DPC Guidance notes that the best interests of a child, the data subject, should prevail in any balancing exercise being performed by data controllers, and that legitimate interests should never conflict with or override what is in a child's best interests. It is submitted that such a conflict does not arise in the context of this Review and that the interests of any children whose data was processed and the interest being pursued by the Review are aligned.

A2.1.4 Is it a Real and Present Interest?

The Terms of Reference provide that the Review is to consider the adequacy of the arrangements currently in place by SJAI for the protection of children and vulnerable adults who come into membership of SJAI, having regard to Tusla's assessment in July 2019. Should such arrangements be inadequate following review, there is potentially a real and present threat to children and vulnerable adults. Time is also of the essence in considering the adequacy with which historical complaints of sexual abuse have been dealt with.

A2.1.5 Does the GDPR (or Guidance) Explicitly Recognise this as a Legitimate Interest?

Recital 47 of the General Data Protection Regulation (the "GDPR") discusses overriding legitimate interests as a legal basis for processing, listing prevention of fraud as an example. It also states:

> "such legitimate interest could exist for example where there is a relevant and appropriate relationship between the data subject and the controller in situations such as where the data subject is a client or in the service of the controller".

The European Data Protection Board ("EDPB") has published guidance on processing personal data in the context of video devices (Guidelines 3/2019[4]). These guidelines briefly discuss processing based on pursuing legitimate interests, saying that prevention of crime can constitute a legitimate interest once the risk is real and present (i.e. not speculative), with past instances or imminent danger being relevant.

4 Guidelines 3/2019 on processing of personal data through video devices; available at: *https://edpb.europa.eu/our-work-tools/our-documents/guidelines/guidelines-32019-processing-personal-data-through-video_en*.

While it predates the GDPR, the Article 29 Data Protection Working Party ("WP29") issued an opinion on the notion of legitimate interests of the data controller (Opinion 06/2014[5]). In this opinion, WP29 gives a non-exhaustive list of interests which could be considered legitimate. The most relevant examples given are "prevention of fraud, misuse of services or money laundering"; "employee monitoring for safety or management purposes"; "physical security"; and "processing for historical … purposes". WP29 also considers the legitimacy of the interests of a third party in the processing of data by a controller, such as assisting law enforcement and/or private stakeholders to combat illegal activities including, for example, child grooming.

The UK Information Commissioner's Office ("ICO") notes that there may be a legitimate interest in disclosing information about possible criminal acts or security threats to the authorities.

As referred to above, the DPC Guidance is that where safeguarding the welfare of children is at issue, the GDPR and the Data Protection Act 2018 do not act as a barrier, irrespective of whether the data subject concerned is a child. In addition, a key output from the DPC Guidance is that the best interests of a child involved are paramount, and that it is in the best interests of children to be protected from violence, abuse or interference/control. It is submitted that the legitimate interests of the Review and the best interests of any child data subjects are aligned.

All guidance agrees that legitimate interests relied upon by controllers can range from trivial to compelling depending on the circumstances. The legitimate interest in carrying out the Review can be said to be a compelling interest and is far from trivial in its nature.

A2.2 Is this a Legitimate Interest?

On consideration of the above, the proper investigation of complaints of alleged child sexual abuse, as well as ensuring the adequacy of the care and protection afforded to children historically and in the present day by SJAI to ensure protection of children and vulnerable people into the future can be considered a legitimate interest.

5 Opinion 06/2014, opinion on legitimate interests of the data controller; available at: *https://ec.europa.eu/justice/article-29/press-material/public-consultation/notion-legitimate-interests/files/20141126_overview_relating_to_consultation_on_opinion_legitimate_interest_.pdf*.

A2.3 Necessity

A2.3.1 Is it necessary, reasonable and proportionate to process personal data for the purposes of these legitimate interests?

In order to carry out the Review comprehensively and in accordance with the Terms of Reference thereof, it was necessary that the personal data at issue be shared. SJAI and the Review have stated their belief that this is the case. The Review have and will use the personal data provided and the Review agreed only to process the personal data for the agreed purpose of the Review pursuant to the Terms of Reference. It was acknowledged that the scope of the Review would be limited to the extent of the data shared by SJAI or to which access was provided to the Review, in compliance with the principle of data minimisation.

A2.3.2 Could these legitimate interests be achieved without processing personal data or in a less intrusive way?

As stated above, both SJAI and the Review believe sharing this personal data is necessary for the purposes of properly conducting the Review. Therefore, the legitimate interest could not be achieved without this processing, and measures have been put in place to ensure the intrusion on data subjects' rights is minimised.

A2.3.3 Overridden by Interests or Fundamental Rights and Freedoms of the Data Subject

The primary data subjects affected by the processing are:

(1) the complainants or other victims of the alleged abuse (whether or not they submitted complaints);

(2) the alleged abuser or, if applicable, abusers;

(3) witnesses or people who may have been privy to or have knowledge relating to the alleged events; and

(4) members and former members of SJAI (or staff and former staff of SJAI) involved in or who (by virtue of their position) may be expected to have a role in the handling of child safeguarding complaints in SJAI.

Notwithstanding the consideration given above to the legitimate interests of the Review and compliance with GDPR procedures in sharing the data, the rights of the data subjects which will potentially be interfered with are:

- personal rights under Article 40 of the Constitution, to include:
  - right to equality before the law (Article 40.1 of the Constitution);
  - right to privacy (Article 40.3 of the Constitution, Article 8 European Convention on Human Rights);
  - right not to be deprived of liberty save in accordance with law (Article 40.4 of the Constitution);
  - right to a good name (Article 40.3.2 of the Constitution);
- Article 8 of the European Union Charter of Fundamental Rights (the "Charter") which states:

  "1. Everyone has the right to the protection of personal data concerning him or her.

  2. Such data must be processed fairly for specified purposes and on the basis of the consent of the person concerned or some other legitimate basis laid down by law";
- right to the presumption of innocence (Article 31.1 of the Constitution); and
- rights derived from Article 38.1 of the Constitution and natural justice to include the right to fair procedures, the right to due process and the right to be heard.[6]

In addition to rights, the "interests" of data subjects must be taken into account and weighed against the legitimate interests pursued by the Review. These interests are linked to, but are wider than, the rights listed above.

6 In *Lawlor v Flood* (1999) 3 IR 107, Murphy J held that where a person is being put in a position of being accused of serious misconduct reflecting on their character and good name, this would rise to the "full panoply" of procedural protections identified in *Re Haughey* (1971) IR 217.

It cannot be said to be in the interests of all data subjects that their data be shared, particularly for the alleged abuser(s) against whom the complaint(s) have been made. While these interests should be taken account of (without prejudice to the outcome of the Review, bearing in mind that WP29 has said that "even individuals engaged in illegal activities should not be subject to disproportionate interference with their rights and interests"), WP29 also acknowledges that one of the "consequences of criminality" is collection of personal data about alleged criminals and suspects. Additionally, this analysis may also take account of those whose interests align with those pursued by the Review, i.e. the position of the complainants or any child data subjects.

If there is a negative impact, how severe is the impact? Have regard to:

- reasonable expectations as to how collected data would be used;
- whether the data subject is informed of the legitimate interests;
- right to object;
- special categories of data or criminal offence data; and
- children or other vulnerable data subjects.

In accordance with Recital 47 of the GDPR, it falls to be considered whether the potential data subjects would consider it reasonable for their personal data to be used for the present purposes of an independent review into historical complaints and current practices. For the complainants and witnesses involved, their expectations as to how their data might be used would likely include the data being shared in order to properly investigate their complaints/take account of their testimony/evidence, particularly given the potential severity of the issues involved.

As for the alleged abuser(s) against whom the complaint(s) have been made and/or any members or former members (or staff) whose handling of complaints may come under scrutiny, the potential impact on such persons needs to be assessed against the backdrop of the DPC Guidance which provides that the data protection rules should not act as a barrier to safeguarding children and vulnerable persons from violence, abuse and interference/control.

The Review is likely to involve the processing of personal data relating to:

(i) persons involved in criminal activity and/or matters the subject of criminal allegations (proven or unproven); and

(ii) victims of, or witness to, criminal activity or matters the subject of criminal allegations,

— all of which would amount to criminal offence data under the GDPR ("Article 10 Data").

Given the risks to affected data subjects, Article 10 of the GDPR provides that the processing of Article 10 Data shall only be carried out under the control of "official authority" or when otherwise authorised by Member State or Union law which appropriately safeguard the rights and freedoms of data subjects.

In this regard, section 55 of the Data Protection Act 2018 states that Article 10 Data may be processed under the control of official authority or in one of the circumstances set out in section 55(1)(b), which includes:

> "processing … necessary to prevent injury or other damage to the data subject or another person … or otherwise to protect the vital interests of the data subject or another person".

Section 55(2) further provides that processing under the control of official authority most relevantly includes processing required for:

- the administration of justice;
- exercising a regulatory function; and
- protection of the public against harm arising from dishonesty, malpractice, breaches of ethics or other improper conduct by, or the unfitness or incompetence of, persons who are or were authorised to carry on a profession or other activity.

It is considered that the processing of the aforementioned Article 10 Data by the Review is in compliance with the above mentioned requirements of Article 10 of the GDPR and section 55 of the Data Protection Act 2018. The express purposes of the Review together with Tusla's involvement in directing/recommending the Review in the course of carrying out its statutory obligations and

functions under the Child Care Act 1991 are supportive of this conclusion. This has also been borne in mind when assessing the severity of the impact on the fundamental rights and interests of affected data subjects.

