3 July 2026

SCOPING EXERCISE IN RELATION TO ALLEGATIONS OF SEXUAL ABUSE MADE AGAINST MICHAEL SHINE

Lorcan Staines SC

Commissioned by the Minister for Health

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Executive Summary

On 3 March 2026, I was appointed by the Minister for Health, Jennifer Carroll MacNeill TD, as the independent facilitator for a scoping exercise requested by Dignity4Patients, a support, advocacy and information organisation representing victims and survivors of former surgeon Michael Shine.

This exercise was not a statutory inquiry. I therefore had no power to compel the production of documents, require witnesses to attend, take evidence on oath, or make determinations of disputed fact, civil liability or criminal liability. My task was to examine the existing record where possible, listen carefully to victims and survivors, identify the principal unanswered questions, assess what further clarity may realistically be achievable, and advise the Government on the appropriate next steps, if any.

The report is concerned with two related tasks. The first is to set out, as clearly as possible, the procedural and institutional background to the issues surrounding Michael Shine. The second is to advise on the most appropriate framework for any further State response, having regard both to the existing documentary record and to the concerns, experiences and requests of victims and survivors.

Where I refer to matters described to me by victims, survivors or other individuals consulted, I record those matters as representations made to me. I do not have authority to make determinations in relation to contested facts, and I do not do so in this report. That being said, Michael Shine is not an alleged sex offender. He is a convicted sexual abuser of boys and young men and was described by the Court of Appeal as a "prolific

sexual offender" who has been convicted of many offences of a similar nature in respect of a similar category of victims.

The victims and survivors whom I met (approximately 75 in all) were middle aged to elderly men from all walks of life in Drogheda and the surrounding areas. They made a considerable impression on me. They were polite, measured, and visibly grateful to have someone listen to them in an informal environment. Many were self-deprecating and underplayed the seriousness of what had happened to them. The damage done to these men was palpable, even following the passage of time. It was also clear that the harm had not been borne by them alone but had often radiated outward to their families and to those who cared for them.

Several common themes emerged from the accounts received. Allegations of abuse reported to me involved a broad range of ages, including reports of abuse when victims were children, teenagers and young adults. Allegations were reported as having occurred in Our Lady of Lourdes Hospital, in Michael Shine's private practice in Fair Street, Drogheda and in Michael Shine's own home, with the earliest allegation said to have occurred in 1964 and the latest in 1990.

Nearly all of the victims who spoke to me were of the view that Michael Shine's conduct was a matter of public knowledge at the time. Many referred to local warnings, local comments, and the phrase that "the dogs on the street" knew what was happening.

There was unanimous agreement among those I spoke to that the response to their allegations had been unsatisfactory. Concerns were raised in relation to virtually every

body or organisation which had responsibility to deal with the alleged conduct, including the Hospital staff and board, the North Eastern Health Board, The Medical Council, An Garda Síochána, the Director of Public Prosecutions, subsequent reviews, and the Courts. The general view of victims was that there had been a series of failures from start to finish and that no one had ever given them an adequate explanation as to;

(a) how Shine's conduct could have continued for such a long period of time, against so many boys and young men, in multiple locations, without detection and,

(b) why the steps that followed were so inadequate, mismanaged and poorly handled.

I have formed the view that, given the number of victims and survivors (currently standing at over 400), and the significant issues raised by them which have not previously been examined sufficiently (or at all) a further State response is required. Given the significant passage of time since the events the subject of this scoping exercise occurred, I am also of the view that any State response should be bespoke and tailored to the specific issues raised, as well as carried out as expeditiously as possible.

I recommend a six-phase Commission of Investigation to be established by way of statutory instrument pursuant to the Commission of Investigation Act 2004. I further recommend that the Commission should be chaired by one person and that all six-phases can and should be run concurrently and start immediately. The approach is designed to avoid an inefficient and lengthy process and to provide a workable form of State response to the issues raised.

Phase 1 should be an independent, document-based examination of the history of the criminal complaints made to the Gardai, the submission of complaints to the Office of the Director of Public Prosecutions, of decisions made to prosecute or not to prosecute and the outcome of those prosecutions in order to provide victims and survivors, and the public, with a clear explanation as to why so few allegations made against Michael Shine resulted in a conviction.

Phase 2 should be an independent, document-based review examining the response of the Medical Council to complaints and allegations concerning Michael Shine.

Phase 3 should be an independent, document-based review examining the circumstances in which Michael Shine retired from the Hospital on 13 October 1995.

Phase 4 should be a short and focused module on current patient-protection policies in the Irish healthcare system.

Phase 5 should be an independent Truth and Recovery Process. This should be a distinct, victim-centred and non-adversarial module, commencing promptly and running alongside preparation for the more formal stage of the investigation. It could and should provide a structured means by which victims and survivors may be heard in their own right. It should enable victims and survivors to describe, in their own words, what happened to them and the impact of the abuse on them in a respectful, structured and potentially evidentially useful way. The purpose of this phase should be to assemble what Professor Scraton described to me as an "accumulated narrative" or an "aggregated truth", so that a coherent history is drawn from recurring patterns in the evidence and

from the individual experiences of those affected for the benefit of the victims themselves and society at large.

Phase 6 should amount to a comprehensive investigation into the actions of and events surrounding the abuse committed by Michael Shine followed by a report setting out, so far as the evidence permits, what was known, by whom, and at what stage (if anything). It should examine the full extent to which relevant bodies received complaints, information, warning signs or indications of risk concerning Michael Shine, what actions they took in response, and whether their actions were adequate and timely in the circumstances as they then stood.

Finally, I do not recommend publication of the Smyth Report at present. In my view, the question of publication should be revisited only after the Commission of Investigation has concluded and its final report has been published.

Chapter One: Introduction

On 3 March 2026, the Minister for Health, Jennifer Carroll MacNeill TD, announced my appointment as the independent facilitator for the scoping exercise requested by Dignity4Patients, a support, advocacy and information organisation representing victims and survivors of former surgeon Michael Shine.

The Government stated that this appointment followed its agreement in November 2025 to a time-bound scoping exercise and that it would run for up to 16 working weeks.

The exercise was to be carried out through direct engagement with victims and survivors of Michael Shine, working alongside Dignity4Patients. It was also indicated that the exercise was to be underpinned by a victim-centred, trauma-informed and human-rights-based approach, and that the final report and recommendations would be submitted to Government to guide the development of an appropriate response (if recommended) to the issues identified by Dignity4Patients on behalf of victims and survivors.

The exercise was not established as a statutory inquiry. The consequence of same is that I had no power to compel the production of documents, to require attendance by witnesses, to take evidence on oath, or to make determinations of disputed fact or of civil or criminal liability. The purpose of the scoping exercise was to examine the existing record (where possible), listen carefully to victims and survivors, identify the principal unanswered questions, assess what further clarity may realistically be achievable, and advise the Government on the appropriate next steps (if any).

The report is therefore concerned with two related tasks. The first is to set out, as clearly as possible, the procedural and institutional background to the issues surrounding Michael Shine. The second is to advise on the most appropriate framework for any further State response (if any), having regard both to the existing documentary record and to the concerns, experiences and requests of victims and survivors.

Where I refer to matters described to me by victims, survivors or other individuals consulted, I record those matters as representations made to me; I do not have any authority to make determinations in relation to contested facts and do not and have not done so. As such any allegations relayed to me remain allegations which can and should be considered in a further state response (should one be established).

That said it is important to record that the information provided to me by the representatives of the victims and the victims themselves should be read in the context of the following comments of Ms. Justice Isobel Kennedy, Judge of the Court of Appeal, in ***MS v. DPP*** [2021] IECA 193 where she noted that Michael Shine:

"has been found to be a prolific sexual offender, who has been convicted of many offences of a similar nature in respect of a similar category of victims."[1]

As such Michael Shine has no presumption of innocence in relation to the nine victims that he was convicted of abusing. He is not an alleged sex abuser. He is a convicted sexual abuser of children and young men.

[1] Para 49

Methodology and Roadblocks

In carrying out this work, I adopted a listening-first methodology. I met with victims and survivors collectively and individually, both in person and remotely. I wished to hear directly from them as to the issues they consider remain unresolved and the questions they wish to have answered. I also discussed with them whether they had an appetite for a future investigative process and if so, what issues they believe this process should address.

I also wrote to relevant institutions and interested parties, inviting them to provide such information, documents or submissions as they wished to place before me. I received a significant amount of documentation from victims and survivors and from Dignity4Patients which I have collated and will provide to the Minister for Health in conjunction with this report. I will not retain any physical documentation and will permanently delete any electronic documentation provided to me.

While I sought all relevant documentation from the parties concerned, given the absence of compellability and the short timeframe within which the work had to be completed, the documentation ultimately received was relatively limited and much was received at the very last moment, with more documentation being received in week 16 of this exercise than in all preceding 15 weeks put together. This reality has justified the insistence of the Minister for Health that this scoping exercise must be completed in a short timeframe - As the adage goes "nothing makes a person more productive than the last minute".

Considering the strict legislation in relation to data protection including but not limited to the identities and personal information of victims many of the parties were understandably cautious about voluntarily providing documentation to me.

On entering into this process, I had hoped to obtain a relatively comprehensive suite of documents to pass to the Minister for Health, and ultimately the Government, in order to assist them in relation to the decisions that will have to be made upon receiving this report.

However, in the end, most of the documents I received were furnished by Dignity4Patients and the victims themselves. This limited the depth to which I can explore certain matters in this Report, however, where a lacuna in information arises, I have recommended that further exploration of this topic be carried out at a later stage (should one be directed by Government).

Nonetheless, I am satisfied that I received sufficient documentation to properly complete my task.

Chapter Two: Terms of Reference for a Scoping Exercise

1. Background

1.1. At its meeting of 26 November 2025, the Government agreed, at the request of the Minister for Health (the "Minister"), that a scoping exercise be undertaken in response to requests from Dignity4Patients on behalf of victims and survivors of Michael Shine.

1.2. The Minister has appointed Lorcan Staines SC (the "Facilitator") to undertake this scoping exercise and to report to the Minister.

1.3 In undertaking his exercise Lorcan Staines SC may seek expert assistance from Maeve Lewis and Professor Phil Scraton.

2. Purpose of the Scoping Exercise

2.1 The purpose of the Scoping Exercise shall be to:

- Consider the circumstances in which the complaints of the victims and survivors arise, including the current state of fact-finding which has been conducted in relation to the conduct alleged, the views of victims and survivors as to whether further action or investigation is required and the mode by which victims and survivors may wish for such further action or investigation to be conducted.
- If a further action or investigation is deemed necessary by the Facilitator, the Facilitator should propose a framework for a State response to these allegations Such a response should consider the sexual abuse carried out by former surgeon Michael Shine, , and the surrounding circumstances relating to how this occurred.

- Make recommendations regarding the scope, breadth and sequencing of such a response, including consideration of whether a modular or phased approach may be appropriate.

3. Scope of Exercise

3.1 Engagement with Survivors

3.10 The Facilitator shall, where he considers it appropriate, engage directly and meaningfully with:

- Victims and survivors of Michael Shine's abuse, whom the Facilitator considers necessary to consult with or who may wish to consult with him;
- Dignity4Patients, representatives of victims of Michael Shine, and any other key individual victims identified by Dignity4Patients who wish to meet with the Facilitator;
- The submission furnished by Dignity4Patients, dated 30 June 2025, entitled "*What do children and young people who were victims of sexual abuse at the hands of former surgeon & convicted sexual offender Michael Shine want from a statutory inquiry/investigation?*"; and
- The outcomes sought by victims and survivors in considering possible next steps including the form of any further State response.

