Developing Directive-compatible practices for the identification, assessment and referral of victims

National Report for Ireland

Co-funded by the Justice Programme of the European Union

National Report for Ireland

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Introduction

This report examines the legal, policy and practice approach to victims in Ireland. The first section will outline the existing legislation relating to victims. Section 2 examines the status and situation of victims through a review of previous studies on victims in Ireland as well as policy documents and recent government initiatives. Following this, a brief overview of the possible entry points to the criminal justice system will be set out in section 3 before going on to examine in detail the practices for identification, assessment and referral of victims, as revealed through interviews with professionals in section 4.

In order to discover these practices, interviews were conducted with 5 frontline members of an Garda Síochána, the Irish police force; 3 frontline professionals from the healthcare service: a social worker; a midwife, and a doctor with experience in Accident and emergency (A&E); and 4 frontline members of victims organisations: a crime victims helpline; a domestic violence agency; a rape crisis centre, and a child victim agency, Children at Risk in Ireland [cari]; interviews were conducted in three cities in Ireland, Dublin, Cork and Limerick. Where available, internal guideline documents were obtained from the above agencies.

The main findings of the Report are as follows:

At a theoretical level, various initiatives described in this Report, such as the strategies set out by Cosc, the development in the Garda Síochána of the Victim Service Office, the Dept of Justice Victims of Crime Office, and the various Policy documents of the HSE all signal a move on paper to ensuring that Ireland will comply with the Directive. However, legislative transposition of the Directive is still in train, despite the deadline for transposition set out in the Directive.

Across all sectors, there is no legal procedure for the identification of a victim. Identification often arises through self-identification.

Garda practices using the system of recording incidents through the internal Garda PULSE system ensures that many aspects covered in Art 22 in relation to assessment of victims and their needs are addressed.

The assessment of victims needs would appear also to have improved through better Garda training.

There is no single inter-agency form or procedure available to professionals in all the sectors to use in assessing victims needs. This reflects a lack of inter-agency cohesion, and needs to be improved to meaningfully comply with the Directive.

Common to all sectors is victim autonomy in the context of referral.

Referrals are more often by way of giving victims information on how to access available services, rather than direct referrals.

The new Garda Victim Service Office provides a centralised mechanism to ensure that all victims are referred on to a specialised agency within an Garda Síochána and are given the information they need and kept informed as cases progress.

The new approach of the Garda Síochána of a centralised recording procedure into PULSE provides Gardaí with easily accessible information on the ground in individual

cases. However across the agencies there is no centralised shared recording system whereby the information recorded at the various entry points would be accessible for all front line agencies to cross reference.

1. Legislation on victims' rights

1.1 Introduction

In the Irish criminal justice system, victims enjoy no special legal status of 'victim', they are simply witnesses and for the most part, are subject to the laws pertaining to witnesses. The Irish courts and legislature are beginning to take more account of the interests of victims of crime and there has been an expansion in service (welfare) and procedural (participatory) rights. At time of writing, the Victims Directive has not been implemented into Irish Law, the only activity to date has been the publication in July 2015 of a General Scheme of a Bill (**Criminal Justice (Victims of Crime) Bill 2015**) to implement the Directive. This has now been published as a Bill, however, in addition to the time it will take for the Bill to be enacted following the legislative process, the implementation of the Directive will be further delayed since some parts of the Bill in turn require the drafting of Regulations in order to activate provisions.

Victims in Ireland currently enjoy more service rights than procedural rights. Procedural rights for victims pertain during the trial stage, as opposed to the investigative stage, however, the exercise of these rights have some impact on the procedures followed during the latter. These procedural rights will first be outlined in this section; the service rights are largely contained in the Victims Charter and are discussed in the section 2 of this Report.

1.2 Legislative procedural rights

Given the emphasis placed by our adversarial system on the orality of the proceedings and the concomitant requirement that witnesses are examined *viva voce* in open court, pre-trial statements are not generally permitted in the criminal process. Provision has accordingly been made for the admission of videorecordings, depositions and out of court statements in certain circumstances. Section 16(1) of the *Criminal Evidence Act 1992* provides that a videorecording of any evidence given by a person under 18 years of age or a person with a mental handicap through a live television link at the preliminary examination of a sexual offence or an offence involving violence shall be admissible at trial. It also renders admissible at trial a video-recording of any statement made by a person under 14 years of age or a person with a mental handicap (being a person in respect of whom such a sexual offence or an offence involving violence is alleged to have been committed) during an interview with a member of the Garda Síochána or any other person who is competent for the purpose, provided the witness is available at trial for cross examination.

Section 13 of the Criminal Evidence Act 1992 provides that victims, among other witnesses, can give evidence in cases of specified sexual or violent offences *via* a live television link. In the case of victims of such offences who are under the age of 18[1] or are persons suffering from a 'mental handicap'(s 19), there is a presumption in favour

[1] The Criminal Evidence Act 1992 originally set this age at 'under 17', but this was amended by section 257(3) of the Children Act 2001.

of giving evidence via television link (s. 13(1)(a)). In all other cases, leave of the court is required (s. 13(1)(b). More recently, section 39 of the Criminal Justice Act 1999 provides that where a witness is in fear or subject to intimidation in any proceedings on indictment for an offence, that person may, with leave of the court, give evidence through a live television link.

Under section 14 (1) of the Criminal Evidence Act 1992, witnesses may, on application by the prosecution or the defence, also be permitted to give evidence in court through an intermediary in circumstances where they are using the live television link and are under 18 years of age or are persons with a 'mental handicap' who have reached that age in relation to a sexual offence or an offence involving violence.

Under section 255 of the Children Act 2001, a judge of the District Court, when satisfied on the evidence of a registered medical practitioner that the attendance before a court of any child would involve serious danger to the safety, health or wellbeing of the child, may take the evidence of the child concerned by way of sworn deposition or through a live television link in any case where the evidence is to be given through such a link. This relates to certain specified offences including cruelty against children, causing or procuring a child to engage in begging, allowing a child to be in a brothel, and causing or encouraging a sexual offence on a child, the murder or manslaughter of a child, any offence involving bodily injury to a child, and most sexual offences.

Section 5 of the Criminal Justice Act 1993 makes provision for the court to receive evidence or submissions concerning any effect of specified offences on the person in respect of whom an offence was committed (victim impact statements). A family member may also give evidence under section 5(3)(b)(ii) of the Criminal Justice Act 1993, as amended, where the victim of the specified offence suffers from a mental disorder (not related to the commission of the offence). Under section 5A of the Act, a child or a person with a mental disorder may give evidence of the impact of the crime through a live television link unless the court sees good reason to the contrary.[2] Where a child or a person with a mental disorder is giving evidence through a live television link pursuant to section 5A, the court may, on the application of the prosecution or the accused, direct that any questions be put to the witness through an intermediary (provided it is in the interests of justice to do so) (s 5B Criminal Justice Act 1993, as inserted by section of the Criminal Procedure Act 2010). The only purpose for which a victim impact statement can be received at sentencing stage is to describe the impact of the offence on the victim (or on the family members if the victim has died as a result of the offence). It cannot be used to adduce further evidence, to suggest the evidence that should be imposed, or to make fresh allegations.

1.3 Proposed legislation to implement Directive

[2] Provision is also made for any other witness, with leave of the court, to give victim impact evidence via a television link

The General Scheme of the **Criminal Justice (Victims of Crime) 2015** was introduced in July 2015 as part of the process of implementing the Victims' Rights Directive, a task which should have been completed by 16th November 2015. The Bill was published in December 2016. The Bill provides some important new measures to strengthen victims' rights. One of the significant developments in this proposed legislation is the increased level of information which will be provided to victims. The Bill provides that an individual contacting the Gardaí to inform them that s/he has been the victim of a criminal offence must be provided with certain information. For example, s/he should be informed about: procedures for making a complaint alleging an offence; services which provide support for victims of crime; the role of the victim in the criminal justice process; available protection measures; legal aid and entitlement to interpretation and/or translation assistance. Victims are also entitled to request certain additional information about their cases and Gardaí are obliged to provide that information 'as soon as is practicable'. For example, under this provision, a victim can request information about significant developments in the investigation of the offence or information relating to the trial of an alleged offender. Other significant developments in the Bill include the requirement that the Gardaí or the DPP to provide victims with reasons for decisions not to prosecute a crime and the introduction of a process for formally reviewing a decision not to prosecute.

A notable feature of the Bill is the introduction of 'victim personal statements' which apply to offences other than those where a victim impact statement may be given. A 'victim personal statement' should 'set out how the victim has been affected by the offence including, as the case may be, physically, emotionally, financially or in any other way but shall not include any prejudicial comment on the offender or comment on the appropriate sentence be imposed on the offender'. This statement is provided to the Gardaí who will forward it to the DPP, as appropriate. These statements are submitted by the prosecutor to the trial court and served on the defence prior to sentencing and must be taken into account when determining the sentence to be imposed. Further protections for victims during investigation and whilst testifying are provided for in Part 4 of the Bill. For example, on the application of the prosecution, special measures such as the testifying via video-link or from behind a screen may be made available to a victim where the court is satisfied that this is necessary to protect him/her. This is a significant extension of the availability of the special measures which are available in the Criminal Evidence Act 1992, which were previously only available to victims of a limited number of offences.

1.4 Legislation relating to Reporting and protection of vulnerable victims

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 makes it an offence to withhold information on certain offences against children and vulnerable adults from the Garda Síochána. The Act defines a "child" as 'a person who has not attained 18 years of age'. A "vulnerable person" is defined as a person who is suffering from a disorder of the mind, an intellectual disability such that severely restricts their capacity to guard themselves against serious exploitation or physical or sexual abuse, and also includes a person who is suffering from an enduring physical impairment or injury to similarly protect themselves against such abuse or to report such exploitation or abuse to the Garda Síochána. The offences listed in the Act include murder, assault, false imprisonment,

rape, sexual assault and incest. An offence is committed when a person who knows or believes that one or more of these offences has been committed by another person against a child or vulnerable adult, and the person has information which they know or believe might be of material assistance in securing apprehension, prosecution or conviction of that other person for that offence, and fails without reasonable excuse to disclose that information as soon as it is practicable to do so to a member of the Garda Síochána.

There are various defences to the offence. They are to do with the circumstances where the child or vulnerable adult made the person acquiring the information aware of their wish for the Garda Síochána not to be informed, or when certain persons or certain professionals hold the reasonable view that the Garda Síochána should not be informed.