In addition to Article 10 Data, certain of the data will likely fall within the special categories of data under the GDPR requiring specific protection (including data concerning a person's sex life, sexual orientation and health). While the GDPR and the Data Protection Act 2018 contain a general prohibition on the processing of such data, the Review considers that the processing of special category data comes within the terms of the exception set out in Article 9(2)(g) of the GDPR—i.e. the processing is necessary for reasons of substantial public interest, on the basis of Union or Member State law which shall be proportionate to the aim pursued, respect the essence of the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

When measuring the severity of the impact, it must also be considered that some data subjects may be children or vulnerable persons.

For example, some of these data subjects may be victims of crime of a serious nature and could be suffering from post-traumatic stress or psychological issues arising from the alleged events. The allegations are such that the data being processed in respect of these individuals may be extremely sensitive and/or could give rise to anguish or upset if ever disclosed.

As noted above, given that Part 1 of the Review covers historical allegations, the relevant data subjects who allegedly suffered abuse are now all adults. As such, children's data (while expected to be within scope) will likely only be potentially processed in respect of Part 2 of the Review.

While accepting that these factors present greater risks and have the potential to render the impact more severe, it is still the case that the Review has been commissioned following Tusla's investigation in response to formal complaints made by alleged victims. It is submitted that it is in the interests of these complainants to have these issues properly investigated and addressed. Therefore, the processing of their data in connection with the Review is more likely to be in furtherance of, as opposed to detrimental to, their interests.

While the Review considered a limited class of people, further mitigating measures in order to protect data subjects' rights as far as possible were considered (see below).

A2.3.4 Should the Legitimate Interest be Overridden?

Despite these interferences with rights and interests, the legitimate interests pursued by the Review are not outweighed. This is the case having considered the importance and compelling nature of the legitimate interest, the necessity of the processing to the proper conduct of the Review and the additional mitigating steps intended to be applied by those with whom access to the data is being shared. This conclusion is also supported by the DPC Guidance referred to above that data protection should not act as a barrier to safeguarding children and vulnerable persons from violence, abuse and interference/control.

A2.3.5 Further Mitigating Steps: Transparency Notice, Opt-Out, Enhanced Compliance with Other Obligations

The legal transparency requirements of the Review have been fulfilled through the publication of a transparency notice on the Review's website: *https://stjohnambulancereview.ie/*. This transparency notice is appended to this Report at Appendix VII. This notice sets out the background to the Review and the commitment of the Review to confidentiality and data privacy. It also describes the aims of the Review and provides detailed information with regard to how interviews will be conducted, for the benefit of all participants. The notice also provides participants with information about accessing their private data and the deletion procedure for interview files.

Participants were informed of the fact that their personal data may be shared. Subjects were also told of the legitimate interests being relied on.

A Privacy Policy – Participant Facing was also provided to all participants in advance of attendance at interviews. This privacy policy is appended to this Report at Appendix VIII. This policy provided detailed information to all participants with regard to how their personal data will be held and stored by the Review, and data security provisions; it also underscored the commitment of the review team to protect the privacy and security of all data relating to participants in the Review.

The review team has made and continues to make every effort to ensure the anonymity of the identity of participants to the Review. The Review has developed a document management system to ensure that data is secure and that participants are only identifiable to members of the review team. The review team has also taken care to use procedures that refrain from naming individuals to the extent possible as and between the review team and the Review instead used anonymised codes to refer to participants. As the review team explained to all participants, while the Review will endeavour to ensure that names are not used and will endeavour from that point of view to ensure participants' anonymity, it is always possible that a court may direct the disclosure of

certain documents, including participants' evidence. Where such an order is made by the court, the review team must comply. As such, the review team cannot guarantee the full anonymity of data.

In addition to the restrictions mentioned above, the Review was subject to further restrictive measures and have applied the following safeguards:

- The Review ensured all hard copy data is kept secured under lock and key.
- The Review has ensured that all data processed electronically is kept on devices that are securely password-protected.
- Data subject consent has been obtained in respect of the proposed processing of personal data contained within any confidential voluntary disclosures or contributions of information by data subjects to the Review and the contents of such disclosures or contributions shall not be divulged to any party unless the Review is required to do so by law.
- No SJAI personal data will be transferred outside of the EEA.

A2.3.6 Other Steps Taken to Mitigate the Risks to the Rights and Freedoms of the Data Subjects

It is considered that the mitigating steps identified above reduce the risks significantly. That said, the Review implemented further mitigating steps, namely the following:

Objection—following their being informed of the data sharing, subjects were afforded the opportunity to object to the processing of their data for the purposes of the Review. Article 21 of the GDPR explicitly refers to data subjects' right to object when the legal basis for processing is Article 6(1)(f).[7]

Data minimisation—further steps were taken to ensure that no more personal data than was necessary for the purposes of conducting the Review was shared, including potential redaction or pseudonymisation of certain information. As noted above, this Report was prepared and presented in a form which protects the identities of the affected data subjects.

7 Where this right is exercised and where Article 6(1)(f) is relied on, the controller shall no longer process the personal data unless the controller demonstrates compelling legitimate grounds for the processing which override the interests, rights and freedoms of the data subject or for the establishment, exercise or defence of legal claims.

A2.3.7 Further Balancing Assessment

The proposed measures (including the additional measures set out above) ensure the principle of data minimisation was complied with and that the privacy rights (and, by extension, other rights) of affected data subjects were impacted as little as was necessary for the purposes of the Review.

These measures also ensure that the data subjects are at least being informed of the transfer of their data, irrespective of whether they may validly object.

A2.3.8 Based on this further balancing exercise, should the legitimate interest be overridden?

Following on from the above analysis, the legitimate interest should not be overridden in the present circumstances.

Appendix III

Saint John Ambulance Ireland Review Website

Message from Independent Reviewer

Transparency Notice

The Review Team

Contact Page

Making Contact

Terms of Reference

Review Process

Timeline for the Review

Help and Support

The St John Ambulance Review

Help & Support Resources
Terms of Reference for the Review
The Review Process Timeline for the Review
Making contact & How we treat your communications
The Review Team Contact

Message from the Independent Reviewer Dr Geoffrey Shannon

Welcome, my name is Dr Geoffrey Shannon. I have been appointed by the Board of St John

Ambulance Ireland (**SJAI**) to conduct an Independent Review into the handling of historical child sexual abuse within SJAI in response to allegations made against one former volunteer in the organisation. I have also been asked to review the current safeguarding practices within SJAI. Both elements of my work will inform

areas of potential learning and further improvement, through the making of recommendations as I consider appropriate.

On this website, you will find information about the Review, including the Terms of Reference for the Review, and the Review Team.

You will also find information about how to contact the Review Team,

and some support services and resources that may be useful.

If you have information you feel is of relevance to the Review's work, I urge you to make contact. Your disclosures will be treated with the utmost care and confidentiality.

The St John Ambulance Independent Review 2021–

Official website for the Review

Made with Squarespace

Contact the Review

Email Contact Page

The St John Ambulance Review

Transparency Notice Help & Support Resources
Terms of Reference for the Review
The Review Process Timeline for the Review
Making contact & How we treat your communications
The Review Team Contact

Transparency Notice

Background

St. John Ambulance Ireland (SJAI) has commissioned Dr Geoffrey Shannon to conduct this Independent Review.

The Review Team comprises Dr Geoffrey Shannon, Ms Hilary Coveney and Dr Cian Ó Concubhair.

1. This document outlines the nature and remit of this Independent Review, including:
    - What the Review Team under Dr Geoffrey Shannon has been asked to examine;
    - What the Review Team is precluded from examining;
    - How the Review Team will conduct this Review; and
    - What the Review Team hopes to achieve by meeting with, and talking to you.
2. This document also explains how we will treat any information you disclose to us during these interviews, and the safeguards we will adopt in protecting you and your rights.

3. Finally, this document seeks to ensure that your voluntary consent to participate in this review is fully informed.

Commitment to Confidentiality and Data Privacy

The Review Team is very conscious of the sensitivity of the issues to be discussed during the Review. This transparency notice and related privacy policy set out our commitment to managing your data privacy respectfully and in line with our obligations.

We commit to keeping all documentation generated by us in the course of the Review confidential. Any data created by us will not be shared with SJAI or with any other third party, unless we are required by law to disclose it. We use sophisticated technology methods to secure the data you share with us and only the Review Panel and our Transcriber Company has authorised access to the data. Here, we explain who we are, how we process your data, why we process it, how long we retain it for and we explain how you can access your personal data and exercise other data protection rights. Our goal is to deliver on the aims of the Review, as set out below, to assist in the maintenance of a comprehensive child-focussed culture and environment that is safe for all. Thank you for helping us achieve this aim.

Aims of this Review

This Independent Review was commissioned by SJAI in response to allegations made against a former volunteer in SJAI.

The Review Team will produce a Report setting out its findings and this Report will be submitted to the Board of SJAI.

There are two primary aims for this Independent Review in the production of its Report:

1. To examine how complaints of child sexual abuse were handled by SJAI.
2. To assess current child safeguarding practices within SJAI.

The Report drafted by the Review Team will not identify individual fault or failings by members of SJAI, nor will any individuals (including any participants such as you) be named in any report furnished by the Review Team to the Board of SJAI. The Terms of Reference published by SJAI on 8 March 2021 (copy attached) do

not allow the Review Team to undertake any investigation as to the merits or otherwise of any allegation or complaint identified in the course of the Independent Review as such matters are reserved to the statutory authorities such as An Garda Síochána. The Independent Review is limited to reviewing how such complaints or allegations were handled by SJAI. The Report furnished to the Board of SJAI will not make any recommendations concerning the specifics of individual complaints.

Instead, this Independent Review is designed to identify systemic and / or cultural issues within the SJAI organisation in relation to child protection and safeguarding. It is open to anyone to make a complaint to An Garda Síochána in relation to any issue of concern to them.

