\HIA REF: [ ]

NAME: [Fionnuala McAndew]

DATE: [27 May 2016]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of the Health and Social Care Board

I, Fionnuala McAndrew, Director of Social Care and Children's Services, Health and Social Care Board, ("the Board"), will say as follows:

1. By correspondence dated 25th May 2016 the Inquiry has requested a further **Rule 9 Statement** from the Board in relation to **Kincora Boys' Hostel**. This statement is filed to respond to the queries raised therein.

2. The Board has filed a detailed statement dated 29th April 2016 to provide a chronology of missed opportunities to detect and prevent abuse occurring at Kincora. A further statement has since been filed, dated 23rd May 2016. At paragraphs 90 and 91 the Board has analysed, with reference to the statement of 29th April 2016, the systemic failings which are identified and accepted.

3. The Inquiry has now posed specific queries to the Board which are detailed herein below. Responses are provided to each. I also append hereto an up-dated and composite list of those failings that are accepted.

When the 1967 complaints were made, should an instruction not have been given to all social workers with children in Kincora to be aware of the fact the allegations were made and without soliciting complaints to ascertain from those with whom they engaged as to whether they had any similar difficulty. If not, why not? Was this a systems failure? If not, why not?

4. The Board does not consider that it was a systems failure in 1967 that the proposed instruction was not given to all Social Workers with children in Kincora.

5. In reaching this position, the Board has taken note of the fact that these allegations were investigated by the Chief Welfare Officer, with the assistance of the Children's Officer, and were not found to be substantiated. The Children's Officer, as a key officer that managed the hostel, was fully aware of the allegations.

6. Belfast Welfare Authority had a duty to the children in its care, which was discharged through the investigation of these complaints, evidenced by the contents of the 'Mason file'. The Children's Officer was also well informed to ensure he could discharge his function to monitor the Hostel.

7. Belfast Welfare Authority had another role, as the employer of Mr Mains. To disseminate unsubstantiated allegations about him would have been, in the HSCB's view, inappropriate.

When in 1971 the District staff received a letter which was to be referred to the Central Police Station, was it not an obvious missed opportunity not to notice the direction on the envelope and provide it to the police. If not, why not? Was this a systems failure? If not, why not?

8. The Board does not accept that there was any missed opportunity or systems failure arising from this particular aspect of the 1971 complaint.

9. The facts and circumstances of how this letter came to the attention of the Social Welfare Officer at the Townsend sub-office are detailed in the Hughes Report at paragraphs 3.144 to 3.146 of the Hughes Report [**HIA 738 – HIA379**]. The Board has also read and considered the evidence of the Social Welfare Officer at **KIN 71721** and **KIN 71731** wherein she confirmed that she did not see the endorsement on the envelope. It is, however, also necessary to note that she immediately took the letter to her Senior Welfare Officer, who did see the note

made on the envelope. That Officer became aware that no step was to be taken at the sub-office because a similar letter had been received at College Street Headquarters, and the Chief Welfare Officer was taking the matter forward.

10. The Board considers that the actions taken by these staff members were appropriate, in immediately ensuring that their superiors were aware of the complaints raised. It would not have been the role of these staff to make a determination about referral to police, that would have been a decision left to their superiors, in whose hands they were assured the matter would be taken forward. In making this assertion the Board notes that some three years later in 1974, regarding complaints by R15 that were not passed to police by a District Officer, the Hughes Report endorsed the position of the Board, stating: "*We do not criticise the [Senior Social Worker] for not making a referral to the police since it would have been irregular for him to do so without consulting Mr McGrath's District management*" [**HIA 776**, para 4.68].

11. The Board does however consider that there was a fundamental failure in 1971. Staff in Headquarters ought to have referred this complaint to police. This is addressed further below.

Further in relation to the 1971 complaint from [redacted], at the end of his letter (KIN 1019) he was providing evidence of finding an ex-resident in Joe Mains' bed. Is there any evidence that anything was done with or about this piece of information? If nothing was done with this information, should something not have been done with it given it potentially involved adult homosexuality going on involving a member of staff at Kincora, including interviewing Mains' about it and also referring it to the police? Is if the case that the significance of this piece of information appears to have been completely overlooked? Was this a systems failure? If not, why not?

