HIA REF: [to be put on]

NAME: SND 491

DATE: 14 March 2014

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT OF

I, SND 491, will say as follows:-

1.

2.

3. During the time that I was employed at [redacted] and during my secondment I had no involvement with the residential child care facilities at either Bishop Street or Termonbacca.

4. During my employment in the [redacted] I was responsible for a number of children who had been placed in both units. My duties included:

- Assisting in the assessment of the needs of each child.
- Contributing to the care planning for each child to ensure that their physical, social, emotional, educational etc. needs were being fully addressed.
- Carrying out visits, at least monthly, to see each child on their own to ensure that their needs were being met in line with their care plan.
- Contributing to the regular reviews in respect of each child where their progress was reviewed and their care plans amended, if appropriate, to meet their changing needs.

I believe that each child in the two units received a satisfactory standard of care.

5. As both [redacted] and as [redacted] I fulfilled a managerial role and was responsible for the planning and organisation of services. This included an oversight role in ensuring that statutory responsibilities were met. Children who were in care were a key priority as the Board acted as corporate parent for them. One of my main responsibilities was in monitoring adherence to statutory duties in particular monthly visits to children in care. This included children placed in Nazareth House (Termonbacca having closed by this time). I also ensured that reviews of children in care were held in line with the timescales prescribed in Regulation.

6. As [redacted] I was responsible for the planning and delivery of all Child Care services, including children in care. Consequently I held responsibilities similar to those describe above but at a higher level. In addition I met on a regular basis with senior

staff members of the Nazareth House to review the overall provision of services in the unit.

Throughout this period I was satisfied that children placed in this children's home were adequately cared for in line with their assessed needs

Statement of Truth.

I believe that the facts stated in this witness statement are true.

Signed SND 491 ....

Dated......14th March 2014............

HIA REF: [to be put on]

NAME: SND 491

DATE: 22 April 2014

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

SUPPLEMENTAL WITNESS STATEMENT OF

I, SND 491 will say as follows:-

1.

In respect of my professional view of Nazareth House and Termonbacca I believe that there were a number of issues associated with the physical environment of both children's homes i.e.

- The size of the units.

- Nazareth House was part of a multipurpose arrangement with a residential home for the elderly, a school and church all accommodated on the one site.

- A somewhat cloistered atmosphere.

However the actual children's facilities on the sites were homelike and very welcoming. I found the care provided in both facilities to be warm and of a high standard. I was satisfied that children placed there received a satisfactory standard of care.

2.

In terms of my working relationship, I believe that I enjoyed a good professional relationship with all the Sisters with whom I came into contact.

The Sister that I had most contact with over the years was SR 2 Initially I met her when she worked in Termonbacca. When that unit closed I understand that she was transferred to but she later returned to work in Nazareth House. I was in frequent contact with her there until the unit closed.

I admired her greatly. She was a very warm, caring and motherly person. She always had the interests of children placed in her care at heart and she was a most effective advocate for them.

3.

When the decision was taken to close Termonbacca I was allocated responsibility for two young people, both males, who were placed there. I visited both young people in Termonbacca and started to establish a professional relationship with them. I carried out an assessment of their needs and then began exploring suitable alternatives for their care. In the case of one young person this involved reinitiating contact with his extended family to ascertain if a return was possible. This turned out not to be a feasible option.

Consequently I secured placements for both young men in Fort James Children's Home (a statutory facility) and took them for introductory visits. I also participated in residential reviews where care plans were drawn for them. In the case of one young person this involved preparation for independent living and in the other case this involved preparation for supported care. I regularly both young people until I transferred to work in as a

4.

With regard to the reasons for the closure of Termonbacca as a frontline or basic grade I was not involved in any of the discussions in relation to the closure of the unit.

My perception was that it was no longer fit for purpose, given its size and layout.

5.

As a and I performed an oversight role.

The key duties of a social worker in respect of children in residential care are:

-Visiting each child on a monthly basis and seeing them on their own.

-Preparing for and Participating in Care Planning Meetings and Reviews.

