

Launch of the Report of the Inquiry into Historical Institutional Abuse 1922 to 1995

**20 January 2017
Sir Anthony Hart**

Welcome to the final public session of the Historical Institutional Abuse Inquiry 1922 to 1995. When the First Minister and deputy First Minister announced the setting up of this Inquiry on 31 May 2012, its Terms of Reference covered the period between 1945 and 1995. Because of concern that the starting date in 1945 would exclude a number of those who are still alive and were in homes before 1945, it was agreed between the Inquiry and the First Minister and deputy First Minister that the starting date for our Terms of Reference would be extended to 1922. Altogether 51 individuals who were admitted to institutions before 1945 applied to the Inquiry, although some would have been within our original remit if they were still in a home in 1945.

The Inquiry had two main components, an Acknowledgement Forum and the Statutory Inquiry. Because the Acknowledgement Forum did not require statutory authority to function, we put our initial efforts into recruiting staff and setting up our procedures in order to enable the Acknowledgement Forum panel members to start their work. They provided a confidential setting within which those who had been in residential homes and institutions within our Terms of Reference could come forward and describe their experiences to members of the Acknowledgement Forum in private when they would be free to describe in their own words what had happened to them, although their accounts were not examined or investigated by the Acknowledgement Forum.

On 22 October 2012, less than five months from the announcement of 31 May, the Acknowledgement Forum saw the first applicants who wished to speak to them. Between then and the end of November 2014 they saw 427 applicants altogether, 261 males and 166 females. In addition the written account of one individual was

accepted, and so a total of 428 applicants to the Inquiry spoke to the Acknowledgement Forum.

The members of the Acknowledgement Forum, supported by our dedicated Witness Support Officers, saw most of the applicants at our premises in Belfast, although 61 were seen in Londonderry, and applicants were seen in the Republic of Ireland, England, Scotland, with 65 being seen in Australia.

From the very beginning the Inquiry was determined to engage as many victims and survivors of childhood institutional abuse as possible to persuade them to come forward so that we could gather as much evidence as possible about their experiences. On 21 February 2013 we launched a promotional campaign involving advertising on 80 bus shelters at strategic locations throughout Northern Ireland to reach those who might not otherwise hear about the Inquiry. We publicised our work widely outside Northern Ireland through Irish groups and associations in the United Kingdom, the USA and elsewhere. The leaders of the four main Christian denominations also agreed to our request to publicise our work amongst their flocks. Members of the Inquiry gave interviews to the media in this country and in Australia and New Zealand in order to ensure that our existence was as widely known as possible. We are very grateful to all those who helped to bring our message to those we wished to contact, some of whom are scattered far beyond Northern Ireland.

So that the Statutory Inquiry could prepare the ground for the various institutions that we would investigate we set a closing date for applications to the Statutory Inquiry of Friday 29 November 2013. Because the Acknowledgement Forum did not have an investigative role it was possible to defer its closing date until Wednesday 30 April 2014. Altogether 526 individuals applied to the Inquiry, including both the Acknowledgement Forum and the Statutory Inquiry. Some of these did not feel able to continue and withdrew their applications, others did not respond to correspondence and eventually we closed their files, although we made it clear to them that if they wished to re-engage with us we would re-open their files.

Altogether 493 applicants engaged with the Inquiry in one form or another. 308 of them, almost two thirds, came from within Northern Ireland. 82 applicants came from England, 63 from Australia and 22 from the Republic of Ireland, with the remainder coming from Scotland, Wales, Europe and North America.

Applicants to both parts of the Inquiry made allegations about 65 institutions. Of these we investigated 22 during the course of our public hearings. A further 6 were the subject of targeted investigations we carried out in order to see whether there were other issues which we required to examine. We do not propose to name the 6 institutions because we were satisfied from our targeted investigations that they did not require further investigation in public and we consider it would be unjust to the institutions concerned if we reveal their names.

The remaining 37 institutions were the subject of complaints by only one, or at most two, applicants. As we explained on 4 November 2015, the panel carefully reviewed the allegations about each of the remaining homes and institutions which we had not publicly investigated by that time. We decided that the 22 homes and institutions which we have now publicly investigated, together with the 6 targeted investigations, were sufficient to provide us with a broad and complete understanding of the nature and extent of systemic failings, not just in those homes and institutions, but within all the types of homes and institutions that came within our remit. We concluded that this understanding would not be improved by conducting full scale investigations into other homes and institutions.