The Children First Act 2015 (at this time, very few sections of the Act are in force) deals with the duty of 'Mandated Persons' to report suspected harm to a child to the Child and Family Agency (Túsla). Under the Act, 'Mandated Persons' include teachers, social workers, psychotherapists and '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;' The legislation applies to those organisations engaged in 'relevant services' defined as: 'Any 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 including: medical practitioners; registered nurses; teachers; social workers; gardai; psychologists; members of the clergy.

Reporting is required:

'where a mandated person knows, believes or has reasonable grounds to suspect, on the basis of information that he or she has received, acquired or becomes aware of in the course of his or her employment or profession as such a mandated person, that a child has been harmed, is being harmed or is at risk of being, he or she shall, as soon as practicable, report that knowledge, belief or suspicion to the Child and Family Agency'. Harm means assault, ill-treatment, neglect or sexual abuse of a child. (s.14 (1). This section however is not yet in force at time of writing.

Section 12 of the Child Care Act 1991 (as amended) empowers members of An Garda Síochána to remove a child where there are reasonable grounds for believing that there is an immediate and serious risk to the health or welfare of a child and bring the child to be cared for by the health authorities. The health authorities are then obliged to make application for an emergency care order under s 13 of the Act at the next sitting of the District Court.

2. Status and situation of victims

Within Ireland, the victims' service rights are outlined and protected within the *Victims' Charter and Guide to the Criminal Justice System* (hereafter *Victims' Charter*) which was originally enacted in 1999 and revised in 2010. The Charter was created by the Commission for the Support of Victims of Crime, in consultation with the various criminal justice system stakeholders and contains commitments from each of these stakeholders regarding the level of service which victims can expect when engaging with them. However, while the Charter contains undertakings with regard to service

provision, it does not give rise to legally enforceable rights and thus can be seen to lack teeth from a protection standpoint.

2.1 The Right to Information: Keystone Service Right

The cornerstone of effective service provision for victims of crime is the provision of information, making the right to information the most important service right to which victims are entitled. The usefulness and effectiveness of the services and supports that are available for victims are dependent upon victims knowing that they exist. Effective provision of information about the criminal justice process (e.g. progress of investigation, timings of hearings, release of offenders etc.) is vital to ensure that victims do not experience secondary victimisation as a result of feeling in the dark about the progress of a case. In 2008, the Irish Council for Civil Liberties (hereafter ICCL) concluded that 'the availability of timely and clear information can have a huge impact on the experience of a victim' (2008, p 14). There is a clear obligation imposed upon the agencies of the criminal justice system to make sure that, from contact with the system (i.e. report to the Gardaí), the victim is kept fully informed about both the progress of the case and all available support services. Information provision 'must be an active and continuing process' (ICCL, 2008, p 20) and it is vital that it is effectively achieved at all stages of the criminal justice process from report through to the release of an offender.

The Irish Council for Civil Liberties (2008: 21) noted the 'lack of initiation on the part of the State actors in their role as information-providers' to victims of crime. Similarly the SAVI (Sexual Abuse and Violence in Ireland) Report in 2002 identified barriers for accessing law enforcement, medical and therapeutic services for those abused and their families. Lack of information from the Gardaí and medical personnel was the main source of dissatisfaction with the services provided. Specifically, the Gardaí were seen to provide inadequate explanations of procedures being undertaken, and medical personnel were seen as needing to provide more information regarding other available services and options. In relation to counselling services, time waiting to get an appointment was the major source of dissatisfaction. A lack of knowledge among criminal justice agencies and actors about the needs of victims of crime also arose as a central concern. For example, a study by McGrath showed that 51% of members of the legal profession were unfamiliar with the provisions of the Victims Charter (2009).

2.2 Under-reporting of crime

The literature reveals problem with the under-reporting of crime, indicating that a significant proportion of victims opt not to make a formal report. (O'Connell and Whelan, 1994: 85); (Kirwan and O'Connell 2001: 10); (McGee et al, 2002: 128-132). *An Garda Síochána Public Attitudes Survey,* 26% did not report the incident (2015, p 9). The primary reasons identified for non-reporting were believing 'that the Gardaí could not do anything, that Gardaí would not do anything or that the incident was not serious enough to report' (p 9). The last *Quarterly National Household Survey Crime and Victimisation Statistics* in 2010 also showed significant levels of non-reporting of crime. 45% of acts of vandalism, 25% of burglaries and 47% of assaults disclosed in the survey were not reported to the gardaí (p 2-3). The most commonly cited reason for non-reporting was that the incident was not considered sufficiently serious to be reported or that no loss was incurred. Similar findings were also evident in empirical research with victims of crime in Ireland conducted by Kilcommins et al in 2010 which

showed that slightly more than 1 in 5 respondents did not report the crime to the Gardaí (p 32). Where victims do not report 'a clear challenge exists in relation to the provision of information' (Grosdanova & de Londras, p 35). In particular, 'victims who do not report crimes may miss a key opportunity to receive information about victim support organisations' (Kilcommins et al, 2010, p 172).

For victims who opt not to report, helplines provide an important source of information and support. The role of such help-lines is particularly closely associated with victims of domestic abuse or sexual violence which are characterised by especially high levels of non-reporting. The importance of such helplines in this area is evidenced in the available statistics from rape crisis and domestic abuse support services. In 2015, Dublin Rape Crisis Centre (DRCC) received 11,789 help-line contacts (2016, p 4). In the same year, Women's Aid experienced very similar levels of demand, responding to 9,308 calls on their national Freephone help-line (2016, p 12). The websites of these organisations also receive very high levels of traffic. In 2015, DRCC's website recorded 83,478 visits and Women's Aid reported 167,229 visits. Although all of these visits would not have been by victims, these figures demonstrate high levels of reliance on supports outside of the formal criminal justice system.

Outside of specialist help-lines like those for victims of sexual or domestic abuse, the Crime Victims Helpline (CVH) represents an important source of support for those who decide not to report. In its first year, the CVH received 168 calls. In 2015, this number had increased to over 3,200 contacts by phone, email and text message (CVH, 2016, p 2). Three-quarters of these contacts were with victims and the remainder were with 'friends or family members; The most common offences callers to the CVH had been victims of assault (26%) and burglary/robbery/theft (20%) (Ibid, p 8). The primary purposes for contact were emotional support (40%) and information regarding the criminal justice system (37%) (Ibid, p 9). The Gardai inform all victims of the CVH when they make a complaint. It is clear from these statistics that the CVH has a significant reach. Further, research with victims conducted by Kilcommins et al has also demonstrated that the CVH is effective in its service provision. Just over a third of the participants in Kilcommins et al's research had used the CVH (2010, p 72). Kilcommins et al (2010) found that a lack of awareness about the CVH amongst both the general public and professionals and representatives of community groups. (also McGrath, 2009). Since then, the CVH have invested much energy into raising awareness about their services.

2.3 Report to the Gardaí and Investigation

The basic entitlements which victims can expect from the Gardaí are listed in the Victims' Charter. Given the breadth of their obligations, for ease of discussion and critique, the services provided by the Gardaí will be considered here under three headings: (i) Report and Recording Practices; (ii) Information Provision and; (iii) Protection of Vulnerable Groups.

(i) Report and Recording Practices

When a victim contacts the Gardaí in relation to a crime or traumatic incident, the Victims Charter states that the Gardaí will 'respond quickly to the call and investigate the complaint. The Garda Inspectorate Report found that victims have experiences some issues with this stage of the process. One such issues related to the physical environment of the public offices in the Garda stations which 'varied greatly from station to station' (2014, Part 3, p 20). A particular issue posed by inadequate facilities

in garda stations was privacy as '[s]ome stations did not have a suitable room available for a person who wished to discuss a matter in a private setting (Ibid). Problems were also uncovered with regard to the information which is available at garda stations. The Inspectorate found that while 'some stations had posters about particular crimes and details about support agencies', 'had little information or had posters that were not maintained and were out of date' (Ibid, p 20-21).

Despite the commitment in the Victims Charter that Gardaí will respond quickly and investigate complaints made to them, there seemed to be some issues regarding the recording of incidents as crimes. Based on a review of cases, the Inspectorate found that the average conversion rate from the call for service to the creation of a PULSE incident was 63%, which was categorised as low (Ibid, p 26). The Inspectorate 'learned of an unacceptable practice where individual gardaí were deciding not to record a crime' (Ibid, p 29). Examples of situations where this might occur include assault cases where the gardaí might give the victim some time to consider whether they will report or not (particularly where alcohol is involved). There was also evidence that some gardaí did not record incidents involving tourist victims as it was felt that these victims would not follow-up on the report. Domestic violence cases were also particularly problematic with regard to non-recording as some members do not record the offence where the victim is not willing to proceed with a formal complaint (Ibid, p 29).

(ii) Information Provision

The Victims Charter places significant recurring responsibilities on the Gardaí in regard to information provision. When a victim makes a complaint to the Gardaí, s/he must be informed of 'the name, telephone number and station of the investigating Garda and the PULSE (Police Using Leading Systems Effectively) incident number (i.e. the unique computer-generated number which is allocated to an incident on the Garda computer system)'. The Gardaí must also '[e]xplain what will happen and keep the victim informed of the criminal investigation' and '[t]ell the victim in writing about the [CVH] and the other services available for victims of crime in Ireland'

Despite the commitments made in the Victims Charter, several studies have shown that there are shortcomings in the information provided by the Gardaí to the victim during the course of investigations. (eg Kilcommins et al 2010); More recently, the Garda Inspectorate also revealed deficiencies in Garda provision of information to victims. In a review of letters sent to victims in the third quarter of 2013, the Inspectorate found that just over 3,000 victims did not receive the first standardised letter and just over 1,500 did not receive the second (2014, Part 7, p 5). The Inspectorate also expressed disappointment that there was 'little or no evidence of supervisors contacting victims of crime to determine the levels of service provided' (Ibid, p 6). In 43% of the cases investigated by the Inspectorate, there were no updates on PULSE in the twelve months that followed the creation of the record (Ibid, p 11). Consequently, the Inspectorate concluded that there was 'an inconsistent approach to updating victims and there was no national standard as to how or when this contact should take place other than the two required victims letters' (Ibid). Most recently, in the Garda Public Attitudes Survey 2015, the respondents included 682 victims of crime and provided further evidence of an information deficit for victims during the reporting and investigation stage of the criminal justice process. Only 34% of the victim respondents were given a PULSE number and just 33% were given the number of victims helplines and services (2015, p 11). The Garda Inspectorate also stated its belief 'that the whole approach to victim care and contact by the Garda Síochána needs

to be urgently addressed' (2014, Part 7, p 10). In response to this criticism, Garda Victim Service Offices have been established.