3.11 Engagement with victims and survivors, both individually and collectively, shall be:

- Accessible;

- Trauma-informed; and
- Supported, where appropriate, by advocacy and legal expertise.

3.2 Review of Documentation and Relevant Materials

3.20 The Facilitator shall, where possible, review all documentation and other materials considered relevant to the completion of the scoping exercise and may seek such court judgments, reports, records, or other evidence as he considers necessary.

3.21 Without prejudice to the generality of the foregoing, this shall include consideration of:

- The 1996 report of the Independent Review Group established by the Board of the International Missionary Training Hospital, Drogheda, chaired by Miriam Hederman O'Brien;
- The report authored by Mr Justice Thomas Smyth concerning events at the hospital;
- Relevant evidence, testimony, rulings, and judgments arising from criminal, civil, regulatory, or professional proceedings relating to Michael Shine's sexual abuse of children; and
- Any other documentary, institutional, or archival material provided to the Facilitator during the 16-week period allocated to this exercise which the Facilitator deems relevant.

3.22 The Facilitator shall consider the Report of Mr. Justice Thomas Smyth and shall make a recommendation as to whether it should be published (which recommendation shall be subject to legal advice which may be received by the Minister for Health).

3.3 Assessment of Options for a Further State Response

3.30 Should the facilitator recommend a further State response the Facilitator shall assess potential options for the most appropriate mechanism in the circumstances. In carrying out this assessment, the Facilitator shall have regard to:

- The extent to which any proposed mechanism is capable of addressing the outcomes sought by victims and survivors;
- The potential impact on victims and survivors, and where relevant, their families;
- Any legal issues arising, including the exercise of powers of compellability or other powers that may be required;
- The potential interaction with any current or future criminal investigation or prosecution;
- Any previous inquiries, reviews, and other processes relating to non-recent sexual abuse, including the Drogheda Review conducted by Mr Justice Thomas Smyth and other comparable inquiries or processes as the Facilitator considers appropriate.

4. Recommendations

4.1 Should the facilitator recommend a further State response the Facilitator shall provide reasoned recommendations to the Government regarding:

- The appropriateness, form, and nature of any response;
- The issues and matters that should be examined in any future investigative process; and
- The structure, scope, sequencing, and methodology of any such process.

4.2 In making these recommendations, the Facilitator shall have regard to practical challenges arising from the passage of time, including the availability of witnesses and contemporaneous documentation.

4.3 The Facilitator may also consider any additional matters agreed with the Minister regarding engagement with stakeholders or other relevant processes.

5. Consideration of Future Response

Where a further State response is recommended by the Facilitator, the Facilitator's recommendations shall include a reasoned and detailed assessment of:

- The most appropriate mechanism, including a bespoke model as he sees fit informed by consultations with victims and survivors during the course of this exercise; and
- The requirement for compellability of witnesses and documents, and the extent to which hearings may be necessary and the extent to which they should be conducted publicly or privately.

6. Timeframe

6.1 The Facilitator shall conduct the scoping exercise as expeditiously as practicable with a commencement date of 3 March 2026.

6.2 A written report shall be furnished to the Minister within 16 working weeks of the agreed commencement date.

Chapter Three: Relevant Parties to the Exercise

There are several individuals and organisations who are relevant to the issues being explored for the purposes of this exercise. This section of the Report sets out each of these persons / bodies and their relevance to the matters at issue in this scoping exercise, as well as the abbreviation used for them throughout the Report if applicable.

Michael Shine ("Shine")

Shine studied medicine at University College Dublin and served as an Intern House Surgeon at the Mater Misericordiae University Hospital from 1956 to 1957. Following his internship, Michael Shine worked as a Senior House Officer (SHO) at the Prince of Wales Hospital from 1957 to 1958. He served as an SHO and Surgical Registrar at the Glasgow Royal Infirmary between 1959 and 1961 and subsequently worked as a Registrar at Hammersmith Hospital and later at King Edward VII Hospital from 1961 to 1963.

Shine returned to Ireland in 1963 and continued his career at Our Lady of Lourdes Hospital in Drogheda. He served as Senior Registrar from 1964 to 1968 before being appointed Consultant Surgeon, a position he held from 1968 until his retirement in 1995.

Michael Shine also had his own private clinical practice in Drogheda at his Fair Street Clinic as well as an examination facility in his home. Throughout his career, Shine held both the Fellow of the Royal College of Surgeons of England (FRCSE) and Fellow of the American College of Surgeons (FACS) qualifications.

Shine served as a representative of the North Eastern Health Board from 1982 to 1995 and as a committee member of Comhairle na nOspidéal, appointed by the Minister for Health in 1989 to 1992.

Beyond his clinical career, Shine supported charitable work internationally. He sponsored children through SOS Children's Villages India and visited them in Kochi. He also volunteered on occasion at the Medical Missionaries of Mary hospital in Nigeria.

During his time practising as a surgeon, Shine was well-connected in the community and strongly supported by staff in the hospital. He was involved in sports, particularly tennis. He is stated to have had a tennis court in his home, to have sponsored tennis competitions and apparently had a trophy named after him for a local competition.

Following his retirement, it appears that Shine went on to do a BA in Philosophy in Milltown Institute from 1996 to 1999.

Allegations of serious sexual abuse perpetrated by Shine first became public knowledge after a complaint made to AGS in March 1994 (though dates of earlier complaints have been considered in this Report). Since this time, Shine has faced several criminal trials and been involved in numerous civil proceedings relating to similar subject matter. Shine is now 93 years old and resides in Dublin 4.

Our Lady of Lourdes Hospital, Drogheda ("the Hospital")

On 8 December 1939, the hospital that would later be known as Our Lady of Lourdes was founded. Our Lady of Lourdes Hospital, Drogheda (the "Hospital") was commissioned on the initiative of Mother Mary Martin of the Medical Missionaries of Mary and was

opened as Our Lady of Lourdes International Missionary Training Hospital in 1955. The Hospital was owned by the Medical Missionaries of Mary ("MMM") during 1970 and to 1997. A 1994 arrangement established a Joint Administrative Executive between the Hospital and North Eastern Health Board to formalise their working relationship and the Hospital was ultimately sold to the North Eastern Health Board in 1997. The Hospital is now owned by the Health Service Executive ("HSE").

Between 1970 and 1997, the Hospital was a public voluntary hospital owned by MMM. As a public voluntary hospital, it was owned by MMM as a religious congregation but received funding from the State, and its services were accessible to the general public as part of the wider publicly funded health system.

Although MMM remained the proprietor between 1970 and 1995, it substantially withdrew from day-to-day operational management, transferring that responsibility to the Hospital Management Board, which was itself accountable to MMM through a three-member MMM Commission. The Board generally met every two months and delegated responsibility for day-to-day operational management to a Chief Executive Officer, who introduced a Corporate Management Group consisting of the Medical Director, the Director of Nursing, the Financial Controller, the Personnel Officer, and himself. In 1996, the Chairperson of the Hospital Board of Management was Eugene Quigley.

The governance chain was therefore:

MMM Congregation (proprietor)

⬇

Three-member MMM Commission (accountability body)

⬇

Hospital Management Board

⬇

Chief Executive Officer

⬇

Corporate Management Group

Medical Missionaries of Mary ("MMM")

The MMM Congregation was the proprietor of the Hospital during the relevant period and was actively managing the Hospital at the time when the earliest of the alleged incidents took place. Six of the eight-member Board of the Hospital were appointed by the Congregation, two of whom were members of the Congregation.[2]

The North Eastern Health Board ("the NEHB")

The NEHB was one of eight regional health boards in Ireland established under the Health Act 1970. The NEHB operated from 1971 to 2004 and was responsible for the administration and delivery of public health and personal social services across Counties Cavan, Louth, Meath, and Monaghan.

The NEHB was later restructured and its functions and responsibilities were ultimately absorbed into the Health Service Executive under the Health Act 2004, which established the HSE and dissolved all previous health boards and regional authorities.

An Garda Síochána ("AGS")

AGS are responsible for the prevention, detection and investigation of crime in Ireland, initially regulated by the An Garda Síochána Act 1924 (as amended) and ancillary

[2] This description of MMM is taken from the Hederman O'Brien report

regulations, and subsequently further regulated by the An Garda Síochána Act 2005 (as amended).

AGS were in receipt of complaints of sexual abuse at the hands of Shine from at least 1994. Their involvement in the receipt of complaints, the actions taken on foot of same, and their investigation of these crimes are considered in this report.

The Director of Public Prosecutions ("the DPP")

The DPP is responsible for the prosecution of criminal offences on behalf of the people of Ireland, established by the Prosecution of Offences Act 1974 and taking over this responsibility from the Attorney General.

The DPP 'Guidelines for Prosecutors' provides an overview of the proper procedures and processes which should be undertaken by the DPP. The first edition of same was published in 2001. The guidelines are now on their fifth edition, the last being published in 2019.

The DPP received files from AGS relating to complaints of sexual abuse by Shine. The manner in which these files were processed and the subsequent prosecutions arising therefrom are considered in this report.

The Medical Council

The Medical Council was created and placed on a statutory footing by the Medical Practitioners Act 1978. The purpose of the Medical Council, according to the Act (as amended), is to regulate medical doctors in Ireland which includes maintaining the General Register of Medical Practitioners and processing complaints of misconduct and

poor professional performance by doctors. The Medical Council also provides education and training to doctors and is primarily concerned with the protection of the public.

Complaints of sexual abuse perpetrated by Shine were made to the Medical Council, who ultimately successfully applied to have Shine struck off the medical register in 2008. The manner in which these allegations and complaints were processed will be considered in this report.

Dignity 4 Patients ("D4P")

D4P is a support, advocacy and information organisation working with people who have experienced sexual abuse or inappropriate sexual behaviour in a medical, healthcare, or therapeutic environment. D4P is a Drogheda-based organisation founded by former nurse and whistleblower, Bernadette O'Sullivan in 2008.

Bernadette O'Sullivan worked as a nurse in Our Lady of Lourdes Hospital and, when first made aware that a patient had made allegations of sexual abuse against Shine, she supported the victim in making a complaint to AGS in 1994. In early 1995, Bernadette O'Sullivan learned that the allegations made had not been brought to the attention of the Hospital and supported the relevant victim in making a complaint to the Director of Community Care in the NEHB, setting in motion the chain of events which ultimately brought to light prolific sexual offending by Shine in the hospital and the extensive criminal and civil litigation flowing therefrom.

Bernadette O'Sullivan acted as Executive Director of D4P from their foundation until 2021 when she was succeeded by Adrienne Reilly. D4P has campaigned since its establishment

for a full inquiry and investigation into the allegations made against Shine and the subsequent handling of the issues arising by the relevant State bodies.

At the date of writing this Report, D4P represent over 400 individuals who allege sexual abuse at the hands of Michael Shine. It was through D4P that the victims and survivors I spoke to for the purposes of this Report contacted me.

Chapter Four: Procedural History

This chapter will consider the history of Shine's alleged conduct, including all previous reviews, reports, investigations and inquiries into these matters, together with views from victims and other contributors to this report in relation to the adequacy of the response.

Early Reports

A number of complaints are said to have been made to MMM and possibly the Gardaí prior to those that were made public. The Hederman O'Brien report notes that MMM indicated that they received complaints of sexual abuse as early as 1977 and 1982/1983. The report records that these two complaints were not recorded in writing. A victim alleged to me that he informed two nuns in MMM in 1979 that he had been abused. No records in relation to such a complaint have been obtained.