As a [redacted] I held regular supervision sessions with each Social Worker in the team. Supervision fulfils a number of functions as follows:

- Looking at continuing professional development needs.

- Reflective practice and

-Holding to Account.

Therefore at each session I reviewed case files of Social Workers to ensure that their interventions were appropriate and statutory functions were met. In addition I attended key meetings with staff including residential care reviews.

As [redacted] I provided the Team leaders in my office with regular supervision sessions. I confirmed that they were themselves providing supervision sessions to their staff and considered any emerging issues. I also attended any residential care reviews if there were any complex issues to be discussed.

6.

I was not involved in discussions regarding staffing issues at Nazareth House during the period [redacted] and [redacted] However I was aware of the discussions regarding the need for parity of arrangements with statutory homes in respect of staffing ratios and training opportunities.

7.

In respect of an awareness of Staffing Issues at Nazareth House as [redacted] my recollection is that I was not involved in direct discussions with the Order in respect of funding. This function was carried out By the Western health and Social Services Board in its commissioning role.

I do remember discussions over the introduction of waking night staff. A decision was taken to introduce such staff after an incident of peer sexual abuse in a statutory residential unit.

I recollect discussions about the need for similar arrangements in Nazareth House. I believe that they were introduced subsequently there as resources permitted.

8.

I believe that a number of factors combined which culminated in the closure of Nazareth House including:

- The changing nature of residential child care. The profile of children and young people entering the care system changed very significantly during the 70s through to the 90s. Because of the development of family support arrangements there were fewer children entering the care system with less complex needs. Rather we were increasingly dealing with children and young people who had experienced compromised parenting or had suffered abuse (physical, sexual and emotional). Also we were dealing with young people who have been involved in substance abuse and deliberate self-harm. This was increasingly a challenge for the order.

-The environment. There was a growing awareness that the physical environment was no longer fit for purpose. Increasingly we believed that if children could not live at home that foster care was the preferred placement. If this was not available or was inappropriate then they should be cared for in smaller, more domestic settings fully integrated into the community. The days of large institutional care had effectively passed.

-The reduction in numbers entering religious orders. Similar to the experience of other orders the numbers were reducing. Consequently the Order no longer had the manpower to deal with this increasing complex area if work.

9.

I believe that the Western Health and Social Services Board's decision making in respect of Section 131 of the Children and Young Person's Act was undertaken through the care planning and review arrangements which were held in respect of the each young person.

10.

With regard to the development of Leaving and After Care services my recollection is that initially there were no formal dedicated aftercare services. It was the responsibility of field social workers in collaboration with residential care staff to help prepare young people for leaving care and to provide on-going support. This was not a satisfactory arrangement as these staff had no specialist knowledge of this area of work and also they carried a broad range of other duties including child protection.

In an effort to develop the service to young people leaving care, semi-independent flats were set up at Fort James Children's Home and a similar arrangement was later rolled out to Nazareth House. However the main impetus to further develop this area of work was a very influential study undertaken by TL 4 and FJ 23 called [redacted]
It looked into the experiences of over 30 young people who had left the care system and provided the evidence that a dedicated Leaving and Aftercare service was required to enhance the opportunities of young people moving out of residential care. Consequently

with the planned closure of Fort James a specialist Team was established and this was later augmented with the introduction of the Children Order.

11.

I believe that the arrangements for the reporting of untoward incidents have evolved and been refined over the years. I am not aware of the precise changes and when they were introduced.

However it is my recollection that "untoward events" were initially recorded and monitored through the monthly monitoring arrangements for residential care.

The arrangements were later developed for the reporting and monitoring of "untoward incidents". Serious adverse incidents are reported to the Health and Social Care Board.

12.

I believe that the procedures for the making and recording of complaints have evolved and developed over the years. I cannot remember the precise changes and when they were introduced.

I do recollect that initially one of the purposes for field social workers seeing children in care on a monthly basis on their own was to ascertain if they had any issues or complaints. Also young people were eventually invited to participate in residential reviews and were allowed the opportunity to raise any concerns that the may have.