This Independent Review is also designed to give you an opportunity to tell your story, and have your experiences and views considered and included in the Review Team's Report.

The Review Team's functions will cease on the date of the provision of its Report to the Board of SJAI.

Why have you been invited for interview?

You have been invited for interview by the Review Team as you have contacted us and indicated that you:

- Possess information and knowledge relevant to the Review's terms of reference, and
- Are interested in participating in the Review's interview stage.

You may also be invited to be interviewed by the Review Team where SJAI has indicated that you may have information or insights that may be useful to the Review Team's work. Please note that the areas to be examined by the Review Team relate to:

- how complaints of child sexual abuse were handled by SJAI and
- assessing current child safeguarding practices within SJAI and to make recommendations on child safeguarding practices.

This means that the matters discussed during your interview will be focused on these areas. Please be reminded that it is not the Review Team's role to investigate any allegation or complaint. This means that it is not the Review Team's role to make any findings in relation to whether any allegations raised or complaints made are well founded or not. The Review Team's role is limited to reviewing how such complaints or allegations were handled by SJAI.

If you want to have your complaint investigated, please contact An Garda Síochána or Tusla.

Do you have to take part in the interview stage of the Review?

You are not obliged to participate in the interview stage of this Independent Review. Your participation is voluntary. If at any time during the interview you wish to end your participation, please let us know and we will bring the interview to a close.

However, notwithstanding the above please note that SJAI has asked any serving member or former member to participate in the Review.

How will the interview be conducted?

If you prefer to be interviewed in-person, subject to pandemic public health restrictions, we will conduct your interview in a corporate suite in the Ashling Hotel, Parkgate Street, Dublin 8, D08 K8P5. These interviews will be audio-recorded using digital audio recording devices. A transcript of your interview will be prepared.

If you prefer to be interviewed remotely, we will conduct your interview using an encrypted version of the Zoom video conferencing platform. These interviews will be audio-recorded using Zoom's audio-recording feature.

These interviews will be conducted at a time and day that suits you during October / November 2021.

Your interview time will be confirmed with you before the interview takes place.

What do I need to do to prepare for my interview?

In preparing for your meeting with the Review Team, you may find it helpful to prepare a short summary of the matters which you would like to discuss with the Review Team, which addresses:

1. Your knowledge of any written or verbal complaints of sexual abuse that were made to officials in SJAI;
2. Your knowledge of how any complaints of sexual abuse were dealt with by officials in SJAI;
3. Your knowledge, if any, of current child safeguarding practices within SJAI.

If you wish, you can share any information or documentation you hold about these issues with the Review Team in advance of your meeting. However, there is no obligation for you to do so. If you wish to send any information or documentation to the Review Team in advance, please send this to g.shannon@stjohnambulancereview.ie.

Who will I be interviewed by?

You will be interviewed by the Review Team. The Review Team comprises Dr Geoffrey Shannon, Ms Hilary Coveney and Dr Cian Ó Concubhair.

Will data be shared by the SJAI with the Review Team?

Yes. SJAI will share data relevant to the Review Team's functions at the request of the Review Team. The type of data to be shared includes any past complaints, relevant personnel and HR information and any other notes or documents that may assist the Review Team with its work.

All data furnished by the SJAI to the Review Team for the purposes of the Review will be returned to the SJAI when the Review Team submits its Report to the Board of SJAI. The Review Team will not retain any of this data whatsoever beyond the date of the submission of its Report to the Board of the SJAI.

Any request for access to SJAI related personal data after the date of the submission of the Report to the Board of SJAI should therefore be made directly to SJAI and not to the Review Team.

Please see the Review Team's Privacy policy which contains further detail in relation to how we process your personal data.

How will we treat the information that you provide us in the interview?

Your interview will be audio recorded in digital form. This recording will be securely stored in encrypted folders on password protected electronic devices. All documentation and information which you provide to the Review Team, before or after your interview or before the Review Team submits its Report to the Board of SJAI will be kept strictly confidential.

The audio recording of your interview will be transcribed using a professional transcription service. This is done to allow the Review Team to better analyse and use your contributions. Once the transcript is prepared, you will be invited to attend a further meeting with either the Review Team or one or two of the members thereof to enable you to read through the transcript and to sign it to confirm that you agree with its contents.

Transcribed versions of your interview will be securely stored in encrypted folders on password protected electronic devices.

Your interviews in either audio or transcribed form will be kept strictly confidential, and will only be shared between members of the Review Team. We will not share your interview with SJAI. All interview notes, interview recordings and any other documentation created by the members of the Review Team in the course of their work in this review will be stored securely. Only the three Review Team members will have authorised access to this information. Any information created by the Review Team, including information in connection with the interview process, will be securely retained and held for a period of one year after the submission of its Report to the Board of the SJAI, unless there is a legal requirement to retain the information for longer or the Review Team deems it necessary to extend the retention period. If such a scenario presents, you will be informed.

We will work carefully to remove information which may identify you from any of your contributions which we choose to incorporate in the Review's Report. This "data removal" process will involve changing identifying names, addresses, ages (to include the approximate time alleged behaviours took place), genders, locations and any other information that in the Review Team's view, may identify an individual. Our aim is to only include "non-identifying" contributions

from your interview as part of the Report, which will be submitted to the Board of SJAI, to protect your privacy.

Am I entitled to counselling?

We have provided you with details of counselling, which you may wish to avail of and which have been arranged by SJAI. Please note that the Review Team is not involved in this counselling in any way. If you decide to avail of counselling through TherapyHub or elsewhere, you do not need to disclose this to the Review Team. However, if you wish to do so, please be assured that this information will be kept confidential and will be appropriately secured in line with the Review Team's Privacy Policy.

Will the Review's Report be published?

The decision on whether to publicise the Report, or to share it with you, (in full or in part) rests with the Board of SJAI and not with the Review Team. The Review Team understands that it is the intention of the Board that our Report will be published.

Can I access my personal data and interview?

Yes, however all data furnished by SJAI to the Review Team for the purposes of the Review will be returned to SJAI on the date of the submission of the Report.

Any confidential interview notes, recordings or other documentation relating to voluntary contributions of information by you or the interview process, together with any related personal data created by the Review Team, will be retained only for one year from the date of the submission of the Report to the Board. This data will be destroyed on the expiration of the one year retention period, unless there is a legal requirement to retain the data for longer or the Review Team deems it necessary to extend the retention period.

When files are destroyed, it will not be possible for the Review Team to facilitate access to your interview or other personal data processed by the Review Team for the purposes of its Review.

If you would like to access your interview (or any other personal data the Review Team processes in relation to you) in either audio-recorded or transcribed form, you can do so by contacting the Review Team after the Report is

submitted to the Board and before they are deleted one year after the date the Report is submitted to the Board.

Please contact the Review Team at g.shannon@stjohnambulancereview.ie to submit your data subject access request to access your interview and other personal data.

Further information in relation to how your personal data is used and your rights in relation to the personal data is contained in the Review Team's Privacy policy.

Are there circumstances where we may be compelled to share your interview outside the Review Team?

While we will treat your interview with strict confidentiality, there may be circumstances where we are legally compelled to share the audio recording and transcript of your interview with others outside the Review Team.

We will only share such interview materials outside the Review Team if we are directed by law to do so.

SJAI may choose to share this Report with you and other participants in the Review, or to publish the Report for the general public to read. The decision on whether to publish the Report, or to share it with you, (in full or in part) rests with the Board of SJAI and not with the Review Team. Again, there will be no reference to any names in the Report.

Deletion procedure for interview files

We will arrange for your interview files to be stored in encrypted folders on password protected devices for a period of one year following the submission of the Report to SJAI or for such extended period as may be required by law or as the Review Team may determine. At the conclusion of this period, all files relating to the Independent Review will be deleted or destroyed.

Please see our Privacy Policy for further information in relation to our approach to data retention and data destruction.

Who do I contact if I have any questions or concerns?

If at any time you wish to discuss your participation in the Independent Review, please contact Geoffrey Shannon at g.shannon@stjohnambulancereview.ie.

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Dr Geoffrey Shannon

Dr Geoffrey Shannon is a solicitor and senior lecturer in Child Law and Family Law at the Law Society of Ireland. He held the role of Special Rapporteur on Child Protection for the Irish government from 2006 to July 2019.

In 2010, he was appointed by the Government to chair the Independent Child Death Review. The Independent Child Death Review Group (ICDRG) examined the deaths of 196 children who died in state care between 2000 and 2010.

Dr Shannon is the recipient of several awards for his work in the area of national and international family

law. These include the 2005 JCI Outstanding Person of the Year Award, the 2006 Canon Maurice Handy Award and the 2013 Irish Law Award. On 23 June 2017, Mr Justice Peter Kelly, former President of the Irish High Court presented Dr Shannon with the Dublin Solicitors Bar Association Award for outstanding contribution to legal scholarship for his entire work to date.

Hilary Coveney BCL (UCC), LLM

Hilary Coveney is a solicitor specialising in Family and Private Client law. She is a former Chair of the Law Society Family Law Committee and the Dublin Solicitors Bar Association (DSBA) Family Law Committee. She is also a former member of the Law Society Council.

Hilary has wide-ranging experience in international family law and is a Fellow of the International Academy of Family Lawyers (IAFL). She was the Irish representative on the CCBE (Council of Bars and Law Societies of Europe) Family Law and Succession Working Group from 2008 until 2012.

Hilary was a member of the Review Group appointed by An Garda Síochána and chaired by Dr Geoffrey Shannon to conduct an audit into child protection powers under the Child Care Act 1991 (Report published 2017).