(iii) Protection of Vulnerable Groups

The lack of recognition of vulnerable witnesses in Ireland has also been indentified in the literature (Bacik 2007, 10-11; Spain et al 2014). Victims of crime with disabilities, for example, remain largely invisible, not least because of the difficulties they pose in relation to information gathering and fact finding for an adversarial justice system which for the most part refuses to engage with the ontological dimensions of disability (Kilcommins et al 2013). A recent study undertaken on victims of crime with disabilities found that people with disabilities 'are not being strategically identified as a victim group, either by victim support organisations, or those engaged at a central government policy level in dealing with victims' issues' (Edwards et al 2012: 100).

A number of key services are offered by the Gardaí to ensure that all victims, regardless of any special sensitivities they might have, are treated equitably at the reporting and investigation stages of the criminal justice process. For victims of sexual offences, a garda of the same gender will be provided to investigate the offence and, as far as possible, a doctor of the same gender will also be provided for examination purposes (Victims Charter, 2010, p. 17). Details of relevant support organisations in the locality will also be provided (Ibid). There are also special services for families of victims of murder or other unlawful killings, most notably, the families' local Garda Superintendent will keep contact directly with them and any support organisation which the family is engaging with (Victims Charter, 2010, p. 17). This contact will be maintained via a Garda Family Liaison Officer (FLO) who is a specially trained member of An Garda Síochána. Victims of domestic violence will be advised about local support agencies. They will also be notified that the Gardaí have a pro-arrest policy in domestic violence cases (Victims Charter, 2010, p. 17).

Issues have also been raised about the response of the Gardai to domestic abuse incidents. Although it is stated that the Gardai have a 'pro-arrest' policy, it would seem that arrests are typically only made for breach of a domestic violence barring order and not for crimes such as assault (Garda Inspectorate Report 2014 Part 3, p 20). Thus, victims who do not have orders in place cannot rely on this 'pro-arrest' policy and may not receive adequate protection. Moreover, '[d]uring field visits, the Inspectorate found a complete absence of supervision in [domestic violence] cases and an absence of management data on how divisions were performing' (Part 3, p 20). Thus, there is insufficient oversight of the implementation of the Garda policy on domestic violence, creating a risk that best practice is not always adhered to.

Other issues identified in the literature include fear of crime (Butler and Cunningham 2010: 429-460); intimidation (Hourigan 2011); victimisation by the process (Kelleher et al 1999; Riegel 2011: 200); attrition rates (Leane et al 2001; Hanly et al 2009; O'Mahony 2009; Leahy 2014; Bartlett and Mears 2011; Hamilton 2011); the lack of private areas in courts; difficulties with procedural rules, legal definitions and directions (Bacik et al 1998; Cooper 2008; Leahy 2013); delays in the system (Hanly et al 2009); the lack of protection and security offered by the justice system (Kilcommins et al 2010: 64-66; Spain et al 2014), the lack of opportunity to participate fully in the criminal process; the lack of information on the progress of criminal prosecutions (Watson 2000); a lack of empathy and understanding in reporting a crime;

overcrowded courtrooms and an inability to hear the proceedings; (Kilcommins et al 2010); and inadequate support services (Bacik et al 2007; Mulkerrins 2003; Deane 2007; Irish Council for Civil Liberties 2008, Cooper 2008).

2.4 Other developments concerning the situation of victims in Ireland

In September, 2008 a new executive office, the Victims of Crime Office, was established in the Department of Justice to support crime victims. The core mandate of this Office is to improve the continuity and quality of services to victims of crime, by state agencies and non-governmental organisations throughout the country. It works to support the development of competent, caring and efficient services to victims of crime. A reconstituted Commission for the Support of Victims of Crime occurred in September, 2008. Working with an annual budget from the Department of Justice and Equality, the Commission provides funding for services and supports to victims of crime. The Commission also works to improve cohesion and consistency of service and information available to victims of crime. A Victims of Crime Consultative Forum held its first meeting in January 2009. It provides a forum for victim support organisations to put forward the views of victims with a view to shaping strategy and policy initiatives.

In 2010, a national strategy was developed by Cosc, the National Office for the Prevention of Domestic, Sexual and Gender-based Violence. That strategy, running from 2010 to 2014, "began to build and strengthen ties across the public sector and between the public sector and the community and voluntary sector". It was reviewed in 2014 and a second strategy is now in place to run from 2016 to 2021. It aims to 'Change societal attitudes to support a reduction in domestic and sexual violence and improve supports available to victims' . Its stated goals are (*inter alia*) 1. To promote a culture of prevention and recognition through increased understanding of domestic, sexual and gender-based violence, and 2. To deliver an effective and consistent service to those affected.' (National Strategy 2010, p. 8)

In 2010, the Health Service Executive published a policy document on Domestic Violence and/or Sexual Violence which has been developed by a multidisciplinary HSE Working Group. It aims to implement an integrated and coordinated health sector response to Domestic Violence and/or Sexual Violence. The goals of the policy are (*inter alia*) :

"1. To ensure that a comprehensive and appropriate Health Service response is delivered at
all points of entry to the Health Service Executive.
2. To promote primary prevention of violence and invest in early intervention.
3. To provide best practice in all service provision to victims of Domestic Violence and/or Sexual Violence
4. To support Multi sectoral approaches.
5. To ensure the safeguarding of children in situations of Domestic Violence and/or Sexual Violence.

The policy promotes training of all front-line healthcare professionals to increase awareness of domestic and sexual violence, in particular to enable them to 'recognise the signs, indications, nature and consequences of abuse; 'to respond appropriately and effectively to ensure victim safety' and to 'know how to make a referral to an appropriate service/agency'. (HSE 2010 p 17).

More recently in 2014, a guide for general practitioners was published: Domestic Violence: A Guide for General Practice , by the Irish College of General Practitioners

Quality in Practice Committee.

3. 'Entry points' of victims to the criminal justice system

3.1. An Garda Síochána – Irish Police Force

Gardaí play a crucial role in the support of victims of crime, not least because a Garda is often the first person to whom a victim recounts the incident (ICCL, 2008, p 50). The Victims' Directive places a clear onus on police to provide adequate services to victims. Article 4 of the Directive sets out a comprehensive list of information which victims must receive 'from the first contact with a competent authority'. The Gardaí are the organisation within the criminal justice system who perform this role. The Gardaí are guided by Garda Síochána Policy on the Investigation of Sexual Crime, Crimes against Children and Child Welfare 2nd edition 2013; Garda Policy on Domestic Violence; Garda Victim Services Offices - Standard Operating Procedures, (this document sets out the standard operating procedures and guidance for all Garda Victim Service Office staff) and Garda Victim Services Offices – Operational Garda, a document 'designed to assist all operational Gardaí by setting out their roles and responsibilities when engaging with victims'. It must be noted that these documents will be updated once domestic legislation is enacted to implement the Victims Directive. In addition, the Domestic Violence Policy is in the process of being updated to take account of the COSC strategies (1&2), the Istanbul Convention, Garda Inspectorate reports, changes in legislation and the EU victims directive, along with developments in Garda processes.

3.1.1 Garda Victims' Service Offices:

Garda Victims Service Offices were launched on 9th December 2015. This involved the creation of 28 Victims of Crime Offices within the Gardaí which aim to make sure that victims are kept informed about the progress of their cases. These offices were originally piloted in Dublin and Waterford and, since December 2015, there is one within every Garda Division. The Offices are staffed by specially trained Gardaí who operate to a Standard Operating Procedure. The Offices are the central coordinating point of contact in each division for all victims. In crimes such as burglary, assault or criminal damage, victims of crime receive a follow-up call from the Victim Service Office to ensure they have all the information they require including contact details of the investigating Gardaí. This call must be made within 3 days of the crime being reported. Victims can also raise any problems or concerns they have in the wake of the crime or issues with the investigation. The role of the Victim Service Offices is to keep victims informed of all significant developments associated with their case, as well as provide contact details for relevant support/counselling services. They will be provided with crime prevention advice and details for external services available from other State and/or Non-Governmental Agencies. Victims of domestic violence, sexual crime or other crimes where there is trauma will continue to be given advice and support in person from investigating or specialist Gardaí.

3.1.2 Garda Statistics

Garda statistics indicate the following numbers of victims recorded for the years 2012 – mid 2016:

Victims Recorded:
2012- 152982
2013 – 147387
2014 – 147534
2015 – 141456
2016 – 69518

Child victims:
2012 -7039
2013 – 6068
2014 – 6442
2015 – 6248
2016 – 3908

Breaches of Domestic Violence court orders
2012 – 354 + 38 + 393 + 534 = 1319
2013 – 358 + 41 + 440 + 615 = 1454
2014 – 427 + 51 + 562 + 684 = 1724
2015 – 407 + 53 + 736 + 796 = 1992
2016 – 268 + 53 + 524 + 521 = 1366 (to august 2016)

Sexual Offences

2012 – 2980 - (this figure includes: 8 aggravated sexual assault; 831 rape offences; 1837 sexual assaults; 143 defilement of child offences; 24 involving sexual offence against mentally impaired person)

2013 - 2413 – (this figure includes: 10 aggravated sexual assault; (500 rape offences; 1635 sexual assaults; 102 defilement of child offences; 15 involving sexual offence against mentally impaired person)

2014 – 2585 - (this figure includes: 5 aggravated sexual assault; (652 rape offences; 1606 sexual assaults; 148 defilement of child offences; 13 involving sexual offence against mentally impaired person)

2015 – 2573 (this figure includes: 11 aggravated sexual assault; (481 rape offences; 1736 sexual assaults; 144 defilement of child offences; 22 involving sexual offence against mentally impaired person)

2016 – 1815 (this figure includes: 8 aggravated sexual assault; (339 rape offences; 1346 sexual assaults; 104 defilement of child offences; 8 involving sexual offence against mentally impaired person)

Withdrawn Complaints (there is no breakdown as to what offences the figures relate to)
2012 – 235
2013 – 294
2014 – 442

2015 – 593
2016 – 270

3.2. Health Services Executive (HSE)

Health workers are guided in relation to child victims by the practices set out in a document issued by the Department of Children and Youth Affairs in 2011, the Children First: National Guidance 2011; they are guided in relation to vulnerable adult victims by the procedures set out in *Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures, 2014,* and in sexual crime and domestic violence, by the HSE Policy on Domestic, Sexual and Gender Based Violence (2010) together with the HSE Practice Guide on Domestic, Sexual and Gender Based Violence (2011).
Entry points for victims to the HSE may arise in a variety of contexts, for example they may be admitted to emergency departments in hospitals, or through interventions by social workers etc. there are dedicated units for cases of sexual assault:

3.2.1 Sexual Assault Treatment Units (SATUs)

'Sexual Assault Treatment Units (SATUs) in the Republic of Ireland, aim to provide holistic, responsive and patient focused care for women and men who have experienced sexual crime. SATUs need to be appropriately staffed and available around the clock to allow prompt provision of medical and supportive care and collection of forensic evidence. SATUs in Ireland work within the context of a core agreed model of care, which includes defined multiagency guidelines and choice of care pathways,2 close links with the Rape Crisis Network Ireland, Forensic Science Ireland, An Garda Síochána3 and allied specialties including Social Services, Túsla: The Child and Family Agency and Infectious Disease Clinics. Such a nationally **agreed** service is invaluable so that all patients are assured of receiving a high quality, standardised care package,4 regardless of where or to whom they disclose.'

