DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 15

KINCORA HOSTEL

(KINCORA)

29 April 2016

I, Hilary R Harrison will say as follows:

This statement has been provided on behalf of the Department of Health, Social Services and Public Safety (the Department) and is the third in a series of statements made in response to the HIAI Rule 9 request dated 5 February 2016 which set out a number of issues to be addressed by the Department and the Health and Social Care Board (the Board). The statement deals with the following request:

"The HIA Inquiry would wish the Department and the Board to provide Rule 9 witness statements specific to the Bawnmore and Kincora module in a similar fashion to those provided by the Department and Board for earlier modules.

The statements should address what the Department and Board want to say to the HIA Inquiry about Bawnmore and Kincora. They should also address the key systems issues, now well known to the Department and the Board. The statements should be focused and evidenced.

You should provide one statement each covering Bawnmore and one statement each covering Kincora.

The statements should identify any systems failures which the Department or Board acknowledge occurred in respect of the involvement of their predecessors in the running or oversight of each of the homes.

In relation to Kincora, the Department should each address in chronological order any missed opportunities to prevent abuse occurring at Kincora".

Information held by the Department

1.1 The Department does not hold any information in current Departmental files relating to the management, operation or inspection of Kincora prior to the scandal in relation to this home breaking in January 1980. There are a number of Departmental files containing information relating to the 1984 Committee of Inquiry into Children's Homes and Hostels (the Hughes Inquiry) and the 1986 Hughes Inquiry Report (the Hughes Report). Although Kincora featured in the proceedings of the Hughes Inquiry and in its 1986 report, the information held within relevant Departmental files is mainly concerned with internal policy matters such as briefings; minutes of meetings and policy papers in relation to the Hughes Inquiry and implementation issues.

1.2 With regard to the issue of abuse of boys in Kincora, the DHSS was made aware of the allegations and incidents of abuse that became known during the police investigation that commenced in 1980, prior to the establishment of the Hughes Inquiry. The DHSS was also alerted to the information revealed during the course of that Inquiry. The Department has been unable to find evidence of any further information regarding abuse in Kincora having been

reported to the Department or its predecessor bodies.

1.3 The Department is therefore reliant on the Hughes Report and evidence received from the HIAI to provide comment in relation to the Rule 9 request outlined above in respect of Kincora. To date, the evidence received from the HIAI in relation to Kincora comprises only the oral evidence provided to the Hughes Inquiry. Should any further information become available, it may be necessary to address this within revised or additional statements.

2. The issues

2.1 The key themes on which the HIAI has sought comment from the Department in respect of the individual institutions considered in previous modules, have generally concerned a) the discharge of inspection and related functions by the Ministry of Home Affairs (MoHA) and the Department of Health and Social Services (DHSS) and b) Departmental knowledge of abuse and action to address this. In the absence of specific questions at this stage from the HIAI, this statement seeks to address these matters, including the question relating to missed opportunities to prevent abuse, solely on the basis of the information referred to above (paragraph 1.3) and within the reference framework of previous Departmental statements to the HIAI. The statement concludes with the Department's considerations of whether the systems operated by its predecessor bodies might have failed children in these homes.

3. Relevant provisions of the regulations

3.1 Kincora was a boys hostel, opened by the Belfast Welfare Authority (BWA) in January 1958. It was closed down in 1982. The BWA was initially responsible for managing the home in accordance with the Children and Young Persons (Welfare Authorities' Homes) Regulations (Northern Ireland), 1952[1] (the Regulations). The Regulations required, *inter alia,* the home to be visited at least once in each month by a member of the welfare committee or by a member of the welfare authority's children's sub-committee[2] who was to *"satisfy himself whether the Home is conducted in the interests of the well-being of the children"*. The home was also to be inspected at least once in each month by the welfare authority's Children's Officer who was also required to *"satisfy himself whether the Home is conducted in the interests of the well-being of the children"* [3]. Both of these welfare authority officials were required to report to the welfare committee or the children's sub-committee and this report was to be entered into the minutes of the relevant committee.

3.2 In 1972 the Eastern Health and Social Services Board (EHSSB) became responsible for the management of Kincora. The Conduct of Children's Homes Direction (Northern Ireland) 1975[4] (the Direction) contained similar provisions to the Regulations regarding what was to be reported upon and the requirement that the "*home is being conducted in the interests of the well-*

[1] HIA 292
[2] Regulation 5 (1)
[3] Regulation 5 (2)
[4] HIA 452

being of the children" but the reporting officers were: a member of the Personal Social Services Committee (PSSC) who was to visit the home at least once in every quarter and a social worker who was to visit the home at least once in every month. It is of note that the explanatory memorandum to the Direction described these as "routine inspections"[5]. Reporting arrangements were respectively to the PSSC and, in the case of the social worker, to the District Social Services Officer and then to the Director of Social Services who would bring any matters of concern to the attention of the PSSC.