Altogether 333 applicants provided evidence to the Statutory Inquiry, either by giving their evidence in person or, where they were unable to attend in person, by way of their written statements to the Inquiry. 246 applicants gave evidence in person, and a further 87 gave evidence through their witness statements. In addition we heard from a further 194 witnesses who were not former residents, including former staff of some of the homes, and retired public officials, making a total of 527 people who gave evidence in either written or oral form to the Inquiry.

My colleagues in the Acknowledgement Forum and the Statutory Inquiry and myself are very grateful to all those who assisted the Inquiry by giving evidence, particularly the applicants. We know that for the great majority of applicants this was the first time they had described their experiences as children in residential care, even in some cases to members of their own family. Describing those experiences was not always easy, indeed at times it was clearly distressing and painful, and we thank them for their courage and determination in doing so. From the beginning of our work we made it clear that we were here to listen, and many applicants travelled

considerable distances to speak to us, sometimes when it was not easy to make the journey, as in the case of the applicant who insisted on discharging himself from hospital to give evidence. We know that members of some families were able to meet again for the first time for many years because they were brought together by the Inquiry process.

We hope that in some measure the process of giving evidence, whether to the Acknowledgement Forum in private, or in public to the Statutory Inquiry, helped those who were not listened to in the past.

Even before we had received the statutory authority from the Assembly to carry out our investigative work, we started the process of gathering evidence from the institutions and organisations we anticipated would be the subject of investigation based on the material we had already gathered. Throughout our work, with only a handful of exceptions, we received a very high degree of cooperation from all of the institutions and organisations we investigated, whether they were religious bodies; government departments and public agencies in Northern Ireland; and, in respect of Kincora, from the United Kingdom departments and agencies. Every organisation provided a great many documents, and made witnesses available to give evidence in response to the issues which we identified. Altogether we received hundreds of thousands of documents. After these were examined and analysed, we placed almost 356,000 documents in our evidence bundles used for the public hearings, although it was not necessary to refer to every document in the public hearings.

The volume of documents, and the number of witnesses who had to be interviewed and then examined before the Inquiry, meant that there was a considerable burden placed on the Inquiry staff to obtain, collate, analyse and then present the evidence to us in the public hearings. We wish to express our thanks to the Inquiry Secretary and the Inquiry Solicitor and all of those who worked so hard to support Inquiry Counsel in presenting the evidence.

Before we turn to describe the findings of the Inquiry it is appropriate to say something of the background against which our findings have to be viewed. Our Terms of Reference, unlike current inquiries elsewhere in the United Kingdom, were not limited to sexual abuse, but included other forms of abuse. We also examined

allegations of physical and emotional abuse, neglect, unacceptable practices, as well as other failings to provide proper standards of child care.

Our Terms of Reference covered 73 years. Over that period of time there have been enormous changes in Northern Ireland in the political, economic and social fields, and we examined the allegations against the changing standards of those times, and not by the standards of today. Before 1945 there was effectively no provision by the state for the welfare of children other than work houses provided by local Boards of Guardians, or in those juvenile justice institutions which were directly provided and funded by the Northern Ireland Government. During that period, the vast majority of children who were in care were the responsibility of the homes provided by a very wide range of religious denominations, voluntary bodies and secular organisations.

In 1947 there were approximately 1,000 children cared for by homes and institutions which were not provided or funded by the Northern Ireland Government. This compared to 501 children in the care of local authorities, of whom 312 were “boarded out”, that is fostered, and only 189 were placed in work houses and other institutions.

Within ten years the position had changed dramatically. By the summer of 1957 the number of children in voluntary care had gone down to 751, compared to 1,148 children in the care of local welfare authorities, although only 266 of those children were actually in homes provided by the welfare authorities.

A very large percentage of those children in care in 1957 were illegitimate, and in the six largest homes for children in Northern Ireland two out of every three children were illegitimate, the percentages ranging from 82.8% in Nazareth Lodge in Belfast to 57.4% in Barnardo's. By the late 1960s and early 1970s the previous pattern whereby most children in residential care could expect to spend all, or certainly the greater part, of their childhood in a voluntary home changed. By this time fewer children were coming into care. This was in part due to families generally becoming smaller, the stigma of illegitimacy was lessening and more support was being provided to assist families in need to stay together. Children who were admitted to care tended to come from disturbed family backgrounds and stayed in care for shorter periods. Big homes had coped more easily with larger families, and these changes placed very considerable pressures on the voluntary homes who found it difficult to cope with the problems associated with some of the children, as well as

with the financial problems brought about by looking after fewer children in large institutions.