In terms of complaints to AGS, it was reported to me by a victim that a complaint was made in 1990. I have no further information in relation to whether complaints were made to AGS prior to the first known recorded allegation in March 1994.

Complaints Become Public / Made known to the Hospital[3]

In March 1994, Mr E made a complaint to AGS in relation to allegations of sexual abuse by Shine. Approximately a year passed in which records were sought from the Hospital

[3] It should be noted that all of the factual findings in this section are taken from the Hederman O'Brien report, save for where a specific letter, document or news article is relied on.

by AGS, but no other contact appeared to have been made with the Hospital in relation to the complaint.

On 29 March 1995 a complaint was made by Mr A to the NEHB. This was conveyed to the Hospital on 31 March 1995. It appears Mr A had become aware of the fact that his complaint (which had been made to AGS) had not been conveyed to the Hospital and therefore, with the support of Bernadette O'Sullivan, a complaint was made to the director of community care in the NEHB.

On 3 April 1995, the Hospital met with Shine and discussed the allegations with him. He agreed to go on leave *"for the time being"*. On 5 April 1995, the Hospital appointed Mr Quigley, Chair of the Hospital board, to initiate the disciplinary and complaints procedures. Legal advice was taken by the board in relation to their power to conduct an investigation in light of a term in the consultant's common contract which stated that allegations against consultants should be made within six weeks of the alleged incident. Having received those advices, Mr Quigley invoked the disciplinary and complaints procedures on 13 April 1995. On 9 May 1995, a letter was written to Mr Quigley from the Hospital Board expressing support for Shine and seeking his reinstatement.

In May 1995 the chief executive officer of the Hospital spoke to a member of AGS who indicated he was investigating a number of complaints against Shine. On 30 May 1995, Mr B wrote to the director of community care in NEHB alleging sexual abuse by Shine. On 6 June 1995, this complaint was passed to the CEO of the Hospital. On 25 July 1995, the Hospital Board wrote to Mr Quigley indicating that they had "unanimously

decided" that Shine should return to work, outlining their view that as the DPP had decided not to prosecute two of the allegations against him, the *"accusations have no major substance."*

On 27 July 1995, as investigations were ongoing, Shine wrote to Mr Quigley informing him of his intention to return to work on 8 August 1995.

On 27 July 1995 Mr Quigley decided not to proceed any further with the complaint by Mr A on account of the passage of time as well as the "*expressions of support for Shine by the Medical Board and staff*". He did not make any decision in relation to the substance of the complaint. At this time, further complaints that had been made to AGS had been published in the media.

On 8 August 1995, Shine returned to the Hospital as an adviser to the locum general surgeons. On the same day, the Hospital issued a press statement stating that it was not proceeding further with the disciplinary and complaints procedure. On 16 August 1995, following a meeting between the NEHB and the Hospital, it was indicated that the return of Shine to the hospital was not acceptable to the NEHB.

On 18 August 1995, the Hospital received a further complaint made by Mr C. On 21 August 1995, the disciplinary and complaints procedures were invoked against Shine once more in relation to Mr C's complaint. On the same date, this complaint was sent to AGS. AGS informed the Hospital that they were now investigating six complaints against Shine. On the same date, Shine agreed to take his remaining leave days up until 4 September 1995.

On 22 August 1995, the Hospital wrote to the Medical Council in relation to a further complaint by Mr C. On 7 September 1995 the NEHB received a further complaint from Mr D which was also forwarded to the Hospital. On 11 September 1995, the disciplinary and complaints procedures were invoked by Mr Quigley in relation to Mr D's complaint.

On 21 September 1995, discussion commenced between the legal representatives of Shine and the Hospital in relation to his possible retirement. On 13 October 1995, Shine retired from the Hospital.

On 23 October 1995, following concerns as to how the Hospital had dealt with complaints of serious sexual abuse, the NEHB indicated that it would be setting up an external group to review the matter and invited anyone who *"believed that they had suffered abuse"* to come forward.

At a meeting on 6 November 1995 the Hospital Board (i) approved the setting up of an independent review group, and, (ii) approved the terms of reference for that review. Dr Miriam Hederman O'Brien was appointed as chairperson of the Independent Review Group. The report which emanated from this review is colloquially referred to as the Hederman O'Brien Report.

The Hederman O'Brien Report

On 7 November 1995, the Board of the Hospital, with the co-operation and support of the NEHB and the Department of Health, established an Independent Review Group chaired

by Dr Miriam Hederman O'Brien. The purpose of the review group was to consider the following matters set out in the Terms of Reference:

1. To examine and report to the Hospital Management Board on the Hospital's response to the complaints of sexual abuse made against a consultant, formerly employed by the Hospital. The manner in which the examination takes place is at the discretion of the Review Group but must take account of the fact that the complaints are the subject of investigation and consideration by the relevant statutory authorities.

2. To examine and report to the Hospital Management Board on the protocols, practices and procedures currently in place in the Hospital relating to the prevention of sexual abuse of patients by members of the Hospital's clinical staff.

3. To consider the Interim Report of the Hospital's Medical Director on this issue and matters arising therefrom.

4. To make recommendations to the Hospital Management Board on any changes or improvements to protocols, practices and procedures for the protection of patients and staff which the Review Group consider necessary having regard to best practice in Ireland and abroad.

The review was ultimately tasked with compiling a report to furnish to the Hospital Board which would then be forwarded to the Minister for Health and the NEHB.

The findings of the report identified failings in the manner in which the complaint by Mr A was dealt with, effectively identifying a “learning curve” as more complaints

came to light. Deficiencies were also identified in relation to the lack of synergy between the NEHB and the Hospital Board, the lack of communication between clinical and administrative staff and possible deficiencies in the Hospital's media engagement. The report finds that the previous complaints in 1977 and 1982/1983 "were dealt with in a manner which would have been regarded as adequate at that period. It would not, however, be acceptable today."

The report also noted a stated desire by Shine to return to Africa to continue mission work, and indicated that it was appropriate for members of MMM to have blocked these attempts while the investigations were ongoing. The report made additional findings and recommendations in relation to complaints procedures and improved safeguarding practices in the Hospital.

However, this review did not provide for:

1. An investigation into the extent of the sexual abuse committed by Shine, including the number of victims involved and the time period over which this occurred;
2. Consideration of the appropriateness of the responses of both Shine and AGS to the allegations, such as Shine's failure to notify the Hospital that complaints had been made in relation him six months prior to the Hospital bringing the allegations to his attention and AGS' failure to alert the Hospital that complaints had been received a year before they were brought to the attention of the Hospital;
3. An investigation or exploration into who within the environs of the Hospital was aware or may have been made aware of the abuse (if anybody); and

4. An investigation or exploration into whether there may have been abuse perpetrated outside of the Hospital, such as that which is alleged to have occurred in Shine's private consulting rooms in Fair Street or at his home, even where such patients were initially patients of the Hospital and were referred from the Hospital onward to these locations.

The narrowness of the terms of reference also meant that the conduct of bodies outside of the Hospital, such as AGS and others, were excluded from consideration.

Following the publication of the Hederman O'Brien report, several alleged inconsistencies and inaccuracies were highlighted by D4P, who indicated their view that the report appeared to have accepted the position as outlined to them by MMM and the NEHB without sufficiently interrogating the accuracy of these positions. There appears, from the non-exhaustive material I have received, to be no substantive response to these complaints.

Criminal Proceedings

On the basis of the papers in my possession, it is not clear when the first complaint was made to AGS in relation to Shine, although one victim stated to me that he made a complaint in 1990. The first complaint made to AGS which resulted in a known investigation and file sent to the DPP was in March 1994. Garda Superintendent PJ O'Boyle stated that Shine was interviewed in relation to these complaints in November 1994. Proceedings began in the District Court in 1996, initially relating to 38 complaints of indecent assault by 18 individuals.

Shine sought to prohibit his prosecution by way of judicial review on the grounds of delay. His application was dismissed by the High Court on 18 February 1999 and, following an appeal, further dismissed by the Supreme Court on 19 December 2000.

In October 2003, Shine was eventually tried for 11 counts of indecent assault of 6 separate complainants in the Circuit Criminal Court in Dundalk. The offences were alleged to have occurred in both the Hospital and Shine's private consulting rooms in Fair Street.

According to news reports and letters obtained from D4P, the following employees of the Hospital gave evidence on behalf of Shine at his trial:

- Dr Carlos McDowell, consultant anaesthetist
- Dr Gillian O'Kane, consultant anaesthetist
- Dr BJ O'Sullivan, consultant paediatrician
- Dr A Murphy, consultant paediatrician
- Dr C Muldoon, medical consultant
- Professor Tom Gorey, consultant surgeon
- Professor Patrick Wall, associate professor of public health
- Bernadette Culligan, ward sister
- Barbara Kennedy, ward sister
- Teresa Costelloe, ward sister
- Roisin Russell, night superintendent

- Nancy Allen, nurse and member of North-Eastern Health Board
- Linda Gunne, staff nurse
- Elizabeth Lynch, senior physiotherapist

Following the close of the prosecution case, the jury was directed to return a verdict of not guilty in respect of the allegations made by the sixth complainant. The remaining charges went to the jury and, following deliberations, Shine was acquitted on all charges.

Serious deficiencies are alleged to have occurred during this trial by complainants and their representatives in D4P. These will not be rehearsed at this time but are contained in the Chapter of this Report entitled Victim Engagement.

In or about 2004, a further complaint was made to the Gardaí and a file sent to the DPP bearing the reference number 2004/4523. I was advised by the office of the DPP that the complainant in this matter withdrew his complaint and a direction of no prosecution was later issued in August 2004.

A second prosecution was directed in 2010 for 22 counts of indecent assault on 20 complainants. Shine again sought to prohibit his prosecution, initiating judicial review proceedings which were unsuccessful in the High Court[4] and unsuccessful on appeal. In ordering that the matter be remitted to the Circuit Court, Hogan J in the Court of Appeal[5] noted that, in relation to complaints from six of the complainants, these could not be

[4] ***MS v. DPP*** [2015] IEHC 84
[5] ***MS v. DPP*** [2015] IECA 309

added to the current indictment without the consent of the accused and would be required to be proceeded with in a separate trial.

Following this, Shine was tried and convicted of three counts of indecent assault against three complainants in November 2017. He was sentenced to 10 months imprisonment in relation to one count, and 10 months imprisonment on the second count to run consecutively. A further 6-month sentence was imposed on the third count to run concurrently. Appeals against sentence and conviction were refused[6] and Shine was refused leave to appeal to the Supreme Court.

Shine was tried and convicted of 13 counts of indecent assault against 6 complainants in February 2019, with a *nolle prosequi* entered in respect of 2 counts in March 2014. A sentence of 4 years was imposed on count 10 and 18 months for each of the remaining counts to run concurrently. This was an effective sentence of 4 years imprisonment. Shine withdrew his sentence appeal, was unsuccessful in his conviction appeal and was refused leave to appeal to the Supreme Court.

On 3 May 2019, Shine was charged with a further 31 allegations from 11 complainants. In June 2020, Shine launched judicial review proceedings seeking to prohibit his prosecution for the allegations. A core complaint by Shine was that, although the direction to charge issued on 11 May 2017, he was not made aware of it until shortly before he was charged on 3 May 2019. He claimed that, as a result, he was not given the opportunity to consent to all remaining charges and complainants to be dealt with together in his third trial. In

[6] ***DPP v. MS*** [2019] IECA 120

May 2020, O'Regan J refused the application for prohibition[7]. This was appealed to the Court of Appeal.