12. In responding to this issue the Board would first note reference to "[redacted]" as an "ex-resident". While this is now known to be true, [redacted] was discharged from Kincora in 1961. Upon reading the letter, unless the recipient immediately recognised the name "[redacted]" it would not have been apparent

that this was an ex-resident. Its seems, however that Mr Mason had made the connection in a record made in 1967. It was also clear that this was an allegation of another man in Mr Mains' bed at a time when homosexuality remained a criminal offence in Northern Ireland.

13. Upon receipt of the letter on 12th August 1971, an investigation was commenced by Mr Mason, Chief Welfare Officer and Mr William Johnston, Deputy Town Clerk. They, with Mr McCaffrey, Assistant Children's Officer, interviewed the complainant, ___________ on 23rd August 1971. Mr Mason and Mr McCaffrey interviewed ______, who had been named by ______________ in his complaint on 24th August 1971.

14. On 25th August 1971 Mr Mason forwarded the file, which contained the details of the investigation in 1967 and ____________ complaint, to the Town Solicitor. He stated "*No other investigations have been carried out regarding the rest of the statements made, but it is thought that there are sufficient grounds to have the matter considered as one which should be referred to the Police in view of the allegations which were made against the same officer in September 1967"*.

15. It therefore appears to the Board that following preliminary enquiries a view was formed that the full detail of what had been alleged was more properly a matter to be taken forward by police.

16. It is known that it appears this was never referred to police. It is also clear that what occurred after this Memo is not recorded on the file, and the Board has made a concession in respect of inadequate recording in this respect at paragraph 90(a) of the Rule 9 Statement dated 23rd May 2016.

17. Having reviewed the concessions at paragraph 91 of that statement the Board would also accept the following failing:

"There was a failure, in 1971, to refer the complaint made by _____________ ________ to the police, see paragraph 45 of the statement dated 29th April 2016"

18. It is clear, as detailed in paragraph 45 of the statement dated 29th April 2016, that, "*on the balance of probabilities, referral of the "Mason File" to the police in 1971 would have proved decisive in the discovery of Mr Mains' and Mr Semple's homosexual activities and would have created a major deterrent to future misconduct".*

19. As the matter was not referred to police, the position was that only a partial investigation was carried out. No step was taken to complete this. The Board accepts:

    "When the matter was not referred to police in 1971, there was a failure to complete an internal investigation of the complaints made by [redacted] [redacted]."

When the 1971 complaints were made, should an instruction not have been given to all social workers with children in Kincora to be aware of the fact the allegations were made and, without soliciting complaints, to ascertain from those with whom they engaged as to whether they had any similar difficulty. If not, why not? Was this a systems failure? If not, why not?

20. Given the circumstances that pertained, namely that a full investigation was not carried out, and a decision was not made as to whether the complaint was substantiated or not, the Board refers to the issues already raised regarding the dissemination of unsubstantiated complaints.

21. The Board does accept if police enquiries had commenced, with indication that there was information to support the complaints, that the information should have been given to all social workers with children in Kincora at that point. The Board considers that this meets a balance between protecting the children and ensuring actions are taken in a manner consistent with their predecessor's duties towards employees.

Was it a systemic failing that after re-organisation the senior staff with line management responsibilities for Kincora did not know of, or at least did not

know all of, the previous complaints about staff at Kincora, and were consequently making decisions in relation to matters arising from the hostel without being cognisant of relevant information? If not, why not?

22. The Board has accepted at paragraph 91(a) that there was a failure to share information with those that had management responsibility for the hostel in 1971.

23. The Board acknowledges that this situation continued to persist after re-organisation and would accept the following failing, adopting the analysis of the Hughes Report at **HIA 749**, para 3.173:

    "[Prior to re-organisation] direct access to the "Mason File" by officials with management responsibility for Kincora had been unduly restricted and the [Assistant Director's] treatment of it [following re-organisation] compounded this problem… The circumstances in which he was given the file, as well as its contents, should have prompted him to brief the incoming management staff at the earliest opportunity to enable them to carry out their duties with the benefit of all available information"

Further to the above, was it a systemic failing that Mrs. Wilson did not have all the information about Joe Mains when she was deciding how to handle the anonymous call to social service about William McGrath? If not, why not?

24. The Board considers that Mrs Wilson should have been made aware of all information in 1971 (see paragraph 91(a) of the statement dated 23rd May 2016). It is further acknowledged above that as a member of the incoming management team on re-organisation a second opportunity to brief her was missed.