Over the same period the large homes, some of which provided care for very large numbers of children, were disappearing and being replaced by smaller units. The standards of material accommodation improved over time, although in a patchy fashion. Gradually a higher proportion of the staff in the child care sector were qualified, although the terms and conditions of employment for residential staff were unattractive, and it was difficult for all residential homes to recruit and retain suitable staff. It was not until after the Hughes Inquiry reported on 31 December 1985 that the level of qualified staff in residential care in Northern Ireland caught up with, and then passed, the rest of the United Kingdom.

For many years the financial circumstances and living conditions of many in Northern Ireland were extremely poor. Whilst unemployment rates were lower after the Second World War, unemployment rates remained high, particularly in some areas in the West of the Province. Housing conditions for many remained extremely poor, particularly in Belfast and in Derry.

When the late Bishop Edward Daly gave evidence to the Inquiry on 20 May 2014 he described that when he spent eleven years as a curate assigned to the Bogside in Derry he “Never experienced poverty of that nature, housing of such an abominable standard...” He described how he found “...sometimes fourteen people in a four bed roomed house with no running water in the house, a tap in the backyard, a toilet in the backyard, ... a memory of rooms full of beds.”

As we set out in some detail in Chapter 28 in Volume 9 relating to Kincora, the extreme violence and civil disorder that characterised so much of Northern Ireland in the 1970s and 1980s did not leave those responsible for childcare untouched, as was graphically demonstrated by the abduction of Bernard Teggart from St Patrick’s Training School and his murder by the IRA in November 1973. The Youth Club run by the Good Shepherd Sisters in South Belfast experienced the murder of a seventeen year old protestant youth who was a member of the club, and a youth leader of the club was murdered in 1974. The staff of Belfast Welfare Authority were unable to cross the city to check Kincora because of the dislocation of traffic. The staff in St Patrick’s Training School struggled with the pressures created by large

numbers of young people placed there on remand on terrorist charges by the courts in the early 1970s.

These factors are largely forgotten today, but they demonstrate that although there were many failings in terms of individual and institutional responsibility in the homes which we examined, those failings must be viewed against the background of the political, social and economic circumstances to which we have briefly referred.

As will become clear, we did not find the same failings in every home or institution that we investigated, nor were there as many allegations about some homes as others. In general the allegations we considered related primarily to the 1940s, 1950s and 1960s. Whilst we necessarily focus in the Report on the failings and abuse we identified, we recognise that in all the homes we examined there were many who devoted their entire religious or professional lives to the children in their care, often working long hours in difficult conditions to do the best they could for them according to the standards of the time.

Not all the evidence we heard referred to abuse or other failings. We saw evidence of good practice in some homes, such as the family placements arranged in the summers by the Sisters of Nazareth. We also heard of the time and energy people gave to trying to help in various ways, including members of the St Vincent de Paul Society, the staff of factories such as Mackie's in Belfast and shirt factories and shops in Derry who gave gifts to, and organised parties and excursions for, children in these homes.

Our investigations covered eleven voluntary homes run by Roman Catholic Religious Orders or other bodies such as Barnardo's, six Training Schools and other institutions in the juvenile justice sector; and five state run residential institutions. As well as the 22 institutions which we examined in the Public Hearings, and the six institutions examined in the targeted investigations we also investigated the implications of the abuse perpetrated on so many children by Father Brendan Smyth of the Norbertine Order, and the circumstances surrounding the operation of the Child Migrant Scheme.

When we investigated each institution, we also examined the role of other agencies or bodies which had responsibilities for children. These included the Ministry of

Home Affairs; the Department of Health and Social Services; the Northern Ireland Office when it was responsible for the operation of the Juvenile Justice Institutions; the Health and Social Services Boards which replaced the County Welfare Authorities, and the Royal Ulster Constabulary.

The Report consists of ten volumes, nine of which are from the Statutory Inquiry, with the tenth being the Report of the Acknowledgement Forum. It is therefore only possible this morning to give a general overview of our findings in relation to each institution and each organisation. These are set out in full in the respective chapters dealing with each institution or topic, and the findings are drawn together in Volume 1, Chapter Three. The description which we give today of our findings should therefore be read in conjunction with, and subject to, the evidence and to the more detailed findings set out in each chapter of the Report. In some of our findings we will refer to individuals by their Inquiry designations, for example BR 17 or BR 77.

Voluntary Homes

The Sisters of Nazareth

The largest number of complaints related to four homes run by the Sisters of Nazareth. Altogether we heard from 72 applicants in relation to Termonbacca and Nazareth House in Derry, and 117 in relation to Nazareth House in Belfast and Nazareth Lodge, 189 in total.