On 12 July 2021, Kennedy J delivered judgment for the Court of Appeal[8], granting Shine's application to prohibit his prosecution. At this stage, there were approximately 189 complaints against Shine which had not yet been prosecuted. In her judgment, Kennedy J relied on a delay of two years in informing Shine of the charges (the DPP stated that, due to oversight, a letter drafted to be sent to Shine's solicitors was not sent) finding that as a consequence of this delay Shine had missed the opportunity to consent to the current charges being dealt with in his third trial. The Court also relied on the age and health of Shine, and the overall delay in the prosecutions as cumulative circumstances warranting the prohibition of these prosecutions.

Since this decision, no further prosecutions have been directed. The position was summarised by the DPP thus in their correspondence to me:

"We have received a number of files from An Garda Síochána since 2021. All of which have had a no prosecution direction issued following the Court of Appeal judgment (delivered on 12 July 2021 by Kennedy J.) which granted the injunction sought by the Applicant (Dr Shine) prohibiting prosecution on the basis of delay and the age and cognitive health of the suspect."

Medical Council Proceedings

[7] ***MS v. DPP*** [2020] IEHC 659
[8] ***MS v. DPP*** [2021] IECA 193

As noted earlier, on 22 August 1995 the Medical Council were made aware of the allegations relating to Shine. Following correspondence between the Hospital and the Medical Council, the Medical Council proceeded with the complaint against Shine and suspended him from the medical register in 1996.

Six notices of intention to hold an inquiry into the applicant's conduct pursuant to Part V of the Medical Practitioners Act 1978 were issued and served on Shine between February 1996 and May 2004. These six notices related to the complaints of twenty-nine complainants with regard to alleged incidents ranging over a period from 1964 to 1994. These notices informed Shine that there would be a hearing before the Fitness to Practise Committee to determine whether Shine had engaged in poor professional practice or professional misconduct.

The first notice of inquiry dated 21 February 1996 concerned the complaints of 16 individual complainants. It was agreed with Shine's solicitors that the hearing of any inquiry would be adjourned pending the outcome of criminal proceedings. In December 1996, Shine was charged with a number of counts of indecent assault. Those charges arose from the same set of circumstances which were alleged in the complaints to the Medical Council.

The hearing before the Fitness to Practise Committee was adjourned pending the outcome of the criminal proceedings. Following Mr Shine's acquittal, a call over was arranged before the Fitness to Practise Committee on 7 July 2004. The committee rejected an application by Shine's solicitor for a further adjournment pending outstanding criminal matters against him. The committee listed the inquiry for 15 November 2004.

Shine brought proceedings challenging the decision of the Medical Council to proceed with the Inquiry on the grounds of unfairness. Specifically, Shine relied on missing records, the frailty of witness memory, and a lack of detail in the complaints themselves as grounds to prohibit any further inquiry.

O'Donovan J delivered judgment in the High Court on 19 December 2006.[9] In relation to the complaints previously prosecuted by the DPP and of which Shine was acquitted, O'Donovan held that further inquiry in relation to these matters would amount to double jeopardy. On that basis, he prohibited these matters from being considered by the Medical Council. In respect of a number of the complaints, the High Court prohibited them on the basis of delay and vagueness, such as the inability of one complainant to remember the names of nurses who were alleged to have been dismissed from the room just before abuse occurred. The High Court allowed the complaints of ten of the complainants to proceed.

The Medical Council challenged part of this judgment by way of appeal to the Supreme Court. The appeal was confined to the prohibition of the complaints which had been the subject of the criminal proceedings on the grounds of double jeopardy; no challenge appears to have been taken in relation to the remaining complaints prohibited by the High Court. On 14 July 2008, Kearns J delivered the judgment of the Court,[10] overturning the order of the High Court in relation to these complaints. He found that, aside from the fact that double jeopardy had not been pleaded, he was not of the view that subsequent

[9] ***Shine v. Fitness to Practise Committee of the Medical Council*** [2006] IEHC 432

[10] ***Shine v. Fitness to Practise Committee of the Medical Council*** [2008] IESC 41

consideration of these matters by the Medical Council would amount to either double jeopardy or inherent unfairness. These complaints, in addition to the ten complaints which had not been prohibited, were remitted to the Medical Council for consideration.

The inquiry therefore proceeded before the Fitness to Practice Committee and was heard over a period of 12 days between 17 January 2008 and 21 July 2008. The Committee heard evidence in relation to nine complainants and made findings of professional misconduct in relation to three of them. The Committee's findings came before a meeting of the Medical Council on 20 October 2008, and a decision was made to erase Shine's name from the General Register of Medical Practitioners. That decision was subsequently confirmed by the High Court on 24 November 2008.

The Smyth Report and Subsequent Litigation

On 15 January 2010, Mr Justice Thomas Smyth was appointed to conduct a review by the Minister for Health and Children. The review was to consider whether further investigation into the procedures and practices operating at the Hospital and the allegations of sexual abuse against Shine would be likely to provide additional information or insight which would be of significant public benefit. In September 2010, Judge Smyth submitted his report to the then Minister for Health and Children. The report recommended that a further investigation should not be held and that, in order to avoid prejudicing any civil or criminal cases, his report should not be published.

Following the Smyth Report, a number of the victims who had engaged with this exercise and provided testimony to Smyth J sought to have transcripts of their evidence released

to them. This appears to have arisen in part from their unhappiness with the manner in which they were questioned by Smyth J as outlined in correspondence from D4P to the Minister for Health.

One such individual made contact with the Department of Health on 16 May 2012 by way of email seeking a copy of the transcript of their evidence before Smyth J. Following several exchanges with the Department, it was indicated by the Department that the information was not held or controlled by them in circumstances where Judge Smyth had clearly indicated that they were not to be opened or released without a Court order for discovery and, as such, refused the request. On 5 July 2012, Judge Smyth communicated to the Department that he was not consenting to the release of the records without a Court order for discovery.

On 4 July 2012, the individual who made this initial request referred the matter to the Information Commissioner. On 7 June 2013, the Information Commissioner (having liaised with the Department, which included by providing a preliminary view and seeking comments in relation to same), concluded that the relevant records were "held" by the person physically in possession of same, that being the Department. In relation to the entity who had "control" over the said records, the Commissioner concluded that there was no such entity of "the Drogheda Review", that Judge Smyth had been contracted to carry out a service on behalf of the Department, and that a simple assertion by Judge Smyth that the records were in his possession or control was not sufficient to satisfy the legal elements of that test. The Commissioner further held that, given the contract for services had now expired, there could be no claim by Judge Smyth over those

records and it was unreasonable for him to continue to direct what use could be made of them.

This ruling was subsequently the subject of an appeal by the Minister for Health to the High Court[11]. In a judgment delivered on 9 May 2014, O'Neill J set aside the order of the Commissioner, holding that it was Judge Smyth who had a proprietary interest in the relevant documentation and that he was entitled to dictate the terms of their review and distribution.

This judgment was appealed to the Supreme Court by the Commissioner, and a judgment was delivered by Finlay Geoghegan J on 27 May 2019,[12] upholding the order of the High Court (though differing slightly in reasoning) and ultimately finding that the Department did not "hold" the documents sought and were therefore not at liberty to grant access or disclosure of same in the absence of a Court order.

To this day, the survivors have not been granted access to the transcripts of the evidence that they gave to Mr. Justice Smyth of the sexual abuse they suffered at the hands of Michael Shine. Nonetheless, several of the victims reported to me that during criminal prosecutions which took place in relation to these allegations, that they were cross-examined on the basis of statements they made to Mr. Justice Smyth. I have not been in a position to verify this.

[11] ***Minister for Health v. information Commissioner & Ors*** [2014] IEHC 231

[12] ***Minister for Health v. information Commissioner & Ors*** [2019] IESC 40

Chapter Five: Timeline

The following is a timeline of the key events which it has been possible to establish from this exercise. Please note that while this chronology is not entirely comprehensive and is reliant on the documentation obtained by me (which is not exhaustive) it seeks to outline the main incidents which have formed part of this Report.

1963	Earliest known allegation of sexual abuse
1977	Complaint to MMM – not recorded in writing
1982/1983	Complaint to MMM – not recorded in writing
1990	First indication by victims of a complaint made to AGS
March 1994	Currently earliest known recorded complaint to AGS (Mr A)
November 1994	AGS interview Shine in relation to complaints
29 March 1995	Maker of complaint A informs NEHB
31 March 1995	Hospital informed of complaint A
3 April 1995	Shine informed of complaint by the Hospital, and he goes on leave
5 April 1995	Mr Quigley, chair of the Hospital Board, initiates disciplinary and complaints procedure
13 April 1995	Following legal advice, Mr Quigley invokes disciplinary and complaints procedure
May 1995	Shine takes 6 months leave

	AGS indicate to the Hospital that they are investigating a number of complaints
9 May 1995	Medical Board writes letter of support for Shine
30 May 1995	Mr B makes allegation of sexual abuse to NEHB
6 June 1995	Hospital informed of complaint by Mr B
25 June 1995	Board informs Mr Quigley of unanimous decision that Shine be reinstated
27 July 1995	Mr Quigley declines to proceed with investigation into complaint by Mr A
8 August 1995	Shine returns to Hospital, restricted to locum consultant role
16 August 1995	NEHB informs Hospital they are dissatisfied with Shine's return
18 August 1995	Hospital receives complaint of sexual abuse from Mr C
21 August 1995	Shine goes on voluntary leave again Mr Quigley invokes disciplinary and complaints procedure in relation to Mr C's complaint Hospital sends complaint of Mr C to AGS and AGS inform Hospital they are now investigating several complaints
22 August 1995	Hospital informs Medical Council of complaint by Mr C.
7 September 1995	NEHB receives a complaint from Mr D and forwards same to Hospital
11 September 1995	Mr Quigley invokes disciplinary and complaints procedure in relation to the complaint by Mr D

21 September 1995	Discussions between legal representatives for Shine and the Hospital about possibility of Shine taking retirement
13 October 1995	Shine retires from the Hospital
23 October 1995	The NEHB indicates external review group should be set up to review handling of complaints against Shine
6 November 1995	The Hospital Board approves the setting up of external review group and approve terms of reference
7 November 1995	The Independent Review Group chaired by Dr Miriam Hederman O'Brien is established
February 1996	First of six notices from the Medical Council issue to Shine
October 1996	Medical Council suspends Shine from register Criminal proceedings initiated in the District Court for Case A
18 February 1999	High Court dismisses Shine's attempt to prohibit prosecution of Case A by way of judicial review
19 December 2000	Supreme Court refuse Shine leave in relation to judicial review of Case A
October 2003	Shine is tried in Case A for 11counts of indecent assault involving 6 complainants in Drogheda Circuit Criminal Court Directed acquittal in respect of complaint by one complainant Shine is acquitted on all remaining counts
May 2004	The final of six notices from the Medical Council issues to Shine

7 July 2004	The Fitness to Practise Committee of the Medical Council refuse Shine's application for further adjournment of the Medical Council proceedings and set the matter down for hearing on 15 November 2004
August 2004	Complaint by one individual which was made to AGS and file sent to DPP is withdrawn.
19 October 2004	Shine makes an application to the Fitness to Practise Committee of the Medical Council to have all complaints against him struck out on the basis of delay. Complaints in relation to 5 individuals are struck out while the remaining complaints retain their hearing date of 15 November 2004
8 November 2004	Shine is granted leave to judicially review the decision of the Medical Council to proceed against him in relation to the remaining complaints listed for hearing
19 December 2006	The High Court prohibits the Medical Council from continuing with all but ten complainants in their inquiry
14 July 2008	Following a partial appeal of the decision of the High Court by the Medical Council, the Supreme Court allows the appeal and remits the complaints of the ten complainants originally permitted by the High Court in addition to the six complainants the subject of the appeal