25. The Board considers that she should have had all of the information to enable her to conduct her investigation in an informed way. It is proposed that the two failings already accepted acknowledge this.

Was it a systemic failing that the 1974 anonymous call, whether before or after investigation by Mrs. Wilson, was not referred to the Area Board? If not why

not? What was the Area Board being told about Kincora in the aftermath of the anonymous call?

26. The Board has accepted this was a failing at paragraph 91(b) of the statement dated 23rd May 2016.

27. In the aftermath of this anonymous call the Area Board would have continued to receive the monitoring reports on the hostel. The Board accepts that this process did not ensure any concerns arising in respect of actions by staff were communicated to the Area Board.

In relation to paragraph 75 is the HSCB position that, to the best of its knowledge and belief, it never received an anonymous telephone call in respect of Kincora in 1975?

28. Having regard to the contemporaneous documentation of its predecessor that is now available to the Board, to the best of its knowledge and belief, the Eastern Health and Social Services Board did not receive an anonymous telephone call in respect of Kincora in 1975.

In relation to paragraph 97, does the HSCB accept that it was a systemic failing for Mr. Scoular to fail to inform the Board representatives of all that the District by then knew so that the Board could decide what of that information also should be passed to the RUC. If not why not?

29. The Board has accepted that this was a failing at paragraph 91(g) of the statement dated 23rd May 2016.

Does the HSCB accept that it was a systemic failure for members of staff in Kincora (Joseph Mains and Raymond Semple) to have failed to pass on complaints they acknowledge they received from boys in their care in respect of behaviour by William McGrath (see for example KIN 10388 [redacted], [redacted], [redacted] & 10413 -). What should have happened to these complaints? Should the individual social workers have been informed?

Should those in head office responsible for the social worker been informed? Should Mains have immediately suspended McGrath and informed district he had done that?

30. In response to the issues above the Board notes that Mr Mains was in receipt of complaints that were not communicated by him to anyone in authority outside the Hostel. This arises in relation to complaints against both Mr Semple and Mr McGrath as follows:
    a. [redacted] in respect of Mr Semple [**KIN 10415** and **KIN 10357**],
    b. [redacted] in respect of Mr McGrath [**KIN 10413**]
    c. [redacted] in respect of Mr McGrath [**KIN 10425**]
    d. Richard Kerr in respect of Mr McGrath [**KIN 10426**]

31. The Board considers that Mr Mains should have reported the information received by him in each instance to both the fieldwork Social Worker for the boy and to his immediate superior.

32. As regards Mr Semple, it is noted that he acknowledged being in receipt of complaints from four boys, namely [redacted], [redacted], [redacted] and [redacted], against Mr McGrath. **KIN 10388**. It appears from **KIN 10393** that Mr Semple reported these matters to Mr Mains.

33. If this is correct, then Mr Semple took the action that would have been expected of him, by reporting to his immediate superior. Mr Mains should then have informed the appropriate personnel, being again the fieldwork Social Worker for the boy and his immediate superior who would have been visiting monthly to monitor the Hostel. Any necessary communication with those in line management for the fieldwork aspect, would then, the Board expects, be followed through by the fieldwork team.

34. In relation to suspension of Mr McGrath, the Board does not believe that Mr Mains would have had the personal authority to take such action. This underlines the importance of his making the information available to his own superiors so that the appropriate Officer in the Residential and Daycare management within

the District, likely the District Social Services Officer, could have directed in respect of action that was necessary to take, including a potential suspension and referral of the matters to police.

35. The Board therefore accepts:

"Throughout the period of Mr Mains' management of Kincora as Officer-in-Charge he failed to report complaints and concerns about homosexual abuse by members of his staff to Belfast Welfare Authority and later East Belfast and Castlereagh District management."