Dr Cian Ó Concubhair LLB (Dub), BCL, DPhil (Oxon)

Dr Ó Concubhair is Assistant Professor of Criminal Justice at Maynooth University Department of Law.

A graduate in law from both Trinity College Dublin and the University of Oxford, Dr Ó Concubhair researches and teaches in the fields of criminal law and policing, with a particular focus on the role of policing in child abuse investigation.

Alongside his academic work, Dr Ó Concubhair also participated in Dr Geoffrey Shannon's 2017 Audit of An Garda Síochána's Child Protection powers under the Child Care Act 1991.

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Contact the Review Team

If you have information you believe is relevant to the Review, please email the Review Team on the below address, or fill out the contact form opposite.

The Review uses the highly secure Tutanota email service.

All communications will be treated with the utmost care and confidentiality.

Email the Review Team
g.shannon@stjohnambulancereview.ie

Name *

First Name Last Name

Email *

Phone *

(###) ### ####

Subject *

Message *

If you prefer not to email, you can also **leave a voicemail** for the Review Team by **telephoning +353 87 719 5363**

Please leave your name and contact details in your voice message so we can respond to your communication

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Making contact with the Review Team

If you have been personally affected by matters relating to this Review, or have direct knowledge about such matters, I am inviting you to come forward to share your experiences and knowledge.

I would be grateful to hear from anyone who may have information on any matters relevant to the above Review Process.

This will greatly assist the Review and ensure I have as much information as possible.

I understand and appreciate how difficult it may be to revisit the past and the courage required to tell others of these events. I hope that this Review process can offer an opportunity for survivors and participants to be heard and I will endeavour to make sure that the Review and all meetings are carried out in as sensitive a manner as possible.

All information provided to the Review will be treated as confidential.

In accordance with the Terms of Reference, I may also meet with members and former members of SJAI, to gather as much information as possible to properly undertake the Review.

Due to ongoing Covid-19 restrictions, it may be necessary to conduct some meetings remotely. Full information as to what is involved will be provided and any technical assistance which may be required so as to ensure the full participation and involvement of all interested parties.

How the Review will treat your communications

Any information you share, or disclosures you make to the Review will be treated with care and confidentiality.

Your contributions will form part of the Independent Review's examination of past and present child protection practices in St John Ambulance Ireland.

Your contributions may also form part of the Review's final report to St John Ambulance Ireland.

This final report will be presented to the Board of SJAI.

We will carefully remove certain data contained within your contributions which we choose to include in the Review's final report. This data removal process will involve changing identifying names, addresses, ages (to include the approximate time alleged behaviours took place), genders, locations and any other information that in the Review Team's view, may identify an individual. We will only include non-identifying contributions in the final report.

Any interview with you will be audio recorded in digital form. The audio recording of your interview will also be transcribed using a professional transcription service.

All of the above information will be securely retained and held for a period of one year after the submission of the final report to the Board of the SJAI, unless there is a legal requirement to retain the information for longer or the Review Team deems it necessary to extend the retention period.

After this 1-year period, your data will be destroyed in line with best data management practices. When files are destroyed, it will not be possible for the Review Team to facilitate access to your interview or other personal data processed by the Review Team for the purposes of its Review.

If you would like to access your interview (or any other personal data the Review Team processes in relation to you) in either audio-recorded or transcribed form, you can do so at any time before those files are deleted.

While all disclosures you make to the Review will be treated with care and confidentiality, there are circumstances in which we may be legally compelled to share your disclosures. You will be fully informed if such circumstances arise.

More information about this will be provided to you prior to any interviews we may conduct with you.

We look forward to hearing from you.

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Review's Terms of Reference

The Terms of Reference published by SJAI on 8 March 2021 state as follows:

St. John Ambulance Ireland (SJAI) is aware of a number of complaints of sexual abuse of members under the age of 18 years relating to one former volunteer member who ceased volunteering with SJAI circa 2000/1. The Board of St. John Ambulance Ireland has commissioned an independent review to undertake a review of the adequacy and effectiveness of:

Part I:

I. the manner in which the aforesaid complaints in relation to sexual abuse made to the SJAI were dealt with when first made taking into account government guidance and SJAI policies on child protection available at that time; the manner in which such complaints were dealt with when re-reported in 2013 taking into account government guidance on child protection and SJAI policies available at that time;

II. whether there were any other complaints (whether in writing or verbal to any person in a position of authority) regarding grooming or abuse in relation to the volunteer concerned over his period of involvement with SJAI, and

III. any other complaints (whether in writing or verbal to any person in a position of authority) relating to any other individual based on reports made to and/or records held by SJAI: and

Part II

I. the adequacy of arrangements now in place for the protection of children and vulnerable adults who may come into membership of SJAI having regard to TUSLA's assessment in July 2019;

all with a view to identifying learning and making recommendations for the organisation.

The Report will be to the Board of SJAI.

Members of SJAI will offer full co-operation to the reviewer as he determines.

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The Review will comprise a comprehensive review of all files held by SJAI and an opportunity for you to meet with the Review Team.

The Review Team will also be meeting with various members and former members of SJAI as set out in the Terms of Reference below.

My role as Independent Reviewer

As Independent Reviewer, I see my role as twofold:

1 – Retrospective Review:

To undertake a detailed review of all documentation and information regarding past complaints of abuse within SJAI in accordance with the Terms of Reference.

2 – Contemporary Review:

To review current safeguarding arrangements employed by SJAI with a view to making any recommendations which I may consider appropriate for SJAI to implement, both now and in the future.

I believe that all information from survivors of abuse and anyone with any knowledge of such events will be fundamental to enable the Review to be carried out properly and fully.

The Terms of Reference published by SJAI on 8 March 2021 state as follows:

a) A review of files held by SJAI on past Safeguarding complaints;

b) An opportunity for complainants to meet confidentially with the Reviewer and to outline their experiences of making Safeguarding complaints to SJAI;

c) An opportunity for the Reviewer to meet with any Member of SJAI with a view to understanding that person's roles and responsibilities in relation to any complaints he/she may have had reported to him/her in his/her time in SJAI;

d) An opportunity for any Member of SJAI identified by a complainant as a recipient of a complaint to inform the Reviewer in relation to his/her actions on foot of his/her receipt of any such complaint;

e) Former Members of SJAI are encouraged to assist the Reviewer by

meeting him at his request to share any information or insights he/she may have on how past complaints were managed;

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Timeline for the Review

The Review is currently in the early preparatory stages, and I am attempting to navigate the challenges presented by the Covid-19 pandemic in conducting an effective review.

I can, however, provide a rough outline of the process, and my ambitions for when different stages will begin.

- **Spring–Summer 2021:** During this time I am inviting those with information relevant to the Review to make contact with the Review Team. The Review team will also begin the important work of gathering and reviewing relevant documentation.
- **Summer–Autumn 2021:** Subject to Covid-19 pandemic restrictions, it is my ambition that the Review Team will begin conducting interviews in early Autumn. If it proves possible to organise these interviews earlier, that will be arranged.

Given the sensitive nature of this review, I believe in-person interviews are the most appropriate format. However, this is subject to the safety of both survivors, review participants, and the review team, and any Covid-19 restrictions which may then be in place. If in-person interviews cannot be facilitated, the Review Team will attempt to facilitate secure remote meetings with survivors and participants.

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Getting Help

I understand that the matters at issue in this Review may be very upsetting for you.

I encourage you to reach out to the following available resources:

Samaritans Ireland

Contact Samaritans Ireland

One In Four

Contact One in Four

Rape Crisis Network Ireland

Contact Rape Crisis Network Ireland

An Garda Síochána

Contact An Garda Síochána

The Child and Family Agency: Tusla

Contact Tusla

HSE Mental Health Services

Contact HSE Mental Health Services

Aware Mental Health

Contact Aware

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Appendix IV

Interview Questionnaire

Independent Review Interview Questionnaire

Participant Questionnaire

Non-recent cases of child sexual abuse

- **(First question should establish if interviewee is a potential complainant/victim-survivor – if so revert to Complainant Questionnaire)**
- **Were you personally affected by grooming or sexual abuse during your time in SJAI?**

General introduction questions:

1. How long have you been a member of SJAI?
2. Which branch are you a member of?
3. Can you describe your role within SJAI?

4. Are you aware of any members or former members of SJAI having suffered abuse – including grooming and sexual abuse – by other members of SJAI?
    a. Do you recall the circumstances around your learning of this abuse?

5. Did you discuss this with anyone else in SJAI, including other volunteers or senior members in the organisation?
    a. Can you recall with whom you discussed it?
    b. To the best of your knowledge, would a record of this have been kept by SJAI?
    c. What happened after you discussed it?
    d. How were you treated by members of SJAI after you discussed it?

6. Did you ever make a formal complaint about this to anyone in SJAI or anywhere else (including An Garda Síochána, Tusla, Charities Regulator)?
    a. Can you recall with whom you made the complaint?
    b. What happened after you made your complaint?
    c. To the best of your knowledge, was this complaint recorded?
    d. If the complaint was internal, how were you treated after your complaint?

7. Do you think the response of SJAI to this abuse was adequate?

8. Are you aware of any formal processes within SJAI for making complaints or raising grievances about other members of SJAI?

Questions relating directly to alleged perpetrator's branch to be put to members in positions of authority

9. It has been suggested by a number of participants assisting this Review, that the branch managed by the alleged perpetrator was not permitted to have a cadet division.

   Do you know why this was the case?

   (If participants answer 'no' – put the following question to them)

   Some participants in this independent review have suggested the alleged perpetrator's branch was not permitted to have cadets because of fears for their safety.

   Does this sound like an accurate explanation?