20 October 2008	The Medical Council confirms findings of professional misconduct made by the Fitness to Practise Committee, a decision is made to erase Shine's name from the General Register of Medical Practitioners
24 November 2008	The erasure of Shine's name from the General Register of Medical Practitioners is confirmed by the High Court
2010	DPP prepares file in relation to Case B
15 January 2010	Mr Justice Thomas Smyth is appointed to conduct the Drogheda Review
September 2010	Judge Smyth submits his report for the Drogheda Review to the Minister for Health
16 May 2012	Contact is made by a participant of the Drogheda Review to the Department of Health seeking a copy of the transcript of his evidence
4 July 2012	The issue of release of the Smyth transcripts is referred to the Information Commissioner
31 July 2012	Shine is charged with offences against 22 complainants in Case B
7 June 2013	The Information Commissioner indicates that the Department of Health can lawfully release the transcripts of the Drogheda Review
9 May 2014	The High Court allows an appeal by the Department of Health in relation to the decision of the Information Commissioner that the

	Department were lawfully permitted to release the transcripts from the Drogheda Review
17 February 2015	High Court dismisses Shine's attempt to prohibit his prosecution for Trial B
5 December 2015	Shine is interviewed by AGS in relation to 57 complainants, later to form part of Case C
22 December 2015	Appeal against the decision of the High Court in relation to Case B is dismissed; Case B split into Case B.1 and Case B.2
11 May 2017	Direction to charge in relation to Case C issues from the DPP
2 November 2017	Shine is tried and convicted of 3 counts of indecent assault in Case B.1
1 December 2017	Shine is sentenced to 10 months imprisonment in relation to one count, and 10 months imprisonment on the second count to run consecutively for Case B.1
8 February 2019	Shine is tried and convicted of 13 counts of indecent assault in Case B.2
10 April 2019	Conviction in relation to Case B.1 is upheld by the Court of Appeal
27 May 2019	The Supreme Court upholds the ruling of the High Court that the Department of Justice may not release transcripts from the Drogheda Review without the permission of Mr Justice Smyth
3 July 2019	Court of Appeal refuses sentence appeal in relation to Case B.1

	Appeal to the Supreme Court is later refused.
3 May 2019	Shine is charged with 31 allegations in relation to Case C
17 November 2020	Shine withdraws his sentence appeal in respect of Case B.2, conviction appeal in relation to Case B.2 is refused and the Supreme Court later refuses leave to appeal
15 December 2020	High Court refuses Shine's attempt to prohibit prosecution in relation to Case C
12 July 2021	Court of Appeal overturns decision of the High Court and prohibits further prosecution of Shine in relation to Case C

Chapter Six: Victim Engagement

Victim engagement was a key element of this exercise, with the Terms of Reference emphasising the importance of their input and voice for the purposes of my task.

It should be noted that for the purposes of both this section and the report more generally, the term "victims and survivors" has been used in relation to the individuals I spoke with. It should be noted that I spoke to those who had obtained convictions against Shine (survivors) and those who have alleged sexual abuse but have not obtained a conviction in relation to same. I have used the term victim for these individuals to reflect (i) the terminology of the terms of reference and (ii) the Victims Directive and the Criminal Justice (Victims of Crime) Act 2017, which ascribes the term "victim" at the allegation stage of an offence. The use of this terminology should not be read as me making any

findings or expressing any view as to the truthfulness or otherwise of the allegations made.

Profile of the Victims and Survivors with Whom I Engaged

The victims and survivors whom I met were composed of men from all walks of life from Drogheda and the surrounding areas. They were middle-aged to eldery, within about 25 years of each other. Importantly, they were a self-selecting group who chose to come forward and meet me, have calls with me, or send emails and letters for my attention. In all, I received views and comments from nearly 75 individuals.

Given the current number of persons engaged with D4P now stands at over 400, I do not suggest that the accounts of those who spoke to me can be treated as representative of all victims and survivors. However, their accounts were important to this exercise in order to understand the procedural history of this matter and the views of victims and survivors as to what, if anything, they wished to happen next.

Another important aspect of meeting victims and survivors was the impressions I formed from meeting them and listening to them. One striking feature was their manner. All were polite. All were grateful to have someone to listen to them in an informal environment. They were, without exception, respectful in their engagement. They were measured, they were courteous and they were not demanding.

Many were self-deprecating, understating what they say happened to them. In a number of cases, there was a clear tendency to minimise the abuse they had suffered. On the

contrary many were restrained and modest in how they described what had been done to them and what it had cost them.

The damage done to these individuals was plain and still visible even following the passage of time. In many cases, it was severe. One stated "time is not a healer." Some had even retained their hospital appointment cards from the date that they say they were abused.

Their manner and modesty did not diminish the gravity of what they described. If anything, they served to underline it. This made a considerable impression on me.

Another significant feature of what I observed was that, in many cases, the harm had not been borne by them alone but had radiated outward. Their families and those who cared for them had often shouldered a heavy share of it.

The expectations of those I met were notably low. Many were downbeat as to what, if anything, would now happen. There was little confidence that the system or that the State would "do right" by them. That lack of confidence did not arise in a vacuum. Many described having been profoundly let down over a long period by systems which they felt should have protected them. That sense of having been failed ran deep.

Themes / Commonalities in the Accounts Received

Allegations of abuse reported to me encompassed a broad range of ages, with reports of abuse when victims were aged 4, 6, 7/8, 10, 11, 14, 15, 16, 17, 18 and 19. Allegations of abuse were reported as having occurred in the Hospital, Shine's private practice in Fair

Street, and Shine's home, with the earliest report to me having occurred in 1964 and the latest having occurred in 1990. Although all accounts differed, some themes emerged.

First, several victims reported being injured while playing sport and attending Shine as he was the 'go-to' doctor for such injuries. Others attended him for treatment for a range of issues but stated that they were abused instead and that as a result, they suffered physical health issues. Others were treated by him but stated that, following their experience of abuse, they did not return for post-surgical follow-up treatment. There were therefore a number of individuals who indicated that they suffered health problems from a lack of healthcare in addition to sexual abuse.

Second, given the time period over which the abuse is alleged to have occurred, several of the victims whose abuse was stated to have occurred in the later stages, particularly the 1980s and 1990s, indicated that they were of the view that had action been taken at an earlier stage, they would not have experienced the abuse that they did. The abuse also permeated through families, with brothers and even fathers and sons alleging to have been abused by Shine.

Third, nearly all of the victims who spoke to me were of the view that Shine's conduct was a matter of public knowledge. Many phrases were repeated; warnings by boys on local sports teams that they should be careful not to sustain an injury for fear that they would end up in Lourdes Hospital with Shine, comments by local women about certain persons being "one of Shine's boys", and references to "the dogs on the street" knowing what was happening. One individual stated that by the early 1980's, his friends and

contemporaries would openly discuss sexual abuse perpetrated by Shine on them and others when they were having a drink or a cup of coffee.

Fourth, almost all of those who spoke to me indicated their view that staff in the hospital were aware of what was happening to them. One victim recounted to me a memory of a nurse walking into the consulting room where he was with Shine and was screamed at by Shine to get out. This nurse was described as being in immense fear. Numerous people stated that trainee/newly qualified nurses at the Hospital were verbally instructed in the early 1980's not to leave young boys alone with Shine when he was conducting examinations.

Fifth, although some of those I spoke to had gone public with their stories, a much larger number had only in recent times told spouses, family or friends and many had never told anyone close to them about the allegations of abuse. Those who had spoken to those close to them about alleged abuse at the time it happened indicated fears from their loved ones that they would be sued by Shine if they "went public" with their allegations, with more than one individual referencing a fear that they would "lose the house". A large number of these middle-aged men told me that they could not report what had happened to them until after their mother had died for fear of the shock and upset it would have caused. I was deeply saddened to be told by one middle-aged man that he had been regularly attending D4P meetings but had been lying to his wife and family as to where he was going as he could not bring himself to tell them what had happened to him.

Sixth, those who had gone public about what had happened to them spoke of being met with an effective wall of silence from all in positions of authority. They complained of

those in the hospital and the community rallying around Shine and them not being believed. They referred to receiving abusive calls from supporters of Shine and being ostracised within their community.

Seventh, many indicated that they had made complaints or reports of the behaviour experienced by them; one individual indicated they made a complaint to two nuns who worked in the hospital in 1979 and other individuals referred to reporting incidents to AGS in 1990, 1995, 1997, 2006/2007, 2021 and 2026.

Eighth, there was unanimous agreement among those I spoke to that the response to their allegations had been unsatisfactory. Complaints were made in relation to virtually every body/organisation who had responsibilities to deal with the alleged conduct; the Hospital staff and board, the NEHB, AGS, the DPP, the subsequent reviews and, to an extent, the Courts. The general view was that there had been a series of failures from start to finish and that no one had ever given the victims and survivors a proper opportunity to investigate how the conduct continued for such a lengthy period of time and why the steps that followed were so inadequate, mismanaged and poorly handled. They described a serious exacerbation of their trauma by what they saw as the continued refusal by any party to expose the depth of the abuse which occurred and to hold relevant individuals and bodies to account.

Issues of Concern to the Victims

As with the features of the allegations made against Shine, there was no one outcome sought by those I spoke to, however, there were common themes which emerged from these conversations which I have categorised below. Many of those I spoke with pointed me to extracts from reports and newspaper articles which supported their views. Where alluded to, I have referred to same.

It should be noted that this section of the Report is concerned solely with articulating the views of the victims and survivors I met and should not be read as an endorsement or affirmation of any of these complaints. As per the terms of reference, I am obliged to engage with victims and survivors to understand the issues of concern to them without making any findings in relation to disputed facts.

i. **Hospital Knowledge, Response and Culture of Reverence**

Victims had many queries in relation to both the extent of knowledge of those working within the Hospital, their failure to support victims when allegations surfaced, the failure to retain documentary evidence, and what they considered to be inappropriate attendance at, and defence of Shine in his 2003 trial.

The culture of the Hospital pre-1996 was described in the Hederman O'Brien report as having a "*strong hierarchical tradition of command and a weak record of consultation.*"[1] At page 56 of the report, it states that most of the clinical staff had been working in the hospital for a long time, with many training and working there their whole professional lives. This created a sense of "family" and reinforced the medical hierarchy. Shine was described as having built the reputation of the Hospital and the report states that "*The possibility that*

the conduct of others might have implied some element of collusion if examined in the light of such allegations is profoundly disturbing to the people concerned." It also refers to the closing of ranks by staff as a result.

Victims were of the view that this description does not accurately depict the position that they encountered in relation to medical staff, and the attribution of closing of the ranks out of a sense of loyalty to Shine is considered to be an underestimation of the reality that existed at that time.

In relation to the specific issue of knowledge, it was stated by many that no one had ever investigated how widespread the knowledge of Shine's conduct was in the Hospital. While several references were made to nurses not leaving Shine alone with young, male patients, Shine dismissing nurses from examination rooms, and staff being aware of, and discussing, the abuse amongst themselves. Victims viewed the 'who knew what and when' question as being of significant importance in relation to hospital staff, and in turn, the Hospital authorities.

In relation to the attitude of the Hospital after the allegations were first brought to their attention, I was directed to the following:

- A letter from two colleagues on the medical board to Shine dated 9 May 1995, stating that Shine had their "full support" during this difficult time, and a further letter in July 1995 again indicating their full support of him. In relation to the timing of the letters, it is noted that complaints of sexual abuse were made to the hospital in March and June 1995.