- In each of the four homes some nuns engaged in physical and emotional abuse of children, with the physical abuse by some nuns in Nazareth Lodge being particularly significant. Emotional abuse in the form of denigrating and humiliating children was widespread in all four homes, as were unacceptable practices such as making children spend excessive time on household chores, using Jeyes Fluid in baths, and the way in which children were treated who suffered from bed wetting.
- The handling of menstruation and sex education, and other practices such as the confiscation of children's belongings, represented poor childcare and amounted to systemic abuse.

- There were a significant number of instances of sexual abuse in each home, usually by adults, but also by older children, mostly older boys. The adults who engaged in sexual abuse included priests and lay staff.
- Many of these failings were known to members of the Congregation at the time who did nothing to stop them.
- Some of the failings occurred, or were able to continue, because there were insufficient staff, both nuns and lay staff. In the early years individual sisters were expected to look after very large numbers of children on their own, for example in one home two nuns were expected to look after around 80 children.
- Some of the nuns and lay staff were unsuited to, and many were inadequately trained for, their work with children.
- The premises were outdated, and while the Sisters of Nazareth did improve and update their homes, they were slow to do so and were hampered by their reluctance to embrace change and to seek state funding.

Rubane House

We received oral or written evidence from 60 former residents of Rubane House near Kircubbin run by the De La Salle Order.

- We were satisfied that there was excessive physical punishment, in some cases amounting to serious physical assault by some brothers and lay staff.
- The Order failed to prevent this, and failed to ensure that corporal punishment was administered in line with statutory regulations and the Order's own rules.
- When incidents of physical violence by brothers and lay staff were brought to the attention of the Brother Director these were not adequately dealt with, nor was the necessary action taken to enable such incidents to be investigated and prosecuted.
- One such instance was where serious assaults by BR 77 were not reported to the police in order to protect the brother concerned, and the reputation of the Order, rather than to protect vulnerable children.
- A number of brothers sexually abused boys in their care, and the Order failed to properly investigate allegations of sexual abuse.

- In a number of instances where the Order was made aware of allegations of sexual abuse by brothers it failed to report the allegations to the proper authorities.
- In the cases of BR 15 and BR 17 the Order failed to report allegations of sexual abuse to the governing board of the school, to the Ministry of Home Affairs or to the police.
- In the case of BR 14 the Order deliberately misled the Ministry of Home Affairs about the extent of BR 14's abuse of boys.
- In the cases of BR 17 and BR 77 the Order moved them to a school where each would have continued access to children, and in the case of BR 17 he then abused children in that school.
- The Order also failed to provide guidance and effective supervision to brothers and lay staff. Particularly in the early years of the home the Order failed to ensure that brothers had a reasonable work load that avoided excessive contact and time with boys.
- We were satisfied that the Order failed to keep the boys in their care free from the pain, fear and distress caused by the physical and/or sexual abuse they suffered or saw others suffering in Rubane.

Barnardo's

We investigated complaints from four applicants relating to Barnardo's homes at Macedon and Sharonmore. We made no findings of failings by Barnardo's in respect of Sharonmore, but found systemic failings in respect of Macedon. These related to the actions of certain members of staff, and the way in which Barnardo's dealt with some of these matters.

- There was a reluctance on the part of some Barnardo's staff in the 1980s to report allegations about staff to the proper authorities.
- There were a number of failings by staff management. For example, although BAR 1 had shown herself to be an unsatisfactory employee, by frightening children with ghost stories and referring to the "Evil Eye";; bathing male children who were of an age when they should have been left to bath

themselves, she was placed in the care of children for a considerable period of time before she was allowed to resign.

- There was a failure to prevent a relationship developing between BAR 2, who was a member of staff, and BAR 47, a female resident, and then to put a stop to it.
- The allegations of bizarre behaviour of BAR 3 were not addressed effectively by senior staff.
- The amount of unsupervised access by BAR 4, a male visitor, to HIA 216, a young boy, and the failure to inform the Eastern Health and Social Services Board that this access was taking place, were systemic failings.

Manor House Home

Manor House Home on the outskirts of Lisburn was run by the organisation now known as the Irish Church Missions. We heard from six former residents of Manor House.