The HSCB is referred to the report from Sussex Superintendent Flenley at KIN 40366 and following, and to the evidence he refers to including the analysis to be found at KIN 40988. What does the HSCB wish to say to the Inquiry about the activities attributed to Mr. David Morrow during the 1970's and 1980's

36. The Board would refer to the conclusions reached by the Hughes Inquiry at **HIA 798**, para 4.213: "*It will be plain that we regard some of the allegations reported in the "Irish Independent" article as inaccurate. We believe that this resulted largely because Mr Morrow, as he himself acknowledged in evidence, speculated freely about matters for which he had no evidence in fact; and because Mrs Gogarty was an impressionable and inexperienced officer who accepted Mr Morrow's speculation at face value and retailed them on that basis….. Having made those observations, we have no doubt that Mrs Gogarty's decision to approach the press was motivated by an entirely commendable concern for the welfare of children in care and that the article was printed in good faith. In addition, we are convinced that the evidence shows that the situation which existed at Kincora would have continued until such times as some decisive intervention was made.*"

37. The Board also references para 933 of Superintendent Flenley's report at **KIN 40372** wherein he states: "*Ironical though it may be however, Mr Morrow, as the originator and promulgator of allegations which were in the main a gross distortion of the truth or completely fabricated, became indirectly responsible for*

stimulating press interest in the affair to such an extent that it ultimately resulted in the true facts being revealed."

38. In making it clear that the Board does not endorse the activities of Mr Morrow during the 1970's, which he himself described to Sussex Investigating Officers in 1982 as 'pure speculation' and 'theorising about the possibility of a link' [**KIN 40994**], the Board accepts and adopts the findings of investigations as detailed above.

What was [redacted], who worked alongside Mains in 1967, in a position to say to . Was it not a systems failure that he does not appear to have reported to the authorities the concerns he was prepared to share with the likes of [redacted] (see KIN 40049, 40937, 10147)?

39. The Board has considered the police statement of [redacted] dated 29th February 1980 at **KIN 10147**. [redacted] reported that in 1968 [redacted] was able to tell him "*to be careful when I was having a bath or in the shower or when I was changing of a man called [redacted] and also of the man in charge, Mr Mains, and if I was approached to speak to him*".

40. The Board has seen no evidence that [redacted] made such concerns known to those in line management for the Hostel.

41. The Board also has not seen any statement from [redacted], and understands that in 1980 the RUC were unable to trace him. It is therefore unknown whether [redacted] accepted that he issued the warning [redacted] has detailed.

42. In those circumstances the Board accepts:

"In the absence of any statement from [redacted], if [redacted] statement is true, there was a failure by [redacted] in 1968 to share his concerns about Mr Mains and [redacted], and their behaviours towards residents of Kincora, with those Officers in line management, specifically the Children's Officer."

43. As indicated at paragraph 3 herein above, I append to this statement an up-dated and signed list of the failings accepted in relation to the oversight and management of Kincora Boys' Hostel. Failings which have been added as a result of being invited to consider the issues in this statement are underlined to denote their addition to the list previously detailed in the statement dated 23rd May 2016.

44. Finally, I would refer the reader to the closing remarks in the Board's statement dated 23rd May 2016, and particularly that in acknowledging these failures, the Health and Social Care Board considers that many, in and of themselves, would not have been capable of preventing or detecting the homosexual abuse that occurred in the Hostel.

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

Signed:

Dated: 27 May 2016

APPENDIX TO STATEMENT DATED 27th MAY 2016

Up-dated and composite list of failings accepted by the Health and Social Care Board in respect of the oversight and management of Kincora**:**

1. At times record keeping was not good enough. The following occasions are noted:
   a. There was a failure by the Chief Welfare Officer to record the outcome of the investigation of complaints in 1971 and the reason for that decision.

   b. In early 1976 there was a failure to make any written record regarding information reported to the Holywood Road sub-office, and passed to Residential and Daycare Management at District Headquarters. The absence of such a record likely influenced the subsequent failure to investigate the information in any way, see paragraphs 86 and 88 of the statement dated 29th April 2016;

   c. There ought to have been a formal record of the Board's engagement with police after March 1976, see paragraph 102 of the statement dated 29th April 2016;

   d. Monthly reports completed by the visiting Social Worker pursuant to the 1975 Direction were completed en bloc and on occasions were submitted late, see paragraph 72 of the statement dated 23rd May 2016. They also did not contain relevant information to allow the Eastern Board to be fully appraised of developments occurring with the hostel in late 1977, see paragraph 120 of the statement dated 29th April 2016;