There are 6 SATUs in Ireland (Cork, Donegal, Dublin, Galway, Mullingar, Limerick and Waterford).[3] The units are 'geographically distributed around the country in such a way as to maximise equitable ease of access' (Kennedy et al, 2016, p. 3) Victims may approach a SATU directly or be referred by a medical practitioner (e.g. GP or Emergency Department) or Gardaí may refer victims to SATUs for the collection of forensic evidence which will be used in the investigation of a criminal offence. Forensic samples may be collected up to 7 days after a rape or sexual assault. If the victim has reported to the Gardaí, a Garda will be present to collect the forensic samples. Upon arrival at a SATU, all victims will meet with a support worker from a Rape Crisis Centre who will support them throughout the forensic examination process, as well as providing them with information about support services that are available from the Rape Crisis Centre.
A significant recent development for victims attending at SATUs is that they can now collect and store forensic samples even if the victim has not or is not going to immediately report to the Gardaí. Where the victim consents, new protocols now allow for collection without Garda involvement and storage for up to one year to allow the victim some time to decide whether to proceed with a formal complaint (SATU, 2014, p. 102).

[3] http://www.hse.ie/eng/services/list/5/sexhealth/satu/#Mid-West SATU (Accessed: 7th July 2016)

Victims who are under the age of eighteen will require the consent of a parent or legal guardian before an examination may be carried out. Children who are below the age of fourteen will not be examined in SATUs but will be referred to the Child and Adolescent Sexual Assault Treatment Service (CASATS) in Galway or examined by another agency within the Health Service Executive. [Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland 2014}

3.3. Victim Organisations

3.3.1 Crime Victims Helpline

The CVH was established in 2005 and is national free-phone helpline staffed by trained volunteers which is funded by the Commission for the Support of Victims of Crime. They also offer a text service, as well as providing a website (www.crimevictimshelpline.ie) which the organisation itself describes as 'one of the most comprehensive information sites for victims of crime in Ireland'. Described as 'a one-stop shop for victims seeking emotional support; information about the criminal justice system; and assistance in coping with the effects of crime', the helpline volunteers can advise callers on how to report to the Gardaí and/or on specialist services which are available in their area which they may wish to contact for advice and support. Volunteers can liaise with Gardaí or other services on behalf of a victim if s/he requests this assistance. The CVH commitments in the Charter include a guarantee of confidentiality, as well as the promise to provide various types of advice and information including: general information about the criminal justice system; the process involved in reporting to the Gardaí; details of relevant specialist support services and; how to apply for compensation.

3.3.2 Children at Risk in Ireland

Children at Risk in Ireland (CARI) offers specialist Child Accompaniment Support Services (CASS), (court accompaniment and pre-trial court familiarisation) for children. This service was first introduced in 2005 and was originally only provided to child victims of sexual abuse who were testifying in court but since 2009, the service is available to all children who are attending court as witnesses in any criminal trial.

3.3.3 Rape Crisis Centres and Domestic Abuse Support Agencies

Other voluntary agencies who provide specialist accompaniment services for victims include the Rape Crisis Centres, One-in-Four and domestic abuse support services such as Women's Aid and ADAPT. In relation to the latter, however, it is important to note that support workers can only attend criminal proceedings in relation to domestic abuse. They are not permitted to support their clients in civil proceedings pertaining to applications for orders under the Domestic Violence Act 1996 as these proceedings are held in camera. This is a significant gap in protection for these victims of domestic abuse whose protection is dependent upon the civil law system as well as the criminal justice process.

3.4. Other points of contact between victim and agencies (not first entry points)

3.4.1 Office of the DPP

The Victims' Charter provides that the Office of the DPP will take the views of a victim into account when deciding whether to prosecute (2010, p 30). The Office of the DPP will provide a summary of reasons for a decision not to prosecute to victims and family members of victims in fatal cases (Office of the DPP, 2015, p. 3). Information about a decision not to prosecute may be provided for fatal cases that occurred on or after 22nd October 2008 or for any case that occurred on or after 16th November 2015 (Ibid, p 4). The extension of the scheme to all offences in 2015 is due to the Office's new obligations under the Victims' Directive and is a very welcome move from a victims' rights perspective.

The Office set up a Communications and Victims Liaison Unit in July 2015 (Office of the DPP, 2016, p 24). The aim of this unit is to ensure that the Office meets its obligations under the Victims' Directive. The Unit deals with all requests for reasons not to prosecute and review requests received from victims and provides information to victims who contact the Office.

3.4.2 The Courts Service

The Courts Service has 'customer liaison officers' who can organise access to special waiting areas where this is available and reserve seating in courtrooms, as well as arranging advance visits to courthouses prior to the trial (Victims Charter, 2010, p 24). One of the most important obligations is the pre-trial meeting between the prosecution legal team and the victim. Although the conversation which occurs is necessarily limited as the lawyers cannot be seen to 'coach' the witness, these meetings are very important to provide victims with important information and so that they can feel that they are not forgotten within the process. 'While the evidence or content of the case is not discussed the victim is made aware of the form of the proceedings, the courtroom and the proximity they will have to the accused'. Also, if evidence is to be given by video-link the victim is brought to the video link room and shown where s/he will sit and how the evidence will be taken (Gorznova & de Londras, 2008, p 11).

3.4.3. Túsla

The Child and Family Agency was established on the 1st January 2014 (Dept of Children and Youth Affairs) and is the dedicated State agency responsible for improving wellbeing and outcomes for children. Prior to this concerns would have been reported to HSE social work child protection and welfare teams. The specific focus of Túsla is on the welfare of the child and family. Its remit is broad, but the aspect relevant to this Report is Child Protection and Welfare. The purpose of the Child Protection and Welfare service is to meet the Agency's statutory responsibilities in accordance with Child Care Act 1991 and Children Act 2001. The Agency is required to identify and promote the welfare of children at risk or in need of protection and to provide family support services.

In 2015, 43,596 referrals were made to Child Protection and Welfare Services. 42% of these relate to abuse/neglect and 58% relate to child welfare issues. (Annual Report 2015). Since 2015, the Online Child Protection Notification System (CPNS) was fully developed and access extended to An Garda Siochána, Out of Hours services, GP Service and hospital EDs. (ibid 14) 2015

Also achieved in 2015 in relation to Domestic, Sexual and Gender Based Violence
• National governance structure for Domestic, Sexual and Gender Based Violence Services established.
• Additional outreach services provided for victims of sexual violence.

The objectives of the agency for 2016 are:
1) Child Protection and Welfare: Ensure an approach to responding to referrals which consistently provides an efficient, effective and proportionate response.

2) Domestic, Sexual and Gender Based Violence: Establish a full National DSGBV Service Team.
• Implement a standard monitoring and reporting framework for DSGBV.
• Contribute to the implementation of the Istanbul Convention.
Develop a cohesive suite of services to support victims of sexual and domestic violence.

4. Victim-related practices in national systems

Introduction
This section will analyse the practices for identification, assessment of needs and referral of victims, as revealed through interviews with professionals in each entry point. In order to discover these practices, interviews were conducted with 5 frontline members of an Garda Síochána, the Irish police force; 3 frontline professionals from the healthcare service: a social worker; a midwife, and a doctor with experience in Accident and emergency; and 4 frontline members of victims organisations: a crime victims helpline; a domestic violence agency; a rape crisis centre, and a child victim agency, Children at Risk in Ireland. Interviews were conducted in three cities in Ireland, Dublin, Cork and Limerick. Where available, internal guideline documents were obtained from the above agencies.

4.1 Identification of victims
a) police

The main actors for identifying a victim are the Gardaí who are called to the scene of a crime. There is no legal procedure for the identification of a victim *per se.* Victims may self identify or failing that, they are identified through speaking to the caller when the Gardaí arrive, from their ascertainment of the crime scene and if witnesses are present, through speaking with the witnesses. If a person has suffered obvious harm, that will be a strong indicator to the Gardaí in their identification of a victim; it may of course transpire through further investigation that they are in fact the perpetrator. The person who calls the Gardaí will not always be the victim, they may have simply reported the incident and it is for the Gardaí to establish who is the victim: *"When go to a call, it is usually obvious who the victim is, they will either approach you or you will know based on the knowledge of the facts of the call you are going to; its never a problem or an issue, you either spot them or they self identify"* [Garda rank 1]. Further victims may be identified also through speaking with witnesses. A victim has autonomy regarding their involvement in the process. If the offence concerns a child victim,

different considerations apply, but where the victim is an adult, they cannot be forced to take a complaint.