- The failure by the Hospital to suspend Shine, allowing him to return in an advisory capacity on 8 August 1995 – which victims allege was not honoured by him or certain nursing staff who worked with him – and allegations that he continued to attend at the hospital after his retirement on 13 October 1995.

- A letter from the Hospital Board to Eugene Quigley on 25 July 1995, stating that the Board had "unanimously decided" that Shine should resume his work as a consultant in the Hospital. This was on the basis that the DPP had decided not to prosecute two cases against Shine and therefore, in their view, the "*accusations have no major substance.*" The Board also recommended he "*be restored so that the surgical patients in the hospital receive the benefit of his long-standing skills and expertise.*"

- Minutes between Hederman O'Brien and representatives from the Department of Health on 7 March 1996 in which it was stated: "*The hospital explained that had they suspended Shine, they could have been sued, due to the "unreliable evidence" against him.*"

- In the Independent Report of 1996 by the Hospital Board, Mr. Quigley stated that one of the reasons that he dismissed the first complaint made to the Hospital was due to "*expressions of support for the consultant by the Medical Board of the Hospital and many other staff*".

Additional questions were asked, such as:

- When did nuns begin to allocate money to an indemnity payment fund?

- Why did the Hospital publicly state in the media that the "*complaints procedures...have been rigorously followed and internal investigations were carried out by the hospital*", but having decided not to investigate the first complaint made to them because of the six-week provision in the consultant 's contract?
- How is it that so many medical records went missing when complaints were eventually made to AGS?
- Was Shine permitted to take any records from the Hospital?

In all, there was general dissatisfaction with the Hospital and a view that, even after allegations had come to light, no real efforts were made to ensure that patient safety was prioritised. Victims believe that the Hospital chose to actively discredit and disbelieve victims and / or to ignore the complaints made in order to protect Shine.

ii. **Questions in Relation to Effective Oversight by the NEHB**

Individuals queried (i) the degree to which the NEHB was both independent and impartial in dealing with matters pertaining to Shine and (ii) the conduct of the NEHB after the allegations came to light.

In particular, it was noted that Shine was permitted to remain on the Board until December 1995, at a time when several complainants had come forward and Shine had retired from the Hospital. I was directed to an article in the Drogheda Independent dated 1 December 1995 entitled "*Health Board Meeting ends over doctor's appearance*." Many asked why this was permitted and the degree to which Shine may have used his position on the NEHB to influence matters pertaining to his own conduct.

Others queried the conduct of the NEHB more generally, with serious concerns that the NEHB were too close to Shine and engaged in inappropriate support for Shine after allegations against him had surfaced. In this regard, many referred to the fact that Hospital staff member, Nurse Nancy Allen, gave evidence in defence of Shine in his 2003 trial at a time when she was also serving a term on the NEHB (between 2002 and 2004).

iii. **Adequacy of Investigations (AGS)**

Many complained that the manner in which AGS dealt with those who sought to make complaints relating to Shine was historically dismissive, unprofessional and amounted to a disregard of their statutory obligations. References were made to files "sitting in drawers" and "falling behind filing cabinets", and in general, that AGS did not take complaints down in writing or make any attempt to pursue investigations or take matters seriously. Some victims alleged to me that they had been actively discouraged from making a complaint against Shine.

Reports were also made to me that there continue to be issues with reporting historic complaints to the present day.

I was also referred to the failure by AGS to alert the Hospital that they had received complaints of sexual abuse in 1994, referred to in a letter from then Minister for Justice, Nora Owen, in November 1995:

"I am advised by the Garda authorities that they received complaints from two persons on 1 March, 1994 and 16 June, 1994 of sexual abuse by a hospital consultant on them during 1975. At that time, the Gardai - before deciding whether a Health Board should be notified of such a complaint -

took into account a variety of factors, in particular ***the reliability of the complainant and the need to ensure that the position and character of the subject of the complaint was not damaged unjustly."***

The main concern from the perspective of victims was (i) identifying when complaints were first made to AGS (ii) understanding why there was either a failure to investigate matters or a delay in doing so, and (iii) understanding why no safeguarding policies were in place requiring AGS to inform the Hospital or the NEHB of the possible risk to child patients.

iv. **Subsequent Prosecutions**

Those who spoke with me outlined serious dissatisfaction with the criminal justice system and the DPP, both in terms of the historic treatment of complaints, the delays within the system and the fact that no further cases have been prosecuted since 2021.

Questions were asked as to how it took so long for the first complaints to be prosecuted, why so many of these first complainants didn't make it as far as the first trial, and the reasoning for a direction of not guilty verdict for one of the complainants. There was a general view that the judicial review and other challenges taken by Shine were not approached with any urgency and that there was a lax attitude taken towards adjournments.

One individual indicated that he was advised that a complaint made by him around this time should be withdrawn as there were other matters ongoing and his complaint may delay those proceedings. He told me that as a result, he withdrew his complaint.

For those involved in, present at, or who had followed the 2003 trial, questions were raised as to the manner in which the trial was run, why certain witnesses were not called, why no expert was called to rebut evidence from doctors in the Hospital who stated that full body examination was normal on admission to the Hospital, as well as other views relating to the failure by the prosecution to object to certain comments and legal directions given by the trial Judge.

For example, it was indicated to me that the jury, after deliberations had commenced asked whether they could find Shine guilty if they believed the account given by one of the complainants. I was informed that the trial Judge indicated that the evidence must be considered "in its totality" and that verdicts must be returned having considered all allegations. Similarly, I was told that the jury was directed to return a verdict of not guilty in respect of one of the complainants, with an indication that the reason for this would be explained in due course, however, it was stated to me that no explanation was ever given. I made extensive efforts to try and obtain a transcript or notes of the trial, the book of evidence and any other material relevant to this case in order to attempt to look into these issues. Unfortunately, at the time of writing, none of this material has been obtained. Considering the timeframe available to me, the passage of time since this trial and the issues surrounding complainant anonymity and data protection this is not surprising.

Further questions were asked as to why a decade passed between the first and second trials of Shine, with the view expressed to me that this delay resulted in a setback for other prosecutions. There was a general view that the consequence of lengthy systemic delays was that, by the time many matters were ready for prosecution, the judgment of

the Court of Appeal in 2021 had been handed down which had the effect of stopping any further prosecutions on the grounds of delay. Had there been more expedient investigation and prosecutions, it was stated, Shine could have been prosecuted long before any possible prohibition arose.

Related to this, as discussed in the Procedural History chapter of this Report, many wanted an explanation for how it was that Shine was not notified of the 2017 direction to charge for complaints made between April 2012 and February 2014 until May 2019, a factor which weighed heavily in the Court of Appeal's decision to prohibit prosecution for these offences in their 2021 judgment. The general handling of those complaints was something for which the victims sought answers.

Finally, it was reported to me that since the decision of the Court of Appeal in 2021 around 50 complaints have been made to the DPP in relation to alleged sexual abuse by Shine all of which the DPP has declined to prosecute. Victims and survivors sought answers from me as to what impact (if any) the judgement of Court of Appeal had on the decisions made by the DPP. Victims wanted to understand the current legal position clearly, and, if it be the case that all future prosecutions are effectively prohibited, they wanted to know how this ultimate position had come about.

v. **Inadequate Response by the Medical Council**

Many of those who spoke with me were concerned at the length of time it took for Shine to be (i) suspended from practice and (ii) ultimately erased from the register. There was also a view that the failure to treat allegations of sexual assault as a distinct category from

other allegations of misconduct meant that the perpetrators of abuse could continue to use their position of power and title to abuse patients during lengthy delays in having matters investigated and findings made by the Medical Council.

Further, in relation to the conduct of other doctors in the hospital in the aftermath of the allegations, some viewed this as a matter which the Medical Council should have given consideration. Correspondence from D4P in July 2010 notes that complaints in relation to six doctors were made to the Medical Council regarding their evidence at the 2003 trial of Shine (which was viewed as being inaccurate and partisan), as well as the general lack of safeguarding of patients in the aftermath of allegations surfacing. All six complaints were dismissed prior to being brought before the Preliminary Practices Committee (the PPC). It does not appear from the (non-exhaustive) documentation I have reviewed that any explanation was ever proffered to D4P in relation to this.

vi. **Treatment by the Authorities Generally**

There was general dissatisfaction amongst those I spoke to with the way allegations of sexual abuse have been handled since first emerging in the public domain including:

- Some of the litigation relating to Shine was held *in camera*, meaning that the names of those involved should not have been published, However judgments were then uploaded onto the Courts Services website with the names of those involved wrongly included. There were delays in removing these names (and identifiers) and complaints were made to the then Information Commissioner due to a perceived failure by the Courts Service to take responsibility for these errors.

- There was a view that many of the former Ministers for Health had made commitments to investigate the abuse by Shine and give the victims and survivors the answers they had been searching for, however, when a report was finally commissioned (the Drogheda Review), the terms of reference were highly restrictive and ultimately no report was ever published.
- Victims and survivors were highly aggrieved by the refusal to provide them with their transcripts from the Drogheda Review and two individuals stated that during the criminal trial of their complaints, counsel for Shine cross-examined them on the basis of these transcripts. Victims were adamant that this needed to be investigated.

ix. **Retirement and Pension**

A recurring issue for victims relates to the manner in which Shine was "permitted" (as they would see it) to retire from the Hospital on a full pension and continue to live a comfortable existence while many of the victims and survivors have been so adversely affected by the abuse suffered by them that they have never managed to fulfil their potential.

I was directed to a newspaper article in the Drogheda Independent dated 23 June 1995 which indicates that, at that time, six complaints had been received by Gardaí. The article also quotes from a statement made by the NEHB on 9 May 1995 that they were “aware that allegations have been made” and that they were currently being investigated by Gardaí. The article correlates with the findings in the Hederman-O'Brien report. In all,

victims and survivors queried why it was that, given the knowledge by Gardaí, the NEHB and the Hospital of multiple allegations of serious sexual abuse by Shine, he was nonetheless "*permitted*" to retire on a full pension. Victims and survivors also queried whether there was some mechanism by which this could be reviewed now, following Shine's convictions.

x. Recognition, Belief and Apology

Of all the issues raised with me, the single most prominent message from victims and survivors is their desire to be properly heard; to speak in their own words, be listened to, believed, and treated with dignity and respect. They wanted an opportunity to do this in public or at least for a summary of the background facts to be made public.

Having articulated their views on the procedural history as set out above, the general feeling was that they had been let down, dismissed, and treated as if they were invisible.

This fed into the very real need for acknowledgement that had been articulated to me. Victims and survivors were concerned not only with facts and records, they were also concerned that their experiences be recognised. They wanted their complaints to be taken seriously. They wanted the gravity of what they described to be properly understood.

They wanted a process that was thorough. An important aspect of this was compellability; a desire that all documents that exist be obtained, reviewed and categorised. Victims and survivors were very concerned about records. They were concerned as to what records exist, where they are held, whether they have been preserved or destroyed, and whether they will be made available to them, their

representatives and the general public. That concern extended to institutional records, medical records, correspondence, Garda material, and other documentary sources.

The concern for victims was that, while a large volume of documentation has now been obtained, it represents only part of the true picture. There was a real sense that much more may exist and was being withheld from them. As already noted, the view of all victims and survivors spoken to was that earlier responses were too limited, under-resourced or conservative and that much remained to be explored.

There was also a need for ongoing communication. Victims and survivors wanted engagement. They wanted lines of communication to be kept open. They wanted updates and advance notice of publications or announcements so as to prepare themselves and their families. They wanted to know what this process could do, what it could not do, and whether it could lead to a fuller investigation, inquiry, or other meaningful step.