   If the participant answers yes, ask:

   Why did SJAI not do more to address this perceived risk?

Scenarios to be put to currently serving members

10. If you became aware that an adult SJAI member had been routinely attending public duties, but had not yet undergone Garda vetting, what would you do?

11. If you became aware that an adult SJAI member was giving cadets lifts home in their car, without any other adult member being present, what would you do?

12. If a cadet approached you, and raised their concerns that an adult SJAI member was involved in an intimate relationship with a cadet, what would you do?

Organisational Culture Questions

13. How would you describe the organisational culture or environment in SJAI?
    a. Would you describe SJAI as a professional organisation? Why/not?
    b. Was SJAI aware and responsive to the needs and vulnerabilities of its members? Why/not?
    c. Was SJAI an open and transparent organisation? Why/not?

General Questions

1. What changes would you like to see happen in SJAI following this Independent Review?

2. Do you have confidence in SJAI to carry out these changes? Why/Why Not?

Appendix V

Letter to Interview Participants

The St John Ambulance Review

[Date]

To: [Name of Participant]

Meetings with the Review Team

Dear [Name of Participant]

Thank you very much for your interest in meeting with me and with my colleagues on the St John Ambulance Ireland ("**SJAI**") Review Team. We are a team of three people: Ms Hilary Coveney (Solicitor), Dr Cian O'Concubhair (Law Lecturer) and me (Solicitor and Senior Counsel).

This letter explains how you can take part in the Review. As you may know, I have been asked to independently review how SJAI handled complaints of sexual abuse in the past, as well as to review SJAI's current arrangements for safeguarding children.

I understand that telling your experience to the Review Team may be difficult. I am extremely grateful to you for coming forward to share your experience and we will try to make the meeting as comfortable as possible. We can take breaks during the meeting, if you wish, and give you every opportunity to tell us about your experience in a supportive and safe environment.

If you think it would be of assistance, you can attend the meeting with a friend or someone who can support you. If you would like someone to attend with you, please let us know before the meeting. It is important that this person would attend in a support capacity only and that you would provide your account of events in your own words.

Before our meeting, please let me tell you a bit more about:

- the Review,
- next steps if you decide to take part, and
- the documents we are sending to you with this letter.

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1. About the Review

It is important that you know what the Review process is for, and what it will involve so that you can be sure that you still wish to take part. SJAI dealt with complaints of sexual abuse of SJAI members under the age of 18 in the past. We will consider if SJAI handled these complaints correctly under the guidelines in place at the time. We will decide this based on our:

- study of relevant SJAI documents, and
- interviews with anyone who may have information about how SJAI handled complaints about abuse, and
- study of how well current arrangements protect children and vulnerable adults who may join or become involved with SJAI.

When we have done this, we will see what we have learned and make recommendations to SJAI about its current child safeguarding practices.

What we will not investigate

The Review Team will not investigate any complaint or allegation of abuse identified during the Review. We do not have the power to do this. We would urge you to contact An Garda Síochána (details below) for this type of investigation if you wish. We also do not want to do anything which might interfere with any existing or future criminal investigations or prosecutions.

If you wish to have your complaint or allegation investigated, please contact An Garda Síochána at telephone number **1800 555222** or Tusla, the Child and Family Agency (**www.tusla.ie**). This Garda telephone number is operated 24 hours a day 365 days a year to deal with complaints and allegations of sexual abuse.

2. Next steps if you decide to take part

If you wish, you can email us any information or documents that you feel are relevant before your meeting.

You might also find it helpful to write a **short note for yourself** about what you would like to tell us, or you can ask someone to help you with this. If you can, please include:

- Your knowledge of any written or verbal complaints of sexual abuse that were made to officials in SJAI;
- Your knowledge of how SJAI officials dealt with any complaints of sexual abuse;
- Your knowledge, if any, of current child safeguarding practices within SJAI.

If you wish, you can share your note with us in advance of our meeting, but you do not have to. We will meet with you whether you send us any information in advance, or not. We will keep your information confidential unless we are obliged by law to share your disclosures. You can find out more about how the Review will deal with any information you share with us on our website www.stjohnambulancereview.ie .

3. Documents we are sending you with this letter

The Review Team want you to understand what is involved if you decide to take part in the Review meeting. That is why we are available to answer your questions.

We have sent you five documents with this letter. We know it is a lot of information to ask you to read, especially online. Please take your time to read through them **or** ask someone you trust to help you understand them.

While all of these documents are important, we ask you to pay particular attention to the **Consent document.** This is a document that we will ask you to sign at the start of our meeting. We will talk you through it on the day, but it is better if you read it carefully before we meet, if possible.

There will be an audio recording of our meeting and a transcript of the recording will be available for review following the meeting, if required.

We are here to help you with any questions you have about this letter or the information we sent you.

Thank you once again for your interest in taking part in the Review. Please do not hesitate to send me any questions you have to g.shannon@stjohnambulancereview.ie.

The St John Ambulance Review

I look forward to hearing from you.

Kind regards.

Yours sincerely

Dr Geoffrey Shannon

The St John Ambulance Review

List of documents we have sent you

1. **A consent document for you to read, study and sign (or make your mark on) at our meeting**

   This short document tells you about what it means if you consent (agree) to take part in the Review. It is the one the Review Team will ask you to sign at the start of our meeting.

2. **Information about counselling**

   This document tells you about the free counselling which is available to be provided for participants. Please do not hesitate to let me know if you have any queries or would like any further information on this, which I will be happy to obtain from SJAI if you would like to look into this counselling option.

3. **A Transparency Notice**

   This note explains the role of our Review Team, how you can help us and other general information about how we will carry out the Review.

4. **A Privacy Policy**

   This document is about how and why we use your personal data and our obligations under Data Protection laws. The Review Team is committed to protecting your privacy and security.

5. **Terms of Reference of the Review**

   This document lists what the Review will study and that our report will be provided to the Board of SJAI.

We have sent you these documents and we hope that they will be of help. If it would be helpful, we encourage you to talk to a person you know about these documents and what taking part in the Review will mean for you.
We are also here to answer your questions. Email us at:
g.shannon@stjohnambulancereview.ie

Appendix VI

Interview Consent Terms

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Confirmation of Consent to Participate

1. I confirm that I have read the interview Transparency Notice (enclosed in letter from the Review Team) and this consent document ☐

   Or

   I confirm that I have had the interview Transparency Notice and this consent document read out and explained to me. ☐

2. I understand that this Independent Review has been commissioned by St. John Ambulance Ireland (SJAI). The Independent Review will be undertaken by a Review Team comprising of Dr Geoffrey Shannon, Hilary Coveney and Dr Cian Ó Concubhair. ☐

3. I understand the scope of the Independent Review as set out in the Terms of Reference published by SJAI on 8 March 2021. I understand that the Review Team is tasked with the role of assessing: ☐

   - how complaints of child sexual abuse were handled by SJAI and
   - to assess current child safeguarding practices within SJAI and to make recommendations on child safeguarding practices.

4. I understand that the Terms of Reference do not allow the Review Team to undertake any investigation as to the merits or otherwise of any allegation or complaint identified in the course of the Independent Review, as this falls to the statutory authorities such as An Garda Síochána and Tusla. I understand the Independent Review is limited to reviewing how such complaints or allegations were handled by SJAI. I understand that the Report furnished to the Board of SJAI will not make any recommendations concerning the investigation of specific complaints, which might interfere with or prejudice any future criminal investigations or prosecutions, nor will the Report make any recommendations in relation to disciplining or taking any action in relation to any individual but that the Report will address how SJAI handled the complaints or allegations made to it. I understand that I should contact An Garda Síochána if I wish to have my complaint and/or allegation subject to investigation. ☐

5. I understand that my participation in this interview stage of the Independent Review is voluntary and that I am free to withdraw myself, at any time, without giving any reason, and without any adverse consequences to me. ☐

6. I understand that my interview(s) with the Review Team will be recorded and that the recordings will be transcribed by a professional transcriber. ☐

7. I understand and agree that after the Review Team has removed any information from my interview notes or transcript that identify me, that the interview notes or transcript may form part of the Review Team's Report shared with the SJAI. I understand that I will not be named in the Report. I consent to my interviews and other necessary personal data being shared in this manner. ☐

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8. I understand that there are two main types of personal data (potentially) processed by the Review Team in relation to me. Type 1 is personal data shared by SJAI with the Review Team. Type 2 is personal data provided by me to or created by the Review Team. ☐

9. I understand and agree that Type 1 data will be returned to the SJAI when the Review Team submits its Report to the Board of SJAI. ☐

10. I understand that Type 2 data is confidential and will be removed prior to the inclusion by the Review Team of any of my voluntary contribution(s) in the final report. I understand that Type 2 data will not be shared by the Review Team with SJAI or any other person, authority or body, except in the limited circumstances referenced in the Privacy Policy (enclosed in letter from the Review Team) or unless the Review Team is required to share it by law. ☐

11. I understand how personal data will be stored, and what will happen to the data at the end of the Independent Review and how the data will be protected. ☐

12. I understand how to raise concerns or make a complaint in connection with my consent to being audio recorded. ☐

13. I consent to those audio recordings, in transcribed form, being used in the final report of this Independent Review. ☐

14. I agree to take part in the interview stage of this Independent Review. ☐

Name of Participant: _____

Signature: _____ Date: _____

Appendix VII

Transparency Notice

The St John Ambulance Review

Transparency Notice

Background

St. John Ambulance Ireland (SJAI) has commissioned Dr Geoffrey Shannon to conduct this Independent Review.

The Review Team comprises Dr Geoffrey Shannon, Ms Hilary Coveney and Dr Cian Ó Concubhair.