A prosecution for public order can proceed without a complaint, but not for an associated assault. A criminal damage offence cannot proceed without a complaint. Since everything is recorded on PULSE, a file on an incident needs to be completed. If a victim does not want to proceed, they would still have to give a statement to the effect that the crime was committed, that they are not being forced not to proceed with making a criminal complaint, and that they do not wish for an investigation to be carried out by the Gardaí. That would then close the file. If the victim does not want to make the above statement, that must also be recorded in PULSE. For serious offences, it is a matter for the DPP to decide whether the prosecution should be continued. One respondent noted a burglary case where the injured party did not wish for a prosecution to proceed, but a file was sent to the DPP who ordered the prosecution to continue. *In that case the victim could be subpoenaed to appear in court. It is then up to judge to decide how to proceed –the judge would be aware of the feelings of the injured party not wanting to proceed."* [Garda rank 1] – *"they should feel involved as much as they want; they can exclude themselves or not".* [Garda rank 2]

Since November 2015, all members of the Gardaí have been issued with an aide memoir, which they carry with them in their notebook. The aide memoire was drawn up since Directive and reflects the key terms of Art. 22. Key victim information must be ascertained by Gardaí at the scene and then entered into the PULSE system; as an additional safeguard, the central controller of PULSE that receives the information from the Gardaí for input into the system will ask the Garda all questions relating to everything covered in the aide memoire. The aide memoire ensures the Gardaí note the nationality of the victim; whether they speak English and their requirements for translation; whether they requested a doctor and whether they requested to be interviewed by a Garda of a Particular Gender. The Gardaí must note any specific characteristics and needs of the victim, such as whether they have needs regarding their hearing, literacy, mobility, or visual capacity, and whether they have protection or other needs. The Gardaí must also note whether the incident involves any discriminatory or other motives. Specific contact requests and times and methods (email, telephone etc.) must also be asked of the victim. Features of the crime are written in the Garda notebook and then entered into PULSE. Once entered into the PULSE system, the identification of a victim automatically transfers to the Victim Service Office allowing their procedures to be put in train.

b) Health authorities

Victims may be identified in the health care service at various stages, depending on which health care unit they are engaged with. The Social Care Division deals with vulnerable adults, vulnerable principally due to age or disability. There are two pathways to this Division: in the residential care setting, a designated officer, who has responsibility to respond to all abuse, identifies a vulnerable adult to be at risk of abuse. Having identified a victim the designated officer refers the victim to the Safeguarding and Protection Team (SPT). A second pathway is via community: the majority of referral notice to the SPT comes via public health nurses in the community context.

Vulnerable persons are advised by whoever is deemed appropriate, eg a key worker, where an incident of abuse/ of concern has been brought to staff attention. They do not have right to prevent the reporting of the incident to the safeguarding and protection team – however if they have capacity to make decisions they can request that their next of kin not be informed. If the allegation of abuse occurs outside of the residential setting, and arises through the community pathway, a different referral form is used.

A victim might come to the attention of healthcare workers through their admission to Accident and Emergency units of a hospital. Where a person has for example a stab wound, that could indicate they are either the perpetrator or victim: *'we have to take a non judgmental view in terms of patient care; the first priority for us is care of the patient, so you try to save lives before you even think of who did what or whether the person is the victim, then as part of treatment you will inevitably ask what happened so out of that you would be considering whether they are victims – the things we would worry about is where people are victims and you fail to identify that – say for cases of child abuse - elder abuse – domestic violence – we get additional training to try to identify hidden victims of crime'.* [A&E staff] If there is no visible indication of a crime, the identification of a victim might arise through their assessment by the psychology team. A victim might be identified also through the disclosures that they make to nurses or to catering staff. Staff are obliged to pass on the information to the medical team in charge of the patient.

A victim may be identified through their engagement with ante-natal and gynecology services (see below 4.1 e).

c) Victim organisations

Identification of victims is made by staff in victim organisations such as the Crime Victims Helpline on the basis of the caller self-identifying or by family members or friends identifying the victim, 'but if someone doesn't want to reveal crime or who they are we don't press them'. If a non-English speaker calls the helpline, they will depend on the volunteers who man the helpline having knowledge of their native language; currently, volunteers to the helpline are able to communicate in 4 languages: Mandarin, Polish, Spanish, Italian. Outside of those languages, no translators are available: *'we muddle through, it is not ideal.'* [CVH staff]

d) Vulnerable Victims: Children

Child victims may be identified by a Garda attending an incident by ascertaining the details of the incident and where possible, by asking certain questions of the child. The safety of the child is paramount; if there is an issue of child safety, the Garda can invoke the Child Care Act to remove the child to the care of the authorities. One respondent gave as an example of such a situation arising in a case where both parents were intoxicated and their child of 5 left the house unaccompanied. Where child safety is at issue, the Garda officer attending the scene must decide there and then to invoke the powers under the Child Care Act. Child victims may also be identified by a parent reporting abuse to the Garda Síochána or in the course of a domestic violence incident where the parent has reported or where the Gardaí are attending a scene.

Healthcare professionals may identify child victims by virtue of the admission of a child to A&E, or visits to the child's home by public health nurses.
Child victims are also identified through a voluntary organisation, Children at Risk in Ireland (CARI); this may be done by a child victim identifying themselves by calling the helpline, or by a call made by parents, however child victims are more often identified following referral to CARI from Túsla (Child and Family Agency), or professionals dealing with the child. Adapt, a domestic violence service identify child victims – in identifying a mother as a victim there is also identification of her child as victim indirectly.

e) Vulnerable Victims: Domestic Violence and Sexual Violence

Victims of domestic violence may be identified where a person contacts the Garda station identifying themselves as a victim. When responding to a call out to a domestic violence incident, the victim is not always obvious: *"there could be several witnesses, one or two may be victims – in domestic violence we generally assume that the female is the victim".* [Garda rank 1]

A victim may be identified through their contact with healthcare services (A&E, public health nurse, gynecology services). Victims may be identified in these settings through their own disclosure to the healthcare professional. This disclosure might not occur during the first contact, and may more often depend on the relationship built up between the healthcare worker and the victim. One respondent expressed concerns that the medical history is often asked in corridor, which is an open location that is not conducive where a woman wants to disclose violence in the home. A disclosure may arise where the woman is taken to a 'safe place' where there is more assurance of privacy such as when accompanied to the toilet, or indeed during the throes of labour. Disclosure may also arise in response to questions set out in the maternity health care record: 'do you have a family social worker?' and 'are there any ongoing problems at present?'

Outside of disclosure, healthcare professionals' identification of a victim may arise through their own observations of the person, largely based on their experience. A recent guideline document suggests a line of questioning a medical practitioner might ask if there is any suspicion of domestic violence:

Broad questions

How are things at home?
How are you and your partner relating?
Is there anything else happening that might be affecting your health?

Specifically linked to clinical observations

You seem very anxious. Is everything alright at home?
When I see injuries like this I wonder if someone could have hurt you?
Is there anything else that we haven't talked about that might be contributing to this condition?

More direct questions

Are there ever times when you are frightened of your partner?
Are you concerned about the safety of your children?
Does the way your partner treats you make you feel unhappy or depressed?

I think that there's a link between your (insert illness or injury) and the way your partner treats you. What do you think?

(Domestic Violence: A Guide for General Practice , Irish College of General Practitioners Quality in Practice Committee 2014).

One respondent working with women in antenatal services indicated that there are certain things that will raise a 'red flag'. Where the woman has obvious injury, she would always assume that something is not quite right and would continue to hold that assumption until she had satisfied herself, through speaking with the woman, that the injury had an innocent explanation*: 'always assume worst, until you have heard the story and the history and the cause of the event, because you are always fighting for the advocacy of that woman and baby'. [healthcare worker midwife]* Other indicators are the behavior of the woman, for example where a woman who is accompanied by a mother or a friend is very withdrawn, and it may be that the companion is acting as a barrier, or is protecting the person who is the perpetrator: *you need to watch the dynamic; if partner consistently answering for the woman, that is a red flag that something is not quite right'. [healthcare worker midwife]*

If there has been an obvious assault, mention of the injuries will be included in the woman's chart, and the woman will be asked if she would like to make a statement to the Gardaí. If there is any indication of a sexual assault, the sexual assault unit is contacted (with consent of the woman): '*if a person discloses that they are a victim of sexual assault, we do not go near the 'scene on the person' for fear of contaminating the evidence; that is a huge concern for nurses and midwives and they definitely don't have enough training in that.' [healthcare worker midwife]*

Victims are identified by the domestic abuse service, Adapt, principally through self-identification. Victims make contact either through the helpline or through the refuge. The respondent at Adapt pointed out that they are not a homeless hostel so it must be established that a person is a victim of domestic violence if they are to be given a place at the refuge, nonetheless, *'we have to take at face value that person is a victim- (eg not homeless) we ask them to come in and talk one to one.'* [Adapt staff member] If the victim is a non-English speaker, there is no translation available on the helpline; if a woman staying at the refuge needs a translator, Adapt has a list of interpreters to call on and also links up with another local organisation, Doras Luimní, a NGO that supports migrants living in Limerick and the wider Mid-West region.
The Dublin Rape Crisis Centre identifies victims either through the self identification by the victim through the helpline, or by meeting a victim who attends the SATU. The RCC gets a call when a person is sent to SATU: *'the nurse will have a note of our roster and whoever is on duty will go there – we try to get time before their examination after the examination they are usually not in form for talking to anybody; our main role is support.* [RCC]

Consistency of the Practice

No common practices have been identified across all the institutions that engage with victims with regard to identification of victims. The practices have not been found to be homogenous, systematic and consistent. Those working in the frontline would welcome improvements, as revealed through the following excerpts from interviews:

We are very reliant on people coming forward to self identify; "We have a victim centered approach – we make ourselves available at all costs to victim to do as much as we can for

them; we keep working on reassurance; It did come to light there were failings for example, instances where no crime is reported where no suspect is identified; Cases of no contact between Gardaí and victim was also a shortcoming; now – with new safeguards in place – that won't happen, it shouldn't happen; I think we are meeting needs of victims now , we are on right path." [Garda rank 2]*;*

PULSE is a good system, has had its teething problems, but now very good system; everything you do is done through it, has all info – omnipotent all seeing presence for information.' [Garda rank 1]

Although healthcare professionals have a duty to treat persons in their care respecting confidentiality, there can be problems in terms of hospital infrastructure: *'many cubicles have curtains and no glass doors so we are very sensitive to that; where clinically possible, we will move the patient to a quieter room, but it is a challenge and would welcome any recommendation that patients entitled to privacy in these situations.' [A&E staff]*

Three areas could be improved: 1st, it is very important to listen to victims themselves: it is really difficult to have the opportunity to speak to/be on your own with the victim: from booking in, the opportunity to be alone must be captured somewhere along the process;
A 2nd difficulty is that the victims carry their own notes; they really scared that if something is disclosed on a chart form or whatever, their abusive partner/family may discover it; charts are generally written using abbreviations, for example 'bp' is blood pressure; perhaps a system could be introduced to use 'v' to signal violence (to an abusive partner it could signify vomiting – I would like to see some sort of discreet way of reporting violence on a form which is then available to others involved in the victims care; the 3rd improvement is in training; healthcare workers should be better trained in observing couples for dynamics.' [healthcare worker midwife]

4.2. Individualised assessment of needs

a) Police

The investigating Garda must complete the mandatory Individual Assessment Screen on the PULSE system. The Gardaí at the scene will note if a victim requires particular sensitivity: if a victim is considered to be vulnerable, that must be highlighted through PULSE. A list of the vulnerable groups are entered in a separate screen on PULSE that captures a Gardaí's assessment of the victim – if for example, the incident relates to domestic violence, the Gardaí member must tick that relevant box which in turn is entered on the PULSE system. All information again automatically transfers to the Victim Service Office. The information is flagged for the superintendent's office – then depending on what the vulnerability is, a different action is taken according to how the superintendent considers appropriate. District Officers must consider what services to provide to victims of crime.