3.3 Both the Regulations and the Direction contained a general duty on the relevant statutory authority to ensure that each home was *"conducted in such a manner and on such principles as will further the well-being of the children in the home".*

4. Inspections of Kincora by MoHA children's inspectors and the Social Work Advisory Group (SWAG)

4.1 The Hughes Inquiry found that according to MoHA's extant records, inspections of Kincora by MoHA children's inspectors took place in October 1965 and April 1972. There was also evidence from the Kincora record book that MoHA inspectors visited Kincora on twelve occasions other than those that resulted in the 1965 and 1972 reports. Some of these visits may have predated the Hughes Inquiry's 1960 starting point and that Inquiry noted that such visits were *"consistent with other evidence"* heard by the Hughes Inquiry *"relating to less formal contacts between the Ministry's Inspectors and Belfast Welfare Authority staff".* With reference to the period 1960 to 1972, the Hughes Inquiry concluded (in summary):

- Inspections by MoHA had minimal potential for preventing or detecting homosexual offences against residents[6] and could achieve little more than a basic assessment of whether the home was functioning satisfactorily[7];

- The scale and nature of the inspections of Kincora could never have been adequate to fulfil the purpose of MoHA's inspections under the 1950 and 1968 Acts which was to examine *"the conditions and treatment of children"[8];* and

- It did not believe there could be any defence of MoHA's record on formal inspections of Kincora although it acknowledged that the Inspectors' less formal visiting would have alerted them to overt signs of deteriorating standards[9].

[5] HIA 457
[6] HIA 701 Para 3.41
[7] HIA 701 Para 3.41
[8] HIA 701 Para 3.42
[9] HIA 701 Para 3.42

4.2 However, in making the above findings, the Hughes Inquiry *"took account of the fact that Article 136 provided an enabling power rather than imposed a mandatory requirement to inspect and that the primary responsibility for the well-being of Kincora residents lay with the Belfast Welfare Authority"*[10].

4.3 With reference to inspections by SWAG, there was one in the period 1973-1980 undertaken in June 1979. The structure and contents of the report followed guidelines laid down by the DHSS in February 1976. The Hughes Report stated:

"the conclusion that Kincora did not receive sufficient attention from the Department during this period is inescapable. In making this criticism of the Department, we would acknowledge that the new format for inspection reports introduced in February 1976 was an advance on what had gone before, although it may have fallen rather short in terms of its provisions for assessing some aspects of child care ….. The Department's evidence satisfied us that the low frequency of inspections arose more from constraints on professional resources than from inspections being given a deliberately low priority"[11].

4.4 The Department has intimated to the HIAI that one of the most basic functions of inspection is to ascertain whether a service is compliant with regulatory or other statutory requirements[12]. With reference to the discharge by the BWA of the inspection, visiting and reporting responsibilities of its Children's Officer (as outlined above[13]), the Hughes Inquiry found that the monthly inspections and reporting requirements were not strictly observed for the years 1960-62 but for the remainder of the period to 1973 there was almost full compliance by the Children's Officer with the statutory requirement. Of note is the following observation within the Hughes Report:

"We attached a special significance to the statutory inspections required of the Children's Officer because we thought this type of regular supervision by responsible management staff might have provided a general deterrent to the commission of offences; an opportunity for peculiarities in the hostel atmosphere to be sensed or detected; and even a channel for specific complaints of homosexual activity or other misconduct to be made by the residents. The history of Kincora, however, demonstrated that the inspections did not, in fact, provide these potential benefits and we considered it important to find out why this was the case"[14]

4.5 Having considered a number of factors, the Hughes Inquiry came to the conclusion that statutory inspections by the Children's Officer were

"unlikely to detect cases of homosexual misconduct unless some sign of distress in a resident became apparent or a complaint was made. They could and doubtless did, however, contribute to the well-being of the boys in terms

[10] HIA 701 Para 3.42
[11] HIA 758-759 Para 4.19
[12] Departmental oral evidence to the HIAI 22 May 2014 Day 38 pages 23-24; 26
[13] See Para 3.1 above
[14] HIA 695 Para 3.28

of the physical conditions and amenities of the hostel."[15]

4.6 The Hughes Inquiry considered the visiting record to Kincora by the Welfare Committee during the period 1960 to 1973. It found that the Committee's record of compliance with statutory visiting duties after 1966 could not escape criticism. Although there was no evidence that this had any bearing on the incidence of homosexual offences, the Inquiry concluded that it was nonetheless unsatisfactory that the Committee should have substantially neglected its statutory duty. Nevertheless it concluded that the conclusions reached on the efficacy of children's officer inspections as a means of detecting homosexual offences, applied with even greater force to the statutory visits of the members of the Belfast Welfare Committee[16].