1. This document outlines the nature and remit of this Independent Review, including:
    - What the Review Team under Dr Geoffrey Shannon has been asked to examine;
    - What the Review Team is precluded from examining;
    - How the Review Team will conduct this Review; and
    - What the Review Team hopes to achieve by meeting with, and talking to you.
2. This document also explains how we will treat any information you disclose to us during these interviews, and the safeguards we will adopt in protecting you and your rights.
3. Finally, this document seeks to ensure that your voluntary consent to participate in this review is fully informed.

Commitment to Confidentiality and Data Privacy

The Review Team is very conscious of the sensitivity of the issues to be discussed during the Review. This transparency notice and related privacy policy set out our commitment to managing your data privacy respectfully and in line with our obligations.

We commit to keeping all documentation generated by us in the course of the Review confidential. Any data created by us will not be shared with SJAI or with any other third party, unless we are required by law to disclose it. We use sophisticated technology methods to secure the data you share with us and only the Review Panel and our Transcriber Company has authorised access to the data. Here, we explain who we are, how we process your data, why we process it, how long we retain it for and we explain how you can access your personal data and exercise other data protection rights. Our goal is to deliver on the aims of the Review, as set out below, to assist in the maintenance of a comprehensive child-focussed culture and environment that is safe for all. Thank you for helping us achieve this aim.

Aims of this Review

This Independent Review was commissioned by SJAI in response to allegations made against a former volunteer in SJAI.

The Review Team will produce a Report setting out its findings and this Report will be submitted to the Board of SJAI.

There are two primary aims for this Independent Review in the production of its Report:

The St John Ambulance Review

1. To examine how complaints of child sexual abuse were handled by SJAI.

2. To assess current child safeguarding practices within SJAI.

The Report drafted by the Review Team will not identify individual fault or failings by members of SJAI, nor will any individuals (including any participants such as you) be named in any report furnished by the Review Team to the Board of SJAI. The Terms of Reference published by SJAI on 8 March 2021 (copy attached) do not allow the Review Team to undertake any investigation as to the merits or otherwise of any allegation or complaint identified in the course of the Independent Review as such matters are reserved to the statutory authorities such as An Garda Síochána. The Independent Review is limited to reviewing how such complaints or allegations were handled by SJAI. The Report furnished to the Board of SJAI will not make any recommendations concerning the specifics of individual complaints.

Instead, this Independent Review is designed to identify systemic and / or cultural issues within the SJAI organisation in relation to child protection and safeguarding. It is open to anyone to make a complaint to An Garda Síochána in relation to any issue of concern to them.

This Independent Review is also designed to give you an opportunity to tell your story, and have your experiences and views considered and included in the Review Team's Report.

The Review Team's functions will cease on the date of the provision of its Report to the Board of SJAI.

Why have you been invited for interview?

You have been invited for interview by the Review Team as you have contacted us and indicated that you:

- Possess information and knowledge relevant to the Review's terms of reference, and
- Are interested in participating in the Review's interview stage.

You may also be invited to be interviewed by the Review Team where SJAI has indicated that you may have information or insights that may be useful to the Review Team's work. Please note that the areas to be examined by the Review Team relate to:

- how complaints of child sexual abuse were handled by SJAI and
- assessing current child safeguarding practices within SJAI and to make recommendations on child safeguarding practices.

This means that the matters discussed during your interview will be focused on these areas. Please be reminded that it is not the Review Team's role to investigate any allegation or complaint. This means that it is not the Review Team's role to make any findings in relation to whether any allegations raised or complaints made are well founded or not. The Review Team's role is limited to reviewing how such complaints or allegations were handled by SJAI.

If you want to have your complaint investigated, please contact An Garda Síochána or Tusla.

The St John Ambulance Review

Do you have to take part in the interview stage of the Review?

You are not obliged to participate in the interview stage of this Independent Review. Your participation is voluntary. If at any time during the interview you wish to end your participation, please let us know and we will bring the interview to a close.

However, notwithstanding the above please note that SJAI has asked any serving member or former member to participate in the Review.

How will the interview be conducted?

If you prefer to be interviewed in-person, subject to pandemic public health restrictions, we will conduct your interview in a corporate suite in the Ashling Hotel, Parkgate Street, Dublin 8, D08 K8P5. These interviews will be audio-recorded using digital audio recording devices. A transcript of your interview will be prepared.

If you prefer to be interviewed remotely, we will conduct your interview using an encrypted version of the Zoom video conferencing platform. These interviews will be audio-recorded using Zoom's audio-recording feature.

These interviews will be conducted at a time and day that suits you during October / November 2021.

Your interview time will be confirmed with you before the interview takes place.

What do I need to do to prepare for my interview?

In preparing for your meeting with the Review Team, you may find it helpful to prepare a short summary of the matters which you would like to discuss with the Review Team, which addresses:

1. Your knowledge of any written or verbal complaints of sexual abuse that were made to officials in SJAI;

2. Your knowledge of how any complaints of sexual abuse were dealt with by officials in SJAI;

3. Your knowledge, if any, of current child safeguarding practices within SJAI.

If you wish, you can share any information or documentation you hold about these issues with the Review Team in advance of your meeting. However, there is no obligation for you to do so. If you wish to send any information or documentation to the Review Team in advance, please send this to g.shannon@stjohnambulancereview.ie.

Who will I be interviewed by?

You will be interviewed by the Review Team. The Review Team comprises Dr Geoffrey Shannon, Ms Hilary Coveney and Dr Cian Ó Concubhair.

The St John Ambulance Review

Will data be shared by the SJAI with the Review Team?

Yes. SJAI will share data relevant to the Review Team's functions at the request of the Review Team. The type of data to be shared includes any past complaints, relevant personnel and HR information and any other notes or documents that may assist the Review Team with its work.

All data furnished by the SJAI to the Review Team for the purposes of the Review will be returned to the SJAI when the Review Team submits its Report to the Board of SJAI. The Review Team will not retain any of this data whatsoever beyond the date of the submission of its Report to the Board of the SJAI.

Any request for access to SJAI related personal data after the date of the submission of the Report to the Board of SJAI should therefore be made directly to SJAI and not to the Review Team.

Please see the Review Team's Privacy policy which contains further detail in relation to how we process your personal data.

How will we treat the information that you provide us in the interview?

Your interview will be audio recorded in digital form. This recording will be securely stored in encrypted folders on password protected electronic devices. All documentation and information which you provide to the Review Team, before or after your interview or before the Review Team submits its Report to the Board of SJAI will be kept strictly confidential.

The audio recording of your interview will be transcribed using a professional transcription service. This is done to allow the Review Team to better analyse and use your contributions. Once the transcript is prepared, you will be invited to attend a further meeting with either the Review Team or one or two of the members thereof to enable you to read through the transcript and to sign it to confirm that you agree with its contents.

Transcribed versions of your interview will be securely stored in encrypted folders on password protected electronic devices.

Your interviews in either audio or transcribed form will be kept strictly confidential, and will only be shared between members of the Review Team. We will not share your interview with SJAI. All interview notes, interview recordings and any other documentation created by the members of the Review Team in the course of their work in this review will be stored securely. Only the three Review Team members will have authorised access to this information. Any information created by the Review Team, including information in connection with the interview process, will be securely retained and held for a period of one year after the submission of its Report to the Board of the SJAI, unless there is a legal requirement to retain the information for longer or the Review Team deems it necessary to extend the retention period. If such a scenario presents, you will be informed.

We will work carefully to remove information which may identify you from any of your contributions which we choose to incorporate in the Review's Report. This "data removal" process will involve changing identifying names, addresses, ages (to include the approximate time alleged behaviours took place), genders, locations and any other information that in the Review Team's view, may identify an individual. Our aim is to only include "non-identifying" contributions from your interview as part of the Report, which will be submitted to the Board of SJAI, to protect your privacy.

The St John Ambulance Review

Am I entitled to counselling?

We have provided you with details of counselling, which you may wish to avail of and which have been arranged by SJAI. Please note that the Review Team is not involved in this counselling in any way. If you decide to avail of counselling through TherapyHub or elsewhere, you do not need to disclose this to the Review Team. However, if you wish to do so, please be assured that this information will be kept confidential and will be appropriately secured in line with the Review Team's Privacy Policy.

Will the Review's Report be published?

The decision on whether to publicise the Report, or to share it with you, (in full or in part) rests with the Board of SJAI and not with the Review Team. The Review Team understands that it is the intention of the Board that our Report will be published.

Can I access my personal data and interview?

Yes, however all data furnished by SJAI to the Review Team for the purposes of the Review will be returned to SJAI on the date of the submission of the Report.

Any confidential interview notes, recordings or other documentation relating to voluntary contributions of information by you or the interview process, together with any related personal data created by the Review Team, will be retained only for one year from the date of the submission of the Report to the Board. This data will be destroyed on the expiration of the one year retention period, unless there is a legal requirement to retain the data for longer or the Review Team deems it necessary to extend the retention period.

When files are destroyed, it will not be possible for the Review Team to facilitate access to your interview or other personal data processed by the Review Team for the purposes of its Review.

If you would like to access your interview (or any other personal data the Review Team processes in relation to you) in either audio-recorded or transcribed form, you can do so by contacting the Review Team after the Report is submitted to the Board and before they are deleted one year after the date the Report is submitted to the Board.

Please contact the Review Team at g.shannon@stjohnambulancereview.ie to submit your data subject access request to access your interview and other personal data.

Further information in relation to how your personal data is used and your rights in relation to the personal data is contained in the Review Team's Privacy policy.

Are there circumstances where we may be compelled to share your interview outside the Review Team?