Victims and survivors constantly echoed the need for accountability. A recurring concern was whether there would ever be real accountability. Victims and survivors were concerned not merely with historical events in isolation, but with whether individuals or institutions would be required to answer for what occurred, for what was missed, or for what was left undone.

Finally, the issue of closure arose repeatedly. Some questioned whether any process could ever provide closure. Others asked whether, at the very least, a thorough investigation might provide some modicum of relief. Nonetheless, there seemed to be a general view that without some form of investigation and understanding as to what

happened and who was responsible for allowing it to happen, there would be no possibility of ever truly moving on.

For some individuals, closure also meant an apology for, not just the initial abuse suffered, but for the failures in the response to that abuse which, in their view, are ongoing. Although there were many who viewed the concept of an apology as "too little, too late", for others it was seen as the ultimate acknowledgment of the trauma they have suffered.

Chapter Seven: Conclusions

Having reviewed the documentation available in this matter and considered both the Hederman O'Brien report and the Smyth report, I am of the view that the concerns and issues raised by the victims and survivors I spoke with have not been sufficiently considered and addressed in previous reviews. In coming to this view, I make no findings as to whether the issues raised by them are substantiated or made out. For each issue or concern raised, an evidential basis has been proffered (which includes the experiences of the individuals in question) that was sufficient for me to come to the view that there is a basis for further investigation in relation to these matters. I go no further than finding that these issues require further exploration.

The Hederman O'Brien report considers in detail the Hospital's response to the initial allegations of sexual abuse made by Shine. However, it was limited in its terms of reference to this issue and did not, therefore, consider the degree to which there may have been knowledge amongst the Hospital staff of sexual abuse, or the number of children and young people who may have suffered abuse.

The Smyth report was similarly confined to considering whether further investigation into these matters would be "likely to provide additional information or insight which would be of significant public benefit". The Smyth report has never been published.

Further, outside of the initial allegations and the response by the Hospital and NEHB, issues have arisen as the matter has developed. As noted in the Chapter of this Report on Victim Engagement, victims have been dissatisfied with the manner in which allegations

have been investigated, prosecutions have been progressed and / or conducted, and the length of time it took for Shine to be erased from the General Register of Medical Practitioners. These are all new issues which have arisen since the Hederman O'Brien report and which fall outside the terms of reference of both previous reviews.

I am therefore of the view that, given the number of complainants (currently standing at over 400 individuals), and the significant issues raised by them which have not been examined sufficiently (or at all) in previous reviews, a further State response is required.

Given the significant passage of time since the events the subject of this scoping exercise occurred, I am also of the view that a State response should be bespoke, tailored to the specific issues raised and should be carried out as expeditiously as possible. In particular, I am recommending a six-phase Commission of Investigation be established by way of statutory instrument pursuant to the Commission of Investigation Act 2004. In the next Chapter, I have outlined my proposed recommendations in this regard.

Chapter Eight: Recommendations

Having considered the many issues which have arisen during this scoping exercise and the desire of victims to make progress in an expedient manner, I am of the view that a Commission of Investigation should be established by way of statutory instrument pursuant to the Commission of Investigation Act 2004 and that such Commission should be broken down into phases. I further recommend that the phases be run concurrently and be chaired by the same person.

The approach taken is consistent with the present time-bound approach to this scoping process and with the stated desire of the Minister (which was consistent with my own) to avoid a process that runs on for years. The Minister is to be commended for her insistence that this scoping exercise be strictly time-bound as it resulted in a focusing of minds within institutions and a (albeit belated) sense of urgency in the manner in which the issues I raised were addressed. A similar approach is recommended for all proposed phases of these recommendations.

Finally, the terms of reference for this exercise specifically requested that I consider the appropriate State response to the issues identified, including by considering a "bespoke model" if required. In that regard, the six-phase approach recommended below has been designed to provide a workable and efficient form of State response to the issues raised.

In summary, I am recommending that a six-phase Commission of investigation be established chaired by one individual. I am of the view that all phases could, and should be run concurrently (although some will naturally conclude before others) and that all

phases could and should begin immediately (although some will take longer to set up than others). The six phases recommended are as follows:

Phase 1

(a) Recommendation

1. As Phase 1 of the State response, I recommend the establishment of an independent, document-based review to set out the history of the making of complaints to Gardai, the submission of complaints to the Office of the Director of Public Prosecutions, of decisions made to prosecute or not to prosecute and the outcome of those prosecutions.

2. This review should be fact-finding in nature and should proceed without oral evidence, unless the Chairperson of the Commission of Investigation determines that oral evidence is necessary.

3. It should have power to compel the discovery of documents, records, correspondence, memoranda etc from An Garda Síochána, the Office of the Director of Public Prosecutions, the Courts Service, the Department of Justice, and any other relevant State body in accordance with the ordinary rules of evidence.

4. It should set out the prosecution history in full and in detail, including the very first complaint(s) made to AGS in the early 1990s, the 2003 acquittals, the 2017 convictions, the 2019 convictions and the 2021 Court of Appeal decision restraining a further trial.

5. In particular, it should explain, in accessible terms, the legal difficulties that arise in historic sexual offence cases and the way in which the law on delay in such cases has developed over time.

6. As this phase would be primarily confined to the documentary record and would not involve oral evidence unless same was considered absolutely necessary, it should be capable of completion within a short and defined time period. It is also noted that much of the groundwork related to this phase has been completed during this scoping exercise, such as the gathering of documentation and applying to the Courts for release of documents (a process which was ongoing even at the time of submission of the within report).

7. It should conclude with a public report and a plain-language summary so that victims and survivors can be given a clear account of the criminal justice history of the complaints and the history of the decisions of the Courts in relation to Michael Shine, including the judgment of the Court of Appeal in 2021 and the implications of that decision.

(b) Purpose

8. The purpose of this phase should be to provide victims and survivors, and the public, with a clear explanation as to why so few allegations made against Michael Shine resulted in prosecution and lesser still in conviction.

9. Victims and survivors repeatedly requested that I explain why the DPP could not prosecute their criminal complaint made against Michael Shine, referencing the

scale of the allegations (referred to by the Court of Appeal as 189 complaints while Dignity4Patients believes that more than 400 boys and young men were abused by Michael Shine between 1963 and 1994). I found it particularly striking that so many of the victims that I met had little or no understanding of the criminal justice system despite having been participants in it.

Phase 2

(a) Recommendation

1. As Phase 2 of the State response, I recommend that an independent, document-based review be established to examine the response of the Medical Council to complaints and allegations concerning Michael Shine.

2. This review should be fact-finding in nature. It should proceed without oral evidence. It should have power to compel the production of documents, records, correspondence, memoranda, committee papers, legal advices and decision-making materials from the Medical Council and any other relevant body subject to the ordinary rules of evidence.

3. The review should set out a full chronology of the Medical Council process, including the six notices of intention to hold an inquiry issued between 1996 and 2004, the extent to which the process was deferred pending criminal proceedings, the judicial review proceedings brought by Shine, the appeal process, the inquiry which commenced on 17 January 2008 and concluded on 21 July 2008, the

Council's decision on 20 October 2008 to erase his name from the register, and the High Court confirmation of that decision on 24 November 2008.

4. This report should explain the statutory and procedural context in which the Medical Council was operating, including any legal constraints which may have affected what the Council could say publicly about whether a practitioner was under investigation and the status of such proceedings while ongoing.

5. It should also examine the effect of the confidentiality and publication rules governing Fitness to Practise matters, including the position that findings were not to be made public unless the practitioner was found guilty and the requirement for High Court confirmation before erasure or suspension took effect.

6. All documentation should be obtained. While the Medical Council provided me with many documents, they specifically suggested to me "*that in the event a formal inquiry is initiated, it should have sufficient powers to obtain information from any relevant parties, including where records and materials are confidential and subject to the in camera rule.*"

7. Finally, as this phase would be confined to the documentary record and would not involve oral evidence, it should be capable of completion within a short and defined period. It should conclude with a public report and a plain-language summary explaining how the Medical Council process unfolded, why it took so long, and what lessons should now be drawn.

8. Similar to Phase One, much of the groundwork for this phase has been laid by this scoping exercise. The additional powers of compellability and ability to make findings of fact would address the remaining matters that cannot be resolved by this exercise and would ensure that this phase is completed without delay.

(b) Purpose

9. The purpose of this phase should be to provide victims and survivors, and the public, with a clear explanation for the delay in removing Michael Shine's name from the Medical Register. Victims continuously asked for clarity as to why Michael Shine was not struck off until 2008, despite numerous allegations of serious child sexual abuse being raised with the Council in the early 1990s.

10. The delay in taking action led to a serious information vacuum, leading to speculation as to the reason for this, a feeling of not being believed and the exacerbation of existing trauma. An information vacuum is never empty; it is quickly filled by suspicion, conjecture or conspiracy. A clear explanation accounting for this time should therefore be provided.

Phase 3

(a) Recommendation

1. As Phase 3 of the State response, I recommend that an independent document-based review be established to examine the circumstances in which Michael Shine retired from the Hospital on the 13th of October 1995. It should also examine the legal and contractual consequences of that retirement, including whether any

lawful alternative existed at that point. It should consider whether there was any lawful mechanism to prevent retirement, continue disciplinary action after retirement, or a legal basis to disturb his pension rights.

2. This review should be fact-finding in nature. It should proceed without oral evidence. It should have the power to compel the production of documents, correspondence, legal advices, Board papers, HR records, pension records, and decision-making materials held by the Hospital, the North Eastern Health Board, the HSE, the Department of Health, and any other relevant body subject to the ordinary rules of evidence.

3. The review should address the chronology of the first formal complaint made to the Hospital on 29 March 1995, Shine's subsequent absence from the Hospital, discussions pertaining to his retirement, the ultimate decision made resulting in his retirement with his full pension in October 1995 and the degree of knowledge of the Hospital at this time of the complaints made against him, including being alerted to complaints being investigated by An Garda Síochána in August 1995.

4. As this phase would be confined to documents, chronology and legal-contractual analysis, it should be capable of completion within a short and defined period. It should conclude with a short, public, plain-language report. Again, much of the work in relation to this Phase, has been completed during this Exercise and therefore, it is expected that this Phase could be completed relatively quickly.

(b) Purpose

5. The purpose of this phase is to provide victims and survivors, and the public, with a clear explanation as to the circumstacnes in which Michael Shine retired, why the disciplinary route was not carried through to conclusion, whether the Hospital could lawfully have prevented his retirement, and whether any mechanism existed to alter his pension entitlements.

6. Victims and survivors have expressed particular concern that (from their point of view) he was "permitted" to retire and to draw his full pension (for more than 30 years at the time of writing) while many of them received what they consider to be inadequate compensation in the civil courts and justice denied in the criminal courts.

Phase 4

(a) Recommendation

1. As Phase 4 of the State response, I recommend that there should be a short and focused module on current patient-protection policies in our healthcare system.

2. This phase should examine, in particular, the current position on hospital safeguarding protocols, intimate examination rules, chaperoning, patient information, complaint routes, whistleblower protections, mandatory reporting and escalation pathways, regulatory categorisation of sexual abuse allegations, interim restriction powers, publication and information-sharing rules, staff training, inspection and audit systems, and whether allegations of sexual assault

by clinicians are treated as a sufficiently distinct category of misconduct in the context of professional complaints.

3. This phase should be permitted to take limited oral evidence from those currently responsible for patient safety, regulation and clinical governance in this jurisdiction, such as current decision-makers in the Department of Health, the HSE, and the Medical Council, together with a small number of international experts for international comparison. It should also have the power to compel documents, data and policy materials where necessary.