4.7 As noted above, the Direction conferred visiting responsibilities for children on the PSSC and the HSS Board social worker. The Hughes Inquiry found that inspection visits by the Board social worker were carried out in full from 1973 until late 1979, with such visits becoming even more frequent than once monthly from late summer 1976[17]. Despite the frequency of these visits they did not appear to act as a deterrent, in that homosexual offences were occurring but were not detected during this period.

4.8 Regarding PSSC visits to Kincora the Hughes Inquiry found that its record on visiting and reporting under the Direction was satisfactory from mid 1974 to 1977 and accepted that allowances could be made in respect of the transitional period following the October 1973 reorganisation. Although the record in relation to the 1978 to 1979 period was unsatisfactory, the Inquiry concluded that this did not have a material influence on the prevention or detection of homosexual offences. In this context, the Hughes Inquiry regarded the change to quarterly visiting, introduced by the 1975 Direction as reasonable and consistent with the PSSC's responsibilities for residential childcare.

MoHA/DHSS knowledge of allegations of abuse in relation to Kincora

4.9 In December 1981, three EHSSB members of staff were convicted of homosexual offences against boys who had been in their care in Kincora. The Hughes Report has catalogued in detail, the information which came into the EHSSB's possession at various times during the period of Kincora's operation as a children's home until January 1980, when the allegations of sexual abuse within came into the public domain. Departmental records and the evidence of senior DHSS officials to the Hughes Inquiry confirm that the DHSS had no knowledge of any of the information received by the EHSSB in relation to staff at the home prior to January 1980.

5. Conclusions

[15] HIA 697 Para 3.31
[16] HIA 699 Para 3.36
[17] HIA 753-754 Para 4.6

5.1 In its review of the above information, the Department has come to the conclusions outlined in paragraphs 5.2 to 5.5 below in relation to Kincora.

5.2 With reference to its inspection record, the Department has in previous statements to the HIAI acknowledged the limitations of the inspection approach adopted by MoHA in terms of its nature and capacity to effectively evaluate the quality of care in the home. The Department has suggested, however, that the MoHA methodology was of an acceptable standard for its time and inspections appear to have been carried out in general on an annual or biannual basis. Unlike Bawnmore, Kincora was, however, only 'formally' inspected twice by MoHA during the 1962-72 period although there is no doubt that in view of the frequency of more informal visiting of the home during that time, MoHA Inspectors would have been reasonably well acquainted with the operation of the home and its staff. The Department has claimed in previous statements to the HAIA that 'visits' to homes were introduced by SWAG following the re-organisation of the HPSS in 1972 and proposed that this may have been due to the influence of a UK-wide Government policy emanating from the Seebohm report[18]. The then Chief Inspector, Mr Pat Armstrong, acknowledged to the Hughes Inquiry that whilst a series of visits took place to children's homes during the 1970s, statutory homes tended to be visited with less frequency than those in the voluntary sector[19]. As noted above, an inspection of Kincora was conducted in 1979 and it whilst it would appear that, apart from the 1979 inspection, there is no evidence of the home having been visited formally or informally between 1972 and January 1980.

5.3 The DHSS did not challenge the criticism of the Hughes Report of its record of inspections in relation to Kincora and the HIAI is now aware of the significant initiatives which both pre-empted and followed the Hughes Report. These evidence the gravity with which the DHSS regarded the events in Kincora and the other children's homes considered by the Hughes Inquiry.

5.4 With regard to the potential for more regular or indepth inspections or visits to Kincora to have detected abuse, the Department has noted above the conclusions of the Inquiry in relation to the inspection visits to the home by the BWA Children's Officers representatives and the EHSSB's visiting social worker. Despite these roles and the roles of the Welfare and Board Committees having been discharged in general compliance with the regulations and with integrity, abuse of children occurred and continued to occur even when such visiting was increased. Even if inspection visits by MoHA or SWAG had been increased during this period, these would naturally have been completed in a manner consistent with contemporaneous knowledge and standards. Therefore the Hughes Inquiry conclusions that the inefficacy of the Children's Officer inspections as a means of protecting against sexual offences applied with even greater force to the monthly statutory visits of the members of the Belfast Welfare Committee might well have applied with greater force again to a programme of annual inspections of

[18] Report of the Committee on Local Authority and Allied Personal Social Services – HMSO London 1968 (Seebohm Report)
[19] KIN 70394

the Kincora home carried out in accordance with the standards of the day. Within this context, the Department believes that the lack of a regular inspection programme by SWAG did not signify a missed opportunity to prevent abuse.

5.5 There is no doubt that inspection methodology in Northern Ireland quickly developed into a more rigorous process, which now examines the care provided in children's homes against defined and measurable standards of quality and care. Whilst inspection does not of itself prevent abuse, it is nevertheless an important element within a framework of factors that work together to safeguard children. The framework itself, is however, continuously developing and improving. One might well find that the standards of today are not the acceptable standards of tomorrow.

Signed

Date **29 April 2016**