While we will treat your interview with strict confidentiality, there may be circumstances where we are legally compelled to share the audio recording and transcript of your interview with others outside the Review Team.

We will only share such interview materials outside the Review Team if we are directed by law to do so.

The St John Ambulance Review

SJAI may choose to share this Report with you and other participants in the Review, or to publish the Report for the general public to read. The decision on whether to publish the Report, or to share it with you, (in full or in part) rests with the Board of SJAI and not with the Review Team. Again, there will be no reference to any names in the Report.

Deletion procedure for interview files

We will arrange for your interview files to be stored in encrypted folders on password protected devices for a period of one year following the submission of the Report to SJAI or for such extended period as may be required by law or as the Review Team may determine. At the conclusion of this period, all files relating to the Independent Review will be deleted or destroyed.

Please see our Privacy Policy for further information in relation to our approach to data retention and data destruction.

Who do I contact if I have any questions or concerns?

If at any time you wish to discuss your participation in the Independent Review, please contact Geoffrey Shannon at g.shannon@stjohnambulancereview.ie.

Appendix VIII

Privacy Policy

St. John Ambulance Ireland ("SJAI") Independent Review (the "Review")

Dr Geoffrey Shannon, Hilary Coveney and Dr Cian Ó Concubhair (the "Review Team")

Privacy Policy

The Review Team is committed to protecting your privacy and security. This Privacy Policy explains how and why we use your personal data. It is intended to help ensure that you remain informed and in control of your information. This Privacy Policy also contains information about how you can access your personal data and exercise other data protection rights.

Our goal is to deliver on the aims of the Review and to assist in the maintenance of a comprehensive child-focused culture and environment that is safe for all. We are mindful of our data protection obligations, including under the General Data Protection Regulation ("**GDPR**"), when seeking to achieve this goal.

1. Who we are

The Review Team in the course of carrying out the Review is a "**controller**" of your personal data. This means that we determine the purposes and means by which any personal data about you that is collected is used.

You can contact the Review Team in a number of ways, which are set out in the 'Contact us' section (see section 13).

2. Your Personal Data

This Privacy Policy applies to anybody who participates in the Review interview process. It also applies to other relevant individuals whose personal data may be collected and used by the Review Team. For example, we may collect personal data about current or former members of SJAI, complainants, alleged perpetrators of abuse, witnesses, members of the SJAI Board and other SJAI personnel. We refer to each such person as "**you**" or "**your**" in this Policy.

We collect "**personal data**", which is information that identifies a living person, or which can be identified as relating to a living person.

Some of the personal data that will be collected by the Review Team will be contained within the records of SJAI that are shared with the Review Team for the purposes of the Review.

As noted above, the Review Team is a "**controller**" of the personal data collected about you, which means that we are determining the purposes and means of the processing of the data collected. In this role, we are responsible for ensuring best practice in line with the GDPR and other applicable data protection laws.

It is important that you read and understand this Privacy Policy carefully, as we would like you to be aware of why and how we are using your data, and of your rights.

3. Personal data we collect and hold

The Review Team processes personal data to assist it to carry out its role. The Review Team's role is set out fully in the Terms of Reference Document (copy attached), which is available at:

https://stjohnambulancereview.ie/terms-of-reference-for-the-review.

In summary, the areas to be examined by the Review Team include the following areas:

- how complaints of child sexual abuse were handled by SJAI and
- to assess current child safeguarding practices within SJAI and to make recommendations on child safeguarding practices.

The Review Team will process categories of personal data that are relevant to its role in carrying out its examination of these matters.

So now that we have explained our Role, it is necessary to explain what is outside the scope of our role.

It is not the Review Team's role to investigate any allegation or complaint, as this falls to the statutory authorities such as An Garda Síochána and Tusla. This means that it is not the Review Team's role to make any findings in relation to whether any allegations raised or complaints made are well founded or not. The Review Team's role is limited to reviewing how such complaints or allegations were handled by SJAI.

If you want to have your complaint investigated, please contact An Garda Síochána.

Specific examples of personal data the Review Team may collect, hold and process include:

- SJAI Membership records which may include, but which may not be limited to, the following personal data:
  - name,
  - gender,
  - address,
  - phone number or other contact information,
  - employment information,
  - relevant correspondence with current and former members of SJAI,
  - past complaints relevant to such members,
  - relevant personnel files and HR information; and
  - any other notes or documents relating to current and former members of SJAI that may assist the Review Team with its work.
- Personal data of (i) complainants in relation to the child sexual abuse complaints under examination, (ii) any individuals against whom allegations of child sexual abuse have been made and (iii) personal data of anyone privy to or who may have knowledge of the matters alleged.
- Personal data of those privy to or involved in any child safeguarding measures within SJAI (both non-recent and current) if not covered by the above categories.

- Personal data of interviewees and other persons with knowledge of the areas under examination who voluntarily come forward to provide information to the Review Team ("**Confidential Contributors**"). For example, the Review Team will:
  - process contact information provided to the Review Team (if any) by the Confidential Contributors to include address, phone number, email address;
  - generate personal data during correspondence and interviews with Confidential Contributors, including by way of transcript and audio recording.

We collect, hold and process the above categories of personal data to properly and fully investigate the allegations and complaints made and to carry out the Review in accordance with the Review Team's functions. We also ensure that we carry out our duties in accordance with the terms of reference ("**TOR**") for the Review. This processing is necessary for the performance of a task carried out in the public interest. In particular, the Review has been commissioned on foot of a recommendation by Tusla exercising its statutory powers. It involves assessing SJAI's compliance with relevant existing legislation and the approach to child protection and child welfare within the organisation. We regard these as matters of substantial public interest. This processing is also being conducted in furtherance of the legitimate interest(s) pursued by the Review Team and/or SJAI. The legitimate interest is to deliver on the aims of the Review and to assist in the maintenance of a comprehensive child-focused culture and environment that is safe for all within SJAI. This is with a view to identifying learnings and making recommendations for the organisation, as recommended by Tusla and sought by the Board of SJAI. Alternatively, the Review Team shall rely on your consent to process your personal data.

3.1. Special category ('sensitive') personal data

Given the subject matter of the Review and the nature of the complaints, the personal data which will be processed by the Review Team may include special or 'sensitive' categories of data such as medical data or data concerning a person's sex life or sexual orientation.

This processing is necessary for reasons of substantial public interest. In particular, the Review has been commissioned on foot of a recommendation by Tusla exercising its statutory powers. It involves assessing SJAI's compliance with relevant existing legislation and the approach to child protection and child welfare within the organisation. We regard these as matters of substantial public interest. Alternatively, the Review Team shall rely on your explicit consent to process your special category personal data.

3.2. Criminal Offence Data

Given the subject matter of the Review and the nature of the complaints, the personal data which will be processed by the Review Team may include personal data relating to criminal offences. For example, we may process information concerning possible criminal activity on the part of the alleged perpetrator(s) of sexual abuse and/or others, as well as data in relation to alleged victims of abuse and witnesses. The Review Team shall only process such data where it is legally entitled to under Article 10 GDPR and Section 55 of the Irish Data Protection Act 2018 and will ensure that all appropriate safeguards are in place to ensure the secure handling of this data.

4. How we use your personal data

We use your personal data for the purposes of carrying out the Review and preparing a Report for the Board of SJAI in accordance with the TOR. We may access and use your personal data as reasonably necessary to:

a) perform our obligations under the TOR;
b) prepare interview notes, transcripts and audio recordings of complainants' and other interviewees' testimony;
c) prepare and collate documentation summarising such testimony;
d) prepare and edit drafts of the Review Team's report to the Board of SJAI;
e) process enquiries and requests for information;
f) manage feedback, comments and complaints we receive;
g) prevent or address security or technical issues in connection with the protection of personal data or confidential information;
h) communicate with you or with others in connection with the Review and arranging meetings with interview participants and witnesses;
i) taking legal advice in connection with the Review;
j) management of suppliers of goods and services (e.g. data storage and stenography service providers);
k) comply with law and to respond to lawful requests, court orders and legal process;
l) enforce our rights, including enforcing contracts or policies, and/or
m) comply with your express written instructions.

5. Withdrawal of consent

If you no longer consent to our processing of your personal data (in respect of any matter referred to in this Privacy Policy as requiring your consent), you may request that we cease such processing by contacting us using the details in the 'Contact Us' section below. See section 13.

6. Disclosing and sharing your personal data

We may share your personal data with contractors or suppliers who provide us with services. Such services are required to enable us to pursue our legitimate interests in managing the conduct of the Review and our related operations. For example, we may use a stenography service provider to prepare a transcript of interviews. We may also use lawyers or digital services providers to support and advise us in respect of matters such as: the conduct of the Review, data storage or any complaints or other issues arising in the context of the Review. These parties are bound by confidentiality obligations and may be subject to discipline, including termination, civil litigation and/or criminal prosecution, if they fail to meet these obligations.

Please also note that, if you decide to avail of counselling through TherapyHub or elsewhere, you do not need to disclose this to the Review Team. However, if you wish to do so, please be assured that this information will be kept confidential and will be appropriately secured in line with the Review Team's Privacy Policy.

We may share your personal data where required to do so for the prevention of crime or where otherwise required to do so by regulators or by law.

Upon any transfer, we will take such reasonable measures to ensure that any receiving party processes your personal data in a manner that complies with applicable data protection laws as well as with this policy. If you have any questions in relation to the recipients, please do not hesitate to contact us at g.shannon@stjohnambulancereview.ie.

7. How long we keep your data for?

The Review Team will generally hold the above categories of personal data for an appropriate and applicable period of time, after which time it will be destroyed if it is no longer required for the lawful purpose for which it was obtained.