As to ascertaining the personal characteristics of the victim, this is principally done by the Gardaí at the scene, through asking questions or by observation of factors indicating obvious disability.: *"we take a common sense approach – we are told to treat everyone according to a high standard and to treat everyone equally, if there is an issue*

like mental disability, we approach everyone professionally, with curtsey, and see how we can help them, see what their problem is and how we can help them, take a mental note – one look at a person and you can generally tell from experience, using a common sense approach." [Garda rank 1]

General training for investigative interviewing is provided for Gardaí at two levels. One respondent related that in the past, Gardaí used their level I training for interviewing (both suspects and victims), but now increasingly use their level 2 training; they used to go into the interview with no plan, they may not have done research to begin with; now, in keeping with their level 2 training, interviews with victims are more structured. They create an interview plan, and structure the interview so as to be probing as much as possible.

There is no legal procedure for assessment – it is done in practice through using the aide memoire: *'you are doing assessment from experience and aide memoire; we follow the practice set out in the Garda Victim Service – operational Gardaí – and standard operating procedures documents–all procedures are within these for making assessment; all boils down to being at the scene, your evaluation of information, have you got all the information; a scene is fluid, it may be volatile, it may need a decision to be made immediately; you have to stay with an incident – keep following up on information;* [Garda rank 2]

In terms of assessing whether there is intellectual disability:

It boils down to how much background info you have at the time, you can get background information by questioning them, take details and do a check on PULSE by phone to see if any previous incidents have been recorded at this address; for example in the context of mental health, information where a person has a tendency to overdose etc. It could have been recorded under Attention and Complaints heading : where x makes a complaint or wants something brought to the attention of Gardaí but there is no crime, we will record it anyway so we have a record of it; there may be an a & c for this person, maybe they went missing and a carer had reported them missing stating that they suffer from mental illness – that is one way of establishing disability at the scene.' Otherwise you identify it through life experience – something may just not be right; you speak to relatives; doctor (with the victims consent) - if you suspect there is something then there possibly is something, therefore investigate to prove or disprove;[Garda rank 2]

Where there has been an assessment that a victim has special protection needs, for example where a witness (who may be the victim) is being intimidated, a Family Liaison officer is assigned; where there is serious threat to a witness, there is also the possibility of entering a Witness Protection programme. In addition, if a person is a repeat victim, or they are seriously threatened, a document notifying them that their lives are in danger is served on them; this document is a GIM form and is normally dealt with at Senior Investigating Officer level – once served, the Gardaí have a duty of care towards the victim. A crime prevention officer may also assist victims who have special protection needs.

b) Health authorities

In the Social Care division in the residential setting, the assessment is conducted by the designated officer or the public health nurse who must complete as

many sections in the referral form as applicable, including gender, age; features of crime such as alleged financial abuse, physical abuse, sexual abuse, psychological abuse, neglect, institutional abuse, discrimination. The designated officer must complete the referral form within 3 days, and must form an opinion based on their preliminary assessment as to whether they believe there are no grounds for further investigation; whether additional information is required or whether there are reasonable grounds to further investigate the incident, and attach with the form an 'interim safeguarding plan'. The team leader of the Social Care Division must then agree or disagree with those outcomes and ensure all necessary safeguarding activities are undertaken by the service. If a victim has been identified via the community pathway, the initial assessment will generally be conducted by a public health nurse, it is then the job of the team leader to ensure safeguards are provided – such could include assisting in getting court orders in cases of domestic abuse. Assessments are guided by Safeguarding Vulnerable Persons at Risk of Abuse – National Policy and Procedures Dec 2014; by internal policies of the Social Care Division, and informed by social work practice, education, theory and the experience of the professionals involved.

In the A & E context, once the medical needs of the victim have been met, assessment would be carried out by a social worker and documented in a separate chart. Special protection needs are noted by the social worker although any measures are ultimately the responsibility of the consultant who is responsible for their care. For victims in need of protection, it would be common in cases of domestic violence, or feuds etc. to have bar on certain people visiting, and to ensure that the victims name is not visible anywhere in the department. This can sometimes be difficult to manage; the ambulance service also need to take care not to bring feuding members to the same hospital. The features of a crime would generally not be noted other than establishing the weapon etc used in order to understand the injury mechanism as part of the medical assessment.

c) Victims organisations

For the Crime Victims Helpline, there is no legal procedure for assessment. *'Assessment is too formal a term, it happens immediately; we try not to assume what a person might need, volunteers are trained not to make assumptions'* [CVH staff]. Callers to the helpline are informed of the available services, given any contact information and told how to access counseling if required.

d) Vulnerable Victims: Children

Where a Garda attending the scene of a crime has identified a child victim, the assessment is undertaken by Gardaí Specialist Interviewers, ie Gardaí who have undergone special training for dealing with child victims. As noted above in s. [legislation]], section 16(1) of the *Criminal Evidence Act 1992* provides for video-recorded interviews with children under 14 by the Gardaí to be admissible in the trial as evidence. These interviews are conducted by the specialist interviewers having assessed that the child is eligible to be covered by s.16(1); if a child is not covered by the section, a written statement may be taken that is not video-recorded, but the

interview with the child is still conducted by the Garda specialist. Children are assessed about their levels of understanding of the importance of giving a truthful statement through a 'truth and lies' model of questioning: *I say to a child, a dog has 5 legs, is that a truth or a lie? This is important later in court if any questions arise around competence of a child in knowing distinction between truths and lies.'*[Garda Specialist interviewer 1]. Interviews with children also use the 'tell explain describe' model: *the statement quality is better, and results in a more correct statement, a free flowing narrative; I pick up and clarify points for example: tell me about this morning; basically I try to get more information - like a funnel, narrow it down and get the child to describe – to expand on, describe, broad to narrow to broad.'* [Garda Specialist interviewer 1].

A number of dedicated interview suites have been developed throughout the country to be used for the video-recorded interviewing of such complainants. These suites may also be used for the taking of written statements from other victims of sexual crime as the setting may be more appropriate than most areas in Garda stations. In conducting the interviews with children, the Garda specialists are guided by good practice guidelines, and by the specialist training they have received. Interviews are conducted by a team of two specialist Gardaí, who meet the child in their home or some other appropriate place, at a time that is not disruptive to the child's school or other activities; they explain the procedure to them, and inform the child that they are not obliged to participate if they do not wish to do so. The Gardaí do not wear uniforms when meeting with the child.

'*We make our assessment to first ensure that they understand what they are undertaking, that they know we are talking to them with the possibility of going to court – so we tell then what the Gardaí do, reassure them that they don't have to do it and ensure they know what is involved in going to court; sometimes people in background are pushing them to do it but the child doesn't really want to; we have to gauge all that; sometimes we meet the child a few times to be sure they understand.' [*Garda specialist 1]

In severe cases we may meet a child a few times before we ever get to the interview stage; we do things as much as possible on their grounds; we may also assess that it may be better for them to have counseling before us.' [Garda specialist 2]

The specialist interviewers discuss the case with the investigating officer and with social workers if they have been involved with the child.

In the healthcare sector, initial assessment of child victims will be carried out by social workers and their needs then assessed by Túsla (Child and Family Agency).

In CARI, staff generally meet with the family/career of the child and get their views on what the child might need, explain the services offered by CARI and allow the family to choose which services they wish to avail of. Staff also seek information from social workers and Garda; '*our job is to prevent revictimization'.* [CARI staff]

e) Vulnerable Victims: Domestic Violence and Sexual Violence

Assessment of victims of domestic violence is carried out by Gardaí through questioning the victim and ascertaining their needs, for example whether they have an existing court order and advising them on how to how to obtain such orders. Because victims have the choice of proceeding with a complaint, the most problematic area for working with victims of domestic violence is the frequency in dropping complaints. Other than recording the incident on PULSE, there is little more that the Gardaí can do.

At Adapt domestic violence service, a limited assessment may happen when the victim calls the helpline, for example if their needs relate to getting a court order (barring orders and safety orders); also, where a woman is seeking refuge, Adapt will also need to establish whether they have any special needs including whether they are engaged with psychiatric services, suffer from any substance addictions, have any disabilities and whether they are on medication. Where a woman attends the refuge, an assessment is conducted on the basis of a checklist, including such matters as date of birth (which can be checked to establish if the woman has previously used the refuge, and details of the risks to the woman's safety. Assessments of women are carried out in the absence of their children.

'We talk them through really to assess their level of risk; some will need immediate refuge- others might want to discuss possibly leaving partner; we can assess if they need other services; if they are at immediate risk in their home we give them refuge; in some cases, outreach might be sufficient, to meet them once or twice a week to help them cope with their situation; we also assess them regarding access issues, access is huge issue - managing difficulties around access. Assessment would usually take an hour as that is enough; following team discussion, assessment is complete within 3 days, and we draw up a support plan then'. [Adapt staff]

Consistency of the Practice

No common practices have been identified across all the institutions that engage with victims with regard to indivualised assessment of needs. The practices have not been found to be homogenous, systematic and consistent. Those working in the frontline would welcome improvements, as revealed through the following excerpts from interviews:

One Garda respondent considered the introduction of level 2 training makes the Gardaí interviews with victims far more satisfactory and reflects the 'victim centered' approach of an Garda Síochána; it allows for interviews to proceed at a slower pace and because it takes an approach which tries to probe as much as possible into all the circumstances of the victim, it provides the Gardaí with the means to assess the victim and identify their needs. The Garda Specialist Interviewers also were very satisfied with their training in interviewing training. However, resources, such as availability of the dedicated interview suites for children were a source of concern.