Subsequently with the introduction of the Children Order procedures were much more formalised and a dedicated Complaints Officer was appointed to deal with children's complaints, including those made by children in residential care. Also a system was introduced whereby all young people entering residential care were given a pack which includes a stamped addressed envelope so that they could raise any concerns direct with the Director of Social Work.

13.

With regard to our understanding and awareness of peer sexual abuse I would say the following:

Society's knowledge of the nature and extent of child abuse has developed very significantly over the last four decades. Initially during the 60s and early 70s we gained an appreciation of the nature and prevalence of the physical abuse of children. Our understanding of other forms of abuse (including sexual and emotional) grew and developed throughout the 70s

I believe that the procedures for the making and recording of complaints have evolved and developed over the years. I cannot remember the precise changes and when they were introduced.

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Statement of Truth.

I believe that the facts stated in this witness statement are true.

Signed: SND 491 ....

Dated: 22nd April 2014

SND-17566

HIA REF: SND 491

NAME: SND 491

DATE: 28-4-14

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT OF

I SND 491 will say as follows:-

1.

I am not aware of any policy or practice whereby a child's keyworker would have been encouraged to take a child to his or her own home in the event that he or she could not go home. Such an arrangement would have been very exceptional.

It is my understanding that this arrangement would have had to be approved in line with the Western Health and Social Services Board's "Residential Child Care Policy". In particular,it should have been approved in line with the framework described in the section "Approval for Absences of Children in Care."

2.

I was not involved in the care planning arrangements in relation to the young person HIA 127

Therefore I cannot comment on the actual decision making process regarding his contact with his key worker outside Nazareth House, in and around [redacted]

I believe that I became aware of this contact in [redacted] following the allegation made by HIA 127 that he had been abused by [redacted] My role was to arrange for Social Work staff from [redacted] who held case responsibility to confirm if such an arrangement was authorised, in order to assist the investigation into the allegation.

Statement of Truth

I believe that the facts ~~stated in~~ this witness statement are true.

Signed: SND 491 ....

Dated: ....28th April 2014..........

SND-14755

Please return. To Dixon TR

WESTERN HEALTH & SOCIAL SERVICES BOARD

FOYLE COMMUNITY UNIT

MEMORANDUM

2 - JUN 1993

WESTERN HEALTH AND SOCIAL SERVICES BOARD -2 JUN 1993

TO: SND 469 CSWA

FROM: SND 425 A/AUGM

DATE: 24th May 1993

RE: **WAKING NIGHT STAFF: NAZARETH HOUSE**

You will recall that I had a brief telephone conversation with you about this matter some weeks ago. In the interim SR 2 has forwarded this letter to me requesting funding for these staff. My calculation is that this would amount to £21,000 per year.

Waking night staff were introduced to Nazareth in November 1992 following a number of incidents in the Home during the night where peer abuse was suspected. I flagged this issue up in the paper I prepared prior to the discussion about the capitation fee though this was not debated in depth at subsequent discussions though you will recall that SR 2 did raise it at the meeting that you attended with SND 507 and I at Nazareth House on 16th April 1993.

I have raised this matter with SND 511 Acting UGM and he has indicated that Nazareth are requesting what amounts to a development of service for which the Unit is not funded. Indeed whilst we introduced waking night staff into Harberton House it was done so in the expectation that until funds were obtained the Board it would be funded out of slippage. The Unit did apply for funding as part of the recent service development.

I believe that the incidents that occurred in Nazareth were sufficiently serious to warrant the introduction of waking night staff. Given this situation and the fact that we have already introduced waking night staff to one of our own facilities I believe that we have no alternative but to agree to this request. However I am of the opinion that the Board should provide the funding for this additional service.

SND 425 this matter in the near future.

TL 19 3/6/93

I would like to discuss this with you.

ACTING ASST UNIT GENERAL MANAGER
(SOCIAL SERVICES AND SOCIAL CARE PROGRAMMES)