2. At times there was no communication to ensure the relevant personnel had access to full and proper information regarding the Hostel and issues arising in relation thereto. The following occasions are noted:

a. In the absence of any statement from KIN 66, if KIN 14 statement is true, there was a failure by KIN 66 in 1968 to share his concerns about Mr Mains and R 2, and their behaviours towards residents of Kincora, with those Officers in line management, specifically the Children's Officer, see paragraph 42 of the statement dated 27th May 2016

b. There was a failure, in 1971, to refer the complaint made by R 8 R 8 to the police, see paragraph 45 of the statement dated 29th April 2016

c. Upon taking up post as Children's Officer in 1971, with a statutory responsibility to visit Kincora, Mr Bunting was not provided with "the Mason File" and was not, therefore, fully appraised of the two complaints that had been investigated in 1967 and 1971. The retention of the file by Mr Mason resulted in a breakdown in the dissemination of information about complaints against Mr Mains to staff with a direct role in management and monitoring the Hostel. It was 'regrettable that [Mr Mason] does not appear to have made Mr Bunting [Children's Officer] and Mrs Wilson [Assistant Children's Officer] fully acquainted with the complaints known to him by referring the "Mason file" formally to them in writing in view of their management responsibility for the hostel". See paragraph 45 of the statement dated 29th April 2016;

d. [Prior to re-organisation] direct access to the "Mason File" by officials with management responsibility for Kincora had been unduly restricted and the [Assistant Director's] treatment of it [following re-organisation] compounded this problem… The circumstances in which he was given the file, as well as its contents, should have prompted him to brief the incoming management staff at the earliest opportunity to enable them to carry out their duties with the benefit of all available information, see paragraph 23 of the statement dated 27th May 2016.

e. The information received by way of anonymous telephone call on 23 January 1974 ought to have been shared as follows:

i. with the police, see paragraphs 57 and 59 of the statement dated 29th April 2016;
ii. with the Board, see paragraph 58 of the statement dated 29th April 2016;

f. In March 1974, there was a failure by police to share relevant information about allegations against a member of staff with the Eastern Board. This was however out with the control of the HSCB's predecessor;

g. In May and September 1974 there was a failure to share information about a complaint by fieldwork staff in the North and West Belfast District with Residential and Daycare Management in the East Belfast and Castlereagh District, who had line management responsibility for Kincora, see paragraphs 69 and 71 of the statement dated 29th April 2016;

h. In 1975 there was a failure to report rumours heard about staff at the hostel to Residential and Daycare Management in the East Belfast and Castlereagh District, who had line management responsibility for Kincora. This in itself would have been unlikely to prevent or detect abuse, but knowledge of it might have influenced their response to future information. See paragraphs 83 and 84 of the statement dated 29th April 2016;

i. In early 1976 Ms McGrath failed to pass information that she had received from the Holywood Road sub-office to the District Social Services Officer, see paragraph 88 of the statement dated 29th April 2016;

j. Between October 1973 and 1976 there was a lack of information shared from the District to the Eastern Board as to serious allegations made against a member of residential staff. This was particularly the case in March 1976 when despite information being received by the District from the Board, there was not a flow of information from the District to allow the Board to be fully informed, see paragraphs 97, 99 and 100 of the statement dated 29th April 2016;

k. The information provided to the Director of Social Services by police in March 1976 ought to have been communicated confidentially to the Chairman of the Personal Social Services Committee and the Board. Given the seriousness of the matter the information ought also to have been shared with the Department of Health. See paragraph 103 of the statement dated 29th April 2016;

l. The manner of recording of the monthly social work visitor reports in late 1977 hindered communication of matters arising with the Hostel from the District to the Board. Further no other form of communication was undertaken to advise the Eastern Board of the issues arising at that time in relation to R18 and R20. See paragraphs 120 and 132 of the statement dated 29th April 2016;

m. Throughout the period of Mr Mains' management of Kincora as Officer-in-Charge he failed to report complaints and concerns about homosexual abuse by members of his staff to Belfast Welfare Authority and later East Belfast and Castlereagh District management, see paragraph 35 of the statement dated 27th May 2016;

3. Systems to implement statutory monitoring of the Hostel were underdeveloped, specifically:
   a. The role of the visiting Social Worker under the 1975 Direction and the information that ought to be contained within reports provided, see paragraph 120 of the statement dated 29th April 2016;

   b. There was a "considerable time-lag" between October 1973 and mid 1974 before the members of the Personal Social Services Committee were given guidance on their statutory duties under the 1952 SR&O, see paragraph 66 of the statement dated 23rd May 2016;

4. When the matter was not referred to police in 1971, there was a failure to complete an internal investigation of the complaints made by [redacted], see paragraph 19 of the statement dated 27th May 2016.

KIN-1473

Signed

Dated 27 May 2016