We continually review what information we hold. We will delete personal data which is no longer required, in line with our Record Retention Policy and the data minimisation requirements under the GDPR.

- SJAI related personal data

  All data furnished by the SJAI to the Review Team for the purposes of the Review will be returned to the SJAI on the date of the submission of the Report to the Board of SJAI. The Review Team will not retain any of this data whatsoever beyond the date of the submission of its Report to the Board.

  Any request for access to SJAI related personal data after the date of the submission of the Report to the Board of SJAI should, therefore, be made directly to SJAI and not to the Review Team.

- Confidential contributions data

  Any confidential interview notes, recordings or other documentation relating to voluntary contributions of information or the interview process, together with any related personal data created by the Review Team, will be retained only for one year from the date of the submission of the Report to the Board.

  This confidential contributions data will be transferred to a Data Custodian appointed by the Review Team immediately after the submission of the Report to the Board. The role of the Data Custodian will be to manage the secure retention of confidential contributions data for the benefit of the persons to whom the confidential contributions data relates and to ensure compliance with data protection laws in respect of such data.

  The confidential contributions data will be destroyed on the expiration of the 1 year retention period, unless there is a legal requirement to retain the data for longer or unless there are other appropriate grounds to extend this retention period as may be determined by the Review Team. We will provide you with the contact details of the Data Custodian once the Data Custodian is appointed.

When files are destroyed, it will not be possible for the Review Team or the Data Custodian to facilitate access to your interview or other personal data processed by the Review Team for the purposes of the Review.

As noted above, we have discretion to retain personal data beyond the retention periods referenced above should any of the following suspension events occur and the Review Team deem it necessary to do so. Please note the below is a non-exhaustive list of suspension events:

- contemplated or actual demand, claim, litigation or regulatory or criminal investigation;
- a subject access request under applicable data protection laws;
- a request from a data subject to invoke their right to restriction, deletion, objection or data portability under applicable data protection laws; or
- an order for production from a regulatory or law enforcement body.

8. Data security

8.1. Protection

We employ a variety of sophisticated physical and technical measures to protect information we hold and to prevent unauthorised access to, use, alteration or disclosure of your personal data. This is also to prevent any accidental loss of the data.

8.2. Where your data is stored

The Review Team is based in Ireland. All data processed by us is stored within Ireland. We may, from time to time, send your data to processors outside of Ireland. We will only do this for very limited purposes such as cloud storage purposes. If this arises, we will implement procedures to protect your data in a way this is consistent with and respects Irish and EU data protection laws.

9. Control of your personal data - Your rights

We want to ensure you remain in control of your personal data and that you understand your legal rights, which are:

a) the right to know whether we hold your personal data and, if we do so, to be sent a copy of the personal data that we hold about you (a "subject access request") within one month;

b) the right to have your personal data deleted (though this will not apply where it is necessary for us to continue to use the data for a lawful reason);

c) the right to have inaccurate personal data rectified;

d) the right to object to your personal data being used for marketing or profiling;

e) (where technically feasible) the right to be given a copy of personal data that you have provided to us (and which we process automatically on the basis of your consent or the performance of a contract if applicable) in a common electronic format for your re-use;

f) the right to restriction of processing in certain cases, for example where (i) we no longer need your personal data but you need it to determine, enforce or defend legal claims or (ii) you have objected to processing based on our legitimate interest in order to enable us to check if our interest overrides your interest; and

g) In some circumstances, you may be entitled to receive the personal data concerning you which you have provided to us in a structured, commonly used and machine-readable format and to transmit those personal data to another controller.

There are some exceptions to the rights above and, although we will always try to respond to any instructions you may give us about our handling of your personal information, there may be situations where we are unable to meet your requirements in full.

Right of Access:

Please note if you would like to exercise your right of access by submitting a subject access request covering access to your interview (and/or any other personal data the Review Team processes in relation to you) in either audio-recorded or transcribed form, you can do so at any time before those files are deleted in accordance with our retention period(s) outlined above. Please contact the Review Team at g.shannon@stjohnambulancereview.ie to submit your data subject access request to access your interview and other personal data.

If you would like further information on your rights or wish to exercise them, please contact g.shannon@stjohnambulancereview.ie

10. Complaints

Should you have a complaint about how we have used ('processed') your personal data, you can complain to us directly by contacting Dr Geoffrey Shannon in the first instance: g.shannon@stjohnambulancereview.ie

If you are not happy with our response, or you believe that your data protection or privacy rights have been infringed, you can write to the Office of the Data Protection Commissioner: Canal House, Station Road, Portarlington, Co. Laois, R32 AP23, Ireland.

11. Links to other sites

Our website may contain links to other external websites. We are not responsible for the content or functionality of any such websites. Please let us know if a link is not working by contacting g.shannon@stjohnambulancereview.ie. If a third party website requests personal data from you, the information you provide will not be covered by this Privacy Policy. We suggest you read the privacy notice of any other website before providing any personal information.

12. Changes to this Privacy Policy

We may amend this privacy policy from time to time to ensure it remains up-to-date and continues to reflect how and why we use your personal data. The current version of our Privacy Policy will always be posted on our website.

13. Contact us:

Any questions you may have in relation to this Privacy Policy or how we use your personal data can be sent to: g.shannon@stjohnambulancereview.ie or alternatively, you can contact us by telephone on +353 87 719 5363.

END

Approval/Revision History

Document Name: Privacy Policy

Document Owner: Dr Geoffrey Shannon

Approved By: The Review Team:

1. Dr Geoffrey Shannon,
2. Hilary Coveney,
3. Dr Cian Ó Concubhair

This Privacy Policy is Version 1.0, issued and approved by the Review Team on 21 October 2021.

This Policy will be reviewed during the course of the Review and any revisions or new releases will be recorded in the table below.

Date	Revision Description	Rev. Change
21 October 2021	First Release	1.0

Appendix IX

Information about Counselling offered to Review Participants by SJAI

Information in relation to Counselling

The following information with regard to counselling may be of assistance.

The Review Team has been advised that St John Ambulance Ireland (SJAI) has an arrangement in place with TherapyHub for counselling, where participants can make direct contact with TherapyHub and the payment for this will be discharged by SJAI.

The Review Team is advised that the identity of those availing of the service will not be shared with SJAI. The Review Team are further advised that TherapyHub is a secure and easy to use online platform which allows participants to find out about their counsellor and communicate with them in a number of ways, check their availability and arrange appointments.

Please note that SJAI proposes the following process for those who might wish to engage with TherapyHub:

1. Each person who wishes to avail of counselling will be provided by Dr Geoffrey Shannon with a unique code. Should you wish to avail of this service, please let Dr Geoffrey Shannon know so that this code can be sent to you.

2. This code is only known to Dr Geoffrey Shannon and the identity of the person to whom each individual code has been allocated is not known to SJAI.

3. SJAI then suggests that each person might visit the website of TherapyHub at www.therapyhub.ie and choose a counsellor or counsellors who you might wish to speak with.

4. An email can then be sent by you to TherapyHub at support@therapyhub.ie to the effect that you are availing of the counselling being provided by SJAI, the name of the counsellor you might wish to speak with and the unique code above. This ensures that you will not be asked for any payment.

5. Once TherapyHub has confirmed the above with the counsellor in question, the counsellor and you can then liaise directly to arrange appointments and other matters which might arise.

6. SJAI has agreed to provide an initial consultation and up to six counselling sessions with TherapyHub.

We hope that you will find this information useful. Please note that the Review Team is not involved in this counselling in any way. However, the Review Team wished to pass on the information to you, in conjunction with SJAI, in the event that it may be of assistance to you or others you may be aware of. Please also note that, if you decide to avail of counselling through TherapyHub or elsewhere, you do not need to disclose this to the Review Team. However, if you wish to do so, please be assured that this information will be kept confidential and will be appropriately secured in line with the Review Team's Privacy Policy.

October 2021

Appendix X

Organisational Structure Chart provided by SJAI

SJAI Organogram

Structure	Notes
Commissioner	The most senior officer
Assistant Commissioners & Chief Staff Officer	Second most senior officers assigned areas of responsibility by Commissioner
Staff Officers	The next line of HQ officers usually assigned individual areas of responsibility (e.g. Training or Events/Public Duty, Cadets etc.)
District Officers	The next or first line of HQ officers given individual areas of responsibility
Individual Divisions (Adults) / **Individual Divisions (Cadets)**	
Superintendents / Cadet Superintendent	In our Divisions, the Superintendent or Cadet Superintendent, is the officer-in-charge and exercises full responsibilities for the running of the Division.
1st Divisional Officers / Cadet Officer	This is the second rank of officers responsible for running Divisions.
2nd Divisional Officers / Cadet Leader	This is the third layer of officers in a Division, often with delegated areas of responsibility.
Sergeants / Cadet Sergeants	Sergeants are the most senior NCOs (non-commissioned officers) with leadership responsibilities among the members.
Corporals / Cadet Corporals	Corporals assist the Sergeants.
Lance Corporals / Cadet Lance Corporals	Lance Corporal is the first rank of NCO awarded to a person expected become Corporal within one year.
Members / Cadets	The rank and file members

For Safeguarding, the above hierarchy does NOT apply. Any member can approach the Child Protection/Safeguarding Officers directly on any issue/report.

The Safeguarding Officers/CPOs decide on actions to be taken vis-à-vis reporting to the statutory authorities, Commissioner etc.

The Commissioner carries the authority to agree to leaves of absence or suspensions of members against whom an allegation has been made

Allegations/cases are only discussed among the Safeguarding Team and the Commissioner. Others ranks are not included.

The Commissioner informs the Board of complaints etc. as a "standing item" at its meetings as of late 2021. Previously, that reporting was as cases arose.