4. The final report should contain a plain language summary together with an implementation plan identifying what changes (if any) are required in order to secure the strongest possible patient-protection framework.

5. As this phase would be tightly confined to an examination of the current systems, a limited witness group, and a targeted international comparison, it should be capable of completion within a short and defined period.

6. This phase should be commenced as soon as possible and should not wait for the conclusion of the formal stages of the Commission of Investigation. As with all phases, this phase can and should be run simultaneously to the other five phases.

(b) Purpose

7. The purpose of this phase should be to determine whether Ireland's current safeguards are adequate to protect children and adults in healthcare settings from

sexual abuse by clinicians and, if they are deemed inadequate, what changes should now be made.

8. Many of the victims expressed to me their wish to ensure that protections are put in place to ensure that what happened to them could never occur again.

9. Dignity4Patients submitted to me that in their view there remained shortcomings in the Medical Council's ethical guidance, including the need for sexual abuse or inappropriate sexual behaviour in medical or health care settings to be specifically named and appropriately investigated, for clearer rules on intimate examinations, exactly what constitutes refusing a chaperone, and for more effective guidance where concerns arise about a colleague's conduct. They also highlighted the need for a review of enforcement policy and accountability in relation to current and future employers of all medical, healthcare and therapeutic practitioners who are or have been sanctioned. This is necessary, they submitted, to act as a deterrent to deviant sexual behaviour, but also to protect unsuspecting future vulnerable patients and health care service users.

Phase 5

(a) Recommendation

1. As Phase 5 of the State response, I recommend the establishment of an independent Truth and Recovery Process as a distinct, victim-centred and non-adversarial module, commencing promptly and running alongside preparation

for the final recommended phase – Phase 6 - the more formal stages of the Commission of Investigation.

2. This process should do more than review records and examine current systems. It should also provide a structured means by which victims and survivors may be heard in their own right. This process is one which has been developed by those such as Professor Phil Scraton who was in a position to advise and assist me for the purposes of this report. He described the concept of a truth-telling first phase in which an independent panel gathers documentary material and hears personal testimony from victims, survivors and families in a non-adversarial forum prior to a Commission of Investigation.

3. This phase should not be treated as a lesser or merely preparatory phase. It should be recognised as a truth-telling process of independent value.

4. The process should be designed to enable victims and survivors to describe, in their own words, what happened to them and the impact of the abuse on them in a way that is respectful, structured and potentially evidentially useful.

5. The taking of these accounts from victims should therefore occur in a safe, informal, comfortable and carefully managed setting rather than in a conventional courtroom environment. The process should be trauma-informed, practically accessible, and supported by measures such as counselling, advocacy and other appropriate assistance insofar as required by participants.

6. An optional facility should be available to audio and visually record such accounts (after the taking of an oath) for those participants who wish or may wish to give evidence in the course of the (recommended) formal phase. By analogy with the pre-recorded evidence model for children and a specific category of vulnerable adults under section 16 of the Criminal Evidence Act 1992, the audio and video recording of the participant's Phase 5 testimony could, if the participant so wishes, stand as their evidence-in-chief in Phase 6. Such a process would avoid unnecessary and potentially traumatic repetition, reducing the burden on victims who are willing to engage in both phases. However, it is important to recognise that some victims may wish to participate only in the truth and recovery process and not in any further (potentially contentious) hearing. As such, the recording of evidence should be entirely optional.

7. In order to preserve the non-adversarial nature of this phase of the process, neither Michael Shine nor any other party should be permitted to cross-examine the participants.

8. Accordingly, Michael Shine should be afforded fair procedures in written form rather than adversarial input during the course of this phase. He should be provided, at an appropriate stage, with sufficient detail of the themes, allegations or draft findings of this report to permit a meaningful written response, while preserving any confidentiality commitments given to participants. Any substantive response made by him should then be fairly summarised and/or appended to the final report.

9. This phase should expressly allow victims and survivors to speak not only to the abuse itself, but also to its personal, medical, psychological and familial consequences over time. Provision should also be made for one close family member, or where appropriate one close friend to participate where the victim is deceased, incapacitated, or otherwise unable to give an account personally.

10. The output of this phase should be an aggregated Truth and Recovery Report which draws together recurring patterns in the evidence and the impact on victims and, where relevant, their families.

11. This phase should also be given meaningful powers in relation to documents and records, including powers to require preservation and production of relevant material. While participation by victims and survivors should remain voluntary and supported, there should also be a power to take evidence on oath.

12. This phase should commence without delay. The age and vulnerability of many of those affected, and the length of time already elapsed, are themselves strong reasons to begin now rather than later.

13. For the avoidance of doubt this phase would not prejudge the separate questions of institutional knowledge, responsibility or failure (if any), which are matters to be considered in Phase 6.

(b) Purpose

13. The purpose of this phase should be to assemble what Professor Scraton described to me as an "accumulated narrative" or an "aggregated truth" by which a coherent

history is drawn from recurring patterns in the evidence and from the individual experiences of those affected. The report delivered at the conclusion of this process should amount to a history of Michael Shine and his actions told through the voices of his victims. I was struck by how little many members of the public (particularly younger people) know of the story of Michael Shine (if anything). It is important to victims, and indeed for the people of Ireland that this story is told and preserved for future generations.

14. Nearly every victim who participated in the scoping exercise indicated their upset at what they viewed as an ongoing silence in relation to the actions of Michael Shine and a wish to break this silence and make their allegations public. However, many were also very vulnerable and emotionally strained from years of PTSD, depression and other mental health issues arising from their abuse as children, teenagers and young adults. This phase specifically gives a voice to those individuals without putting them through the strain of an adversarial process.

Phase 6

(a) Recommendation

1. As Phase 6 of the State response, I recommend a formal investigation be established with power to hold public and private hearings, compel witness attendance, require the production of documents, take evidence on oath, and make findings of fact on the matters within its terms of reference.

2. The investigation should be directed to examine the full extent to which the Medical Missionaries of Mary, the authorities in Our Lady of Lourdes Hospital, the North Eastern Health Board and its successors, An Garda Síochána, the Department of Health, and any other relevant public bodies or office holders received complaints, information, warning signs or indications of risk concerning Michael Shine (if any), what actions they took in response, and whether their actions were adequate and timely in the circumstances as they then stood.

3. Its central question should be: who knew what, when, and from what source (if anything), and what, if anything, was done in response. Closely related questions are whether concerns ought reasonably to have been identified sooner, whether there were missed opportunities for intervention, and whether systems of reporting, escalation and protection operated as they should have done.

4. The investigation should have power to obtain every surviving record bearing on these issues, including hospital records, complaint files, Garda material, Department of Health records, Health Board records, board papers, correspondence and decision-making records.

5. The investigation should be framed broadly enough to investigate abuse alleged to have occurred in the Hospital, in private rooms or other locations, together with the routes by which boys and young men came under Michael Shine's care and the conditions that may have allowed that access to continue over time.

6. The investigation should examine the chronology from at least the 1960s to the present, including:

(i) AGS: Concerns raised regarding the the response of An Garda Síochána, including whether complaints were received, recorded, investigated and communicated appropriately, and whether any delay, limitation or failure in that process had consequences for child protection, institutional response or later accountability.

(ii) The Hospital: The degree to which complaints were made to staff or staff had any awareness as to the sexual abuse being perpetrated by Shine in the hospital, whether such complaints (if any) were recorded, whether there existed features of hospital culture or wider social culture that may have inhibited disclosure, reporting or intervention, including hierarchy, deference, fear, reputation, informal influence, or reluctance to challenge authority.

(iii) NEHB: The make-up of the Board, the time that Shine spent serving on the Board, his relationship with other members of the Board, when the Board first became aware of any allegations against Shine, the nature of such allegations and the response to same.

(iv) MMM: The degree to which complaints (if any) were made to members of MMM or that members of MMM had any awareness as to the sexual abuse being perpetrated by Shine in the hospital, whether such complaints (if any) were recorded, any resulting actions, and whether there existed features of a culture

within the organisation that may have inhibited disclosure, reporting or intervention, including hierarchy, deference, reputation, informal influence, or reluctance to challenge authority.

7. The statutory terms should expressly investigate whether the aforementioned bodies or any other relevant body were notified of allegations or concerns, what action each took, what powers each had at the relevant time, and whether their actions were adequate by reference to the standards and systems then applicable.

8. It should examine the timing, nature and significance of any support expressed for Michael Shine after complaints or concerns had emerged, including support from colleagues, staff or others, insofar as such evidence may assist in determining whether complaints were discounted, minimised or insufficiently acted upon. It should also carefully examine the extent to which Michael Shine engaged in what one might call social grooming - social manipulation as a calculated evolving process where an abuser exercises status, power and charisma, builds trust, meets emotional needs, and gradually breaks down boundaries, the primary goal being to garner social influence and consolidate power and reputation in order to convince society (particularly those in positions of authority) that allegations of impropriety must be malevolently fabricated.

9. It must be acknowledged that a fully successful or comprehensive outcome may prove difficult, and in some respects impossible, because of the passage of time, the deaths of witnesses and victims, the loss or destruction of documentation, faded memories, and the ordinary limitations of any retrospective inquiry. Those

difficulties are significant. They are not, however, a reason not to proceed. On the contrary, they are a reason to attempt now, while evidence still remains, to establish as much of the truth as can still be established and to address these issues fully and finally so far as the evidence permits.

10. The output of Phase 6 should be a public report, with interim reports if necessary, setting out, so far as the evidence permits, what was known, by whom, at what stage (if anything), what was done in response, what failures or missed opportunities are established, and what lessons, accountability measures and reforms should now follow.

11. Unlike the earlier paper-based phases, this phase will inevitably be the longest and most contentious stage. It is, however, the phase capable of answering the central question now raised by victims and survivors, namely how could so many men and young boys be abused (some repeatedly) for decades without anyone knowing or suspecting that something was amiss.

(b) Purpose

13. This phase is justified by the scale and seriousness of the matters disclosed in the course of this scoping exercise, including allegations said to extend over three decades and across more than one setting. The existence of criminal convictions means that the investigation need not re-try concluded criminal issues. Its purpose should instead be to address the wider institutional and systemic questions that could not be resolved through the criminal process.

Publication of the Smyth Report

1. One further matter should be addressed separately. Term 3.22 of the terms of reference require me to consider whether the Drogheda Review, commonly referred to as the Smyth Report, should be published. At present, I do not recommend publication.

2. In my view, the question of publication should be revisited only after the Commission of Investigation has concluded and its final report has been published (should it be established). It would be preferable for the issue of publication of the Drogheda Review to be considered in light of the findings, recommendations and overall context provided by that completed process, rather than in advance of it.

3. The Drogheda Review took place more than 15 years ago. Since then, the legal and policy landscape, particularly in relation to the centring of victims within the criminal justice system, has changed dramatically. Having carefully read the report I am concerned its publication could have the collateral consequence of deterring some victims and survivors from coming forward to participate in Phases 5 and 6 of the recommended process. Any step which might possibly create apprehension among potential participants as to how their experiences will be handled, described or disclosed should be approached with caution. At this point, the priority should be to maximise confidence in the proposed Commission of Investigation and in particular the truth and recovery phase, so that those affected feel able to participate.

4. For those reasons, I consider that publication should be deferred for the present. The matter should be reconsidered after the conclusion of the Commission of Investigation and after publication of its final report, when the position can be assessed in a fuller and more informed way.

5. Should it be the case that my recommendations are not followed, and a Commission of Investigation is not established, I request that this issue be returned to me for reconsideration.