In the healthcare sector, those interviewed highlighted hospital infrastructure, training, resources and the treatment of victims of sexual offences as problematic:

There is room to improve with regard to training, social work support and infrastructure. Some hospitals would have issues with security – it is better in some than in others; say for example if a person is taken to an injury unit with a sprained wrist, it could be domestic violence, it more difficult to keep them safe than in a hospital where there is 24/7 security.
One concern is where victims of sexual violence who don't want to go down the Gardaí line and don't therefore get brought to the sexual assault treatment unit on the night, although they can self-refer later – I would worry about those people that the care they get may not be so good because they don't want to go through Gardaí – I think our services here for victims of sexual violence are not good – It would be better to have the specialists from SATU to come here rather than having to send the victim there - if there is no SATU in the hospital you arrive at, you are sent to another hospital, so that is area that could be improved – that the service would come to the victim rather than the victim going to the service – I would be concerned that victims would get lost along the way; I would be concerned also about hospitals that don't have medical social workers - that victims of crime may not be getting as good a service as they do in hospitals that do have on site social workers; I also have concerns about out of hours access to social workers. [A&E staff]

Public health nurses get training in needs assessment, but not midwives, and that definitely could be introduced, it doesn't happen - not for a community midwife; a further problem is a lack of communication between agencies, for example whether there is a court order in a domestic violence context– often domestic violence kicks off after a baby is born so you may get disruption on the ward. There is often alcohol involved after a birth too! Also, social workers and Túsla *staff, they work 9 to 5, no social workers are available out of office hours!*
Training is definitely needed around victims and non-contamination of evidence – it goes against our caring and empathetic profession not to be able to comfort a person but we need to stay away from them in cases of sexual assault to avoid contamination of evidence. [midwife]

Our assessment works for us, I would love to see cases where there are case conferences or meetings where all the professionals sit down together. Where we have had this, the case runs like clockwork. It is very important for cases with children; it is done if the Garda or social worker is really on the ball; it is done on best practice but not on standard practice – pre-trial meeting with DPP has become more standard practice. There is good cooperation between agencies, over the last few years the Gardaí have become so much more inclusive and they have reached out to victims and victims agencies, [CARI]

It would be good to have interpreters more easily accessed and funded; we deal with many women from different countries; no trained interpreters either for specific situations; we have to be really trusting of translators and hoping translators are not saying extra stuff. [Adapt]

4.3. Referral mechanisms

a) Police
Relevant documents: Internal Guidelines: Garda Victim Service Office Standard Operating Procedure & Garda Victim Service Office Operational Garda; Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland 2014; Child Care Acts; Children First: National Guidance for the Protection and Welfare of Children.; Children First Act 2015.

At one time, the Gardaí would automatically pass details of victims to the Victim Support organisation (a voluntary organisation which provided support to victims of crime in Ireland until 2005). However, victims' consent was not obtained prior to this information sharing and it became apparent that victims were not being made aware that their information was being passed to the Victim Support. Thus, concerns arose as to whether this practice was compatible with data protection rules. Having reviewed the matter, the Data Protection Commissioner advised that the Gardaí could no longer engage in this practice and that if a referral to a victim support organisation was to be made, this could only be done with the victim's informed consent (Office of the Data Protection Commissioner, 2001). The Data Commissioner cautioned that 'even when acting in furtherance of "good causes" – organisations must be sensitive to people's privacy rights, to ensure that inadvertent breaches of data protection law are averted' (Ibid). Thus, the practice has developed that the Gardaí now advise victims of relevant organisations but do not inform these organisations about victims.

All victims are referred to the Garda Victim Service Office through the Gardaí system – the GVSO Operational Gardaí requires that all Gardaí record 'any engagements with victims' through PULSE. Information is formally communicated to victims within 3 days of the offence via standardised victim letters that are issued by the Garda Victim Service Office using the PULSE system. The first letter that a victim receives acknowledges the victim's complaint and provides the PULSE reference number, details of the investigating Garda and, the contact details for the Crime Victims Helpline. A leaflet with the contact details of other support organisations is also enclosed with this letter. A second letter advises them of the developments in the investigation. A third advises them to contact the GVSO regarding the outcome of their case and a fourth letter is used to advise that the investigation cannot be progressed due to lack of evidence. The Victims Office make contact with victims throughout the whole process. In addition to the standard PULSE letters, they also contact victims by phone and ascertain if they have any needs, such calls would usually be done in the early stages of the process. Local files sections of Garda stations also issue the Gardaí with court files and the investigating Gardai will then contact the victim to update them either at the stage when a direction to prosecute or not is given and also when the case is completed in court. These stages are also covered by letter 3&4 which would be issued by the Victims Office.

Gardaí must be aware of victim privacy and safety at all times, especially in terms of how they wish to be contacted. The GVSO Standard Operating Procedure requires personal contact rather than PULSE letters be used throughout the investigation in communicating with certain victims.

b) Health authorities

Relevant documents: Child Care Acts; Children First: National Guidance for the Protection and Welfare of Children; HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures 2014; The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012; Rape/Sexual Assault: National Guidelines on Referral and Forensic Clinical Examination in Ireland 2014; Children First Act 2015.

Health care workers are statutorily obliged to respond to concerns of abuse if they discover an offence has been or may have been committed against a victim who is a vulnerable adult; the obligation to report abuse/crime to Garda Síochána arises under the 2012 mandatory reporting legislation, and this is reinforced through the 2014 HSE Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures: 'Where there is a concern that a serious criminal offence may have taken place, or a crime may be about to be committed, contact An Garda Síochána immediately'. In addition, healthcare workers working with vulnerable adults are required to take any immediate actions to safeguard anyone at immediate risk of harm 'including seeking, for example, medical assistance or the assistance of An Garda Síochána, as appropriate.' In the residential care setting, the designated officer must refer the case to the Safeguarding and Protection team leader, and must complete the referral form within 3 days.

In the A&E setting, or GP setting, victims may be referred to SATU (but only with the victim's consent) for the collection of forensic evidence for the investigation of a criminal offence, or SATU's advice may be sought. SATU staff must obtain victim's consent to send on the report of the forensic medical examination to their GP. Where suspicions of trafficking arise, there is no specific policy/guidance document and no specific training.

We have had cases of trafficked people; we would ask them whether they want us to contact police, and we would alert medical social workers in the hospital to that suspicion; if medical social worker has been alerted, we would ask the person whether they consent to being contacted by the social worker - we have social workers present here Monday to Friday 9-5; if it is outside those hours, we will flag it for their attention on computer. We ask their consent before that referral – it is always up to the person to consent to referral to Gardaí and to social worker except if children are involved in any way. In that case, under Children First, we have to escalate that and report to the social worker, Gardaí and Túsla*; generally it would be the social worker would make the report to the Gardaí; not all hospitals have on site social workers; we have translation in all languages available through agencies.* [A&E staff)

In the maternity context, referral depends on a victims consent: *If we see risk to Mother we ask the mother for her wishes whether she wants to make statement to Gardaí, her autonomy dictates (if no child at risk); if a child is involved, we operate the Children First guidance and escalate it up to* Túsla*, usually to the social worker and its out of our hands then.* [Midwife]

c) Victims organisations

The role of the Crime Victims Helpline is to assist by making appropriate referrals, but no direct referrals are made; victims are given the information so as to arrange their own access to the appropriate services.

d) Vulnerable Victims: Children

Relevant documents: Children First: National Guidelines for the Protection & Welfare of Children; Policy on Investigation of Sexual Crime, Crimes against Children and Child Welfare 2014; Children First Act 2015; Child Care Acts; Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 ;

Where a Garda at the scene has identified a child victim under 14 or an adult victim with a disability, they are referred to a specialist interviewer; where there are difficulties in identifying a victim who may have an intellectual disability, the Garda may contact the specialist interviewer and the latter decides whether the case warrants a specialist interviewer. Child victims under the age of 14 must be referred to the child specialist interviewer; for other complainants of sexual crime over the age of 14 years, they are referred to a specialist interviewer where appropriate.

Where a complaint is taken at the Garda station that in any way involves a child, which may often be the case if it is related to domestic violence, the Garda on duty must refer the case as quickly as possible to the specialist interviewer; the case is followed up at a daily meeting of the specialist interviewer and the sergeant where a decision is made as to the necessary course of action.

Under the Policy on Investigation of Sexual Crime, Crimes against Children and Child Welfare 2014, where a member of An Garda Síochána is interacting with a child for any reason, the welfare of that child must always be considered. Any concerns for a child's welfare must be reported to Túsla. All instances of cruelty to children must be notified to Túsla. [p 88.] This reflects Children First: National Guidance. When the 2015 Act introducing mandatory reporting comes into force, this will become a statutory duty.

In sexual offences against child victims under 18 years, they may be referred to SATU for forensic examination, only with the consent of the parents/guardians, and the young person is also 'encouraged to co-sign' the consent form. Children who are below the age of fourteen are not examined in SATUs but are referred to the Child and Adolescent Sexual Assault Treatment Service (CASATS), or other appropriate HSE unit.

Following referral to Túsla and HSE social workers where required, cases conferences are held between the Gardaí and these agencies in order to ascertain how best to meet the victims' needs.

Healthcare workers are statutorily obliged to report certain crimes to Garda Síochána under the Withholding of Information Act 2012 where the crime affects a child under 18 or vulnerable adult; staff at SATUs must refer children and vulnerable adults to Gardaí under Withholding of Information Act 2012; SATUs also refer to the Rape Crisis Centers with consent-SATUs must also refer the child to Túsla under the Children First Guidelines.

CARI do not make direct referrals; if they are unable to assist they direct the callers to the helpline to more appropriate services. CARI staff would be required to report to Gardaí in any cases covered by the Withholding of Information on Offences against Children and Vulnerable Persons Act 2012, and to Túsla under Children First (and 2015 Act when it comes into force).

e) Vulnerable Victims: Domestic Violence and Sexual Violence

While children under 14 must be referred to Garda specialist victim interviewers, the Guidelines on Referral and Forensic Clinical Examination recommend that 'Specialist Victim Interviewers should be considered for the taking of written statements from all other complainants of sexual crime, where Specialist Victim Interviewers are available.'(p24) *'Gardaí dealing on ground might also bring a case if the Gardaí feel a victim may be vulnerable, and might ask for assistance in conducting the interview; it happens fairly often - I do that every week'* [Garda Specialist interviewer 2].

Victims of sexual offences may be referred to SATU for forensic examination, but only having obtained a victim's informed consent. Where the complainant is under 18 years of age, the consent of the parents/guardians is required. Regarding the consent of the young person, 'if a parent or guardian is signing the consent, the young person, if appropriate, should also be encouraged to co-sign the consent form.'

The GVSO Standard Operating Procedure requires personal contact rather than PULSE letters be used throughout the investigation in communicating with victims of domestic and sexual violence.

In the healthcare sector, 'If concerns exist regarding domestic violence/interpersonal violence it is vital that as well as being provided with a place of safety if required, the patient should also be given information of their local support services.' [p94]Satu. There is no statutory obligation to refer suspected domestic abuse to the Gardaí unless it involves children –this would include situations where a midwife recognises domestic violence in the maternity setting since the unborn child may be at risk).

The 2014 Domestic Violence: Guide for General Practice contains a guideline for referral in the following terms:

Referral, in the context of victims of domestic violence, is different from the standard referral process familiar to GPs. The approach when such a disclosure is made should be to empower the patient to undertake action that she deems appropriate at a time that she deems appropriate.

The term 'refer' in this context describes the intervention whereby a doctor provides a patient with information about the resources available, and encourages her to contact those specialist support or state agencies which are in a position to help her when she is ready to do so. Counseling is important in supporting the woman so that she may soon find herself in a position to make a change.

Referral to another individual or agency should have the approval or expressed consent of the patient, as 'referral' by the GP to an agency or an Garda Síochána without the patient's direct involvement is rarely helpful and potentially harmful. It is often advisable to encourage your patient to make the contact herself. This may take the form of a telephone call in the privacy of your consulting room with your encouragement.

Adapt do not make direct referrals, but if a mental health issue arises, they refer to other voluntary agencies that deal with mental health, addiction and self harm issues with the victims consent.

Consistency of the Practice

Beyond the statutory requirements imposed regarding referral of children and vulnerable adults to Gardaí under the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 and to Túsla under Children First: National Guidance, no common practices have been identified across all the institutions that engage with victims with regard to referral. The practices have not been found to be homogenous, systematic and consistent. Clearly those working in the frontline would welcome improvements, as revealed through the following excerpts from interviews:

I don't feel there is good support plans working together with child protection and our service – but that is me speaking from my perspective in relation to our service; I feel it always seen to be the woman's fault, guards are not supporting her, social workers are not supporting her, the judge is not supporting her, so its very difficult; we put an aftercare plan in place, but it is up to woman to link in, we try to contact as far as we can, but we can only do so much; the cycle often starts again 6 months later. I have not seen improvement since the opening of the Garda Victim Services offices; some Gardaí have been very good, and we have very good community Gardaí – but they are busy and are not on duty at all times; Gardaí response is a problem– responses are at odds with the various policy documents – it is not happening on the ground; there is a gap between policy and practice. [Adapt staff]

I *have issues about social workers availability only in office hours, many victims come in on a Saturday night.*
I also think there could be more training – understanding the legal procedures as opposed to the medical procedures – more training on that would be useful [A&E staff]

We could do with improvements in manpower – Specialist Interviewers are swamped; for a referral to Sis where the victim is victim of sexual crime, a victim could wait up to 6 – 8 weeks – but there is a priority system and children will be dealt with sooner. In sexual crime, there is definitely a very coordinated approach – we need to know what has happened, has anything happened in the past – has any doctor made a referral to HSE of something suspect that hasn't come before us yet;
Cooperation now is there between the agencies – it is vital. [Garda rank 2]

5. Synthesis: good practice, gaps and challenges

Introduction

Legislative transposition of the Directive is still in train, despite the deadline for transposition set out in the Directive. At a theoretical level, various initiatives described in this Report, such as the strategies set out by Cosc, the development in the Garda Siochana of the Victim Service Office, the Dept of Justice Victims of Crime Office,

and the various Policy documents of the HSE all signal a move on paper to ensuring that Ireland will comply with the Directive. However the analysis of the current practice shows more generally a lack of inter-agency cohesion between the sectors dealing with victims on the ground, except in the case of child victims.

5.1. Identification of victims

Across all sectors, there is no legal procedure for the identification of a victim. Identification often arises through self-identification, or by the front line workers at the scene of a crime or hospital setting; better identification arises where the front line worker has experience. Common to all agencies, victims have autonomy in regard to their involvement in the process, unless children are involved. Translation is readily available in police and healthcare settings, but not as accessible in the context of victim organisations. Recording has been greatly improved in Garda setting, but gaps have been identified in the healthcare setting. Training has also greatly improved in Garda setting. Training is considered lacking in healthcare setting by healthcare staff. This would appear to be especially the case in the context of identifying domestic violence victims, where it was evident that healthcare staff had not received any dedicated training in this regard – one respondent drew on her experience with social work background and training to assist her in identifying domestic violence; another used identifying skills she had obtained in the context of being involved in teaching antenatal groups, which exposed her to issues of family and couples dynamics. Lack of privacy for patients in the healthcare setting is a problem in identifying victims, again especially in the domestic violence context. Lack of discrete recording of domestic violence incidents on medical charts was also identified as problematic. It is suggested in the GP guideline that gps should assist the patient in coming up with a medical 'alibi' so that a partner would not be aware of the reasons for a victim visiting a gp.

5.2. Individualised assessment of needs

Gardaí are already operating closely in line with Art 22 of the Directive through their Policy and internal guideline documents, despite the fact that legislation has not yet transposed the Directive into national law. The Garda aide memoire ensures that pertinent questions are asked of victims by the Gardaí; the system of recording incidents through the PULSE system ensures that many aspects covered in Art 22 in relation to assessment of victims and their needs are required to be entered into the system, and the change from the practice whereby individual Gardaí entered the details of incidents themselves to the system to the current practice of a central controller entering all details to the system would appear to ensure that no details are missed. The PULSE system would also appear to have facilitated the identification and assessment of whether a person may have particular needs due to the inclusion of incidents that have not resulted in a Garda investigation under the heading of Attention and Complaints. There also appears to be good mechanisms in place to assess and protect victims from re-victimization through the Family Liaison officer system.

The assessment of victims needs would appear also to have improved through the training that Gardaí now get in relation to interviewing victims. The introduction of Garda specialist interviewers and the training given has been praised by those interviewed, who felt they have benefited greatly from their training.

All these aspects contribute to the effective implementation of the Directive.

While the Garda have a pro-arrest policy in relation to domestic violence, it appear from the statistics to work well where there is a breach of a court order – crucially this does not depend on the complaint being continued by the victim. However, domestic violence incidents in the absence of a court order breach continue to be problematic and much needs to be done in this regard to assess and protect victims from re-victimization.

One healthcare worker found a training resource useful in interviewing and assessing victims, especially domestic violence victims, even though the resource, Supporting Staff following an Adverse Event: the ASSIST ME model, is directed at supporting staff following a traumatic event in their healthcare environment rather than victims.

There is no single inter-agency form or procedure available to professionals in all the sectors to use in assessing victims needs. This reflects a lack of inter-agency cohesion, and needs to be improved to meaningfully comply with the Directive.

5.3. Referral mechanisms

Common to all sectors is victim autonomy in the context of referral. The consent of the victim must always be obtained, and this also goes for children attending SATU units for collection of forensic evidence. Children also have autonomy where it comes to meeting with specialist interviewers in order to give video-recorded interviews that may be used as evidence in the criminal trial. The only areas where victims do not have autonomy in relation to referral are in the context of certain offences against the elderly, vulnerable persons and child abuse. In relation to elderly abuse, this must be referred to the Safety and Protection team leader, and in relation to certain offences against children and vulnerable persons, there is a statutory duty to inform the Gardaí and it is an offence not to do so. In addition, there is a duty that applies to professionals in all the sectors under the Children First guideline to refer cases to the Child and Family Welfare Agency – Túsla, although currently this is not a statutory duty given the delay in bringing s 14, which makes it mandatory to report to the Agency, into force.

Referrals are more often by way of giving victims information on how to access available services, rather than direct referrals. This would appear to be always the case when it comes to referrals by the victim organisations, and where it arises in the context of Garda referral to victim agencies. Due to privacy issues, the Gardaí may no longer make direct referrals to victim agencies.

Conclusion

Case conferences between Gardaí, Túsla and the HSE are considered to work extremely well regarding child victims, and in some cases of victims of sexual offences – these could work as a model for better cohesion amongst the relevant agencies in regard to a broader remit of victims. The domestic violence agency Adapt response reflects a need for much greater cooperation between all the agencies in relation to domestic violence victims.

The launch in 2015 of the dedicated Garda Victim Service Office is a welcome development. It provides a centralised mechanism to ensure that all victims are referred on to a specialised agency within the Garda Síochána and are given the information they need and kept informed as cases progress; it also should ensure that victims are dealt with in a consistent manner throughout the country within the Garda Síochána. The Victim Service Office is still relatively new and all Gardaí interviewed were fully aware of its existence. Nonetheless, it is too early to say what effect the Office will have on the provision of information to victims, and whether it will develop to become a more sustainable personalised service or whether it will operate more along the lines of standardised correspondence that does not effectively engage with victims. The provision of information as it currently operates through sending out PULSE letters will improve the problem regarding lack of information for victims identified by the Garda Inspectorate and the Garda public attitude surveys, and it would see the Garda Síochána operating in compliance with the Directive – but to be *meaningfully* compliant, it might be preferable to staff the Victims Service Office with sufficient personnel to meet their demands, including specialist civilians (social workers, counsellors) who could engage with victims of crime on a more personalised basis.

The new approach of the Garda Síochána of a centralised recording procedure into PULSE provides Gardaí with easily accessible information on the ground in individual cases so that they are in a better position to assess and refer victims to appropriate agencies. However across the agencies there is no centralised shared recording system (with the exception of Túsla) whereby the information recorded at the various entry points would be accessible for all front line agencies to cross reference. The challenge remains however of data protection and privacy. It contributes to a lack of inter-agency cohesion, and needs to be improved to allow those dealing with victims to meaningfully comply with the Directive.

Overall, the examination of practices in Ireland relating to identification of victims, individualised assessment of victims needs and referral mechanisms, beyond the statutory requirements imposed regarding referral of children and vulnerable adults to Gardaí and Túsla outlined above, suggests that there are no common practices across all the institutions that engage with victims. Therefore, it cannot be confidently stated that the practices are homogenous, systematic and consistent.

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