- When the home closed for a period in 1929 because of inadequate funding, the decision of the General Committee to reopen it as a children's home was irresponsible, and amounted to a failure to ensure that the home provided proper care.
- By 1953 the home was in a general state of dilapidation. This, and the inadequate sleeping, toilet and washing facilities for the children, the poor heating, and the low staffing levels all amounted to a systemic failing.
- It failed to ensure that the home provided proper care.
- In the 1940s and 1950s there was a harsh response by staff to children who suffered from bed wetting, segregating them and make them sleep in unacceptable conditions.
- Staff failed to take steps to prevent, detect and disclose sexual abuse involving the abuse of three boys by a male visitor.
- A lack of supervision of children, particularly at night, was indicated by the extent of sexual activity between boys in the home in 1975 to 1977, and by a child, MH 23, with boys and girls.

The Homes run by the Good Shepherd Sisters

The three remaining voluntary homes we investigated were run by the Good Shepherd Sisters in Belfast, Londonderry and Newry. As we explained at the time, the Inquiry did not engage in a wider investigation into what are commonly called Magdalene Homes or laundries, or mother and baby homes. That was because those institutions contained adults over the age of eighteen and our Terms of Reference confined us to examining residential homes or institutions for children under eighteen. Whether their experience should be investigated is a matter for the Northern Ireland Executive and the Northern Ireland Assembly.

We heard from nine applicants who had been residents in one or more of these three homes. Our findings in respect of these homes were of unacceptable practices, some of which occurred in more than one of the homes. These included the following.

- It was unacceptable for young girls under the age of eighteen to be expected to do industrial work in the laundries on the premises.
- It was an unacceptable practice to read out the misdemeanours of children in front of others, and of making the offender kneel in front of others, or to stand to eat her meal.
- The sisters failed to ensure that proper care was provided for the children who they accepted on a long term basis when they were under school leaving age, such as HIA 107 and her companions who were sent to the home in Londonderry by a court when they were very young.

Juvenile Justice Institutions

We examined six institutions to which children were committed by the courts. Usually children were sent to these institutions because they had committed criminal offences, but some were sent for other reasons, because they failed to attend school or because their behaviour whilst in care was such that they could not be dealt with in any other way. We refer to these institutions as juvenile justice institutions for convenience, although some children in the training schools who had not committed criminal offences were on what was called the “care side”.

St Patrick's Training School

We received evidence from 19 witnesses, and written statements from a further eleven, who had been resident in St Patrick's Training School. We also considered the accounts of a further 39 former residents who had given information to the police, or who had made civil claims.

St Patrick's Training School was run by the De La Salle Order, and we identified several areas of systemic abuse.

- Physical and emotional abuse involved the use of informal corporal punishment.
- Unauthorised physical punishment was prevalent in the 1960s and early 1970s.
- Older boys were permitted to punish others when supervising them in the dormitory in breach of the Training School Rules.
- There were a number of occasions of humiliation by stripping a boy naked to stand in full view of others.
- There was also systemic sexual abuse by brothers including BR1.
- Allegations of abuse by DL 137 in 1978 and in 1980 were not reported to the police or to the Board of Management, instead DL 137 was allowed to resign and given a positive job reference.
- Other systemic failings involved not taking adequate measures to counter absconding.
- The frequent use of secure rooms, including their use for young children, was contrary to the Training School Rules.
- We have already referred to the abduction and murder of Bernard Teggart. The failure to report his abduction, and that of his brother, was a systemic shortcoming on the part of the Brother Director, as was the failure of the Board of Management to meet after Bernard's death to investigate and to provide support to the staff and boys.

Rathgael Training School

Rathgael Training School initially catered only for boys, but following the closure of Whiteabbey Training School the girls who had been in Whiteabbey were transferred

to Rathgael, which then catered for both boys and girls. We heard from 18 former residents. We found a number of systemic failings relating to this Training School.

- The extent of the unregulated physical punishment applied by some staff, including RG 17's practice of using frequent unrecorded informal corporal punishment, amounted to systemic abuse.
- The failure to prevent bullying by peers.
- The lack of training in control and restraint was a systemic failing.
- A small number of staff sexually abused girls.
- This, together with the sexual exploitation of HIA 236, who was a female resident, by RG 47, a male member of staff; his failure to raise concerns about her crush with colleagues; and their failure to question the relationship, all constituted systemic abuse.

Lisnevin Training School

Lisnevin Training School was a secure training school, and twelve applicants referred to their time there, although two made no comment other than referring to the periods they spent in Lisnevin. We found a number of systemic failings relating to this institution.

- The director failed to refer allegations of assault of a boy by staff to the RUC.
- There were several instances where there were failures to ensure that Lisnevin provided proper care.
- These were the lack of schooling between September 1981 and May 1982.
- A delay in providing adequate training in control and restraint for staff.
- Making boys store clothes in the corridor outside their bedroom.
- The use of a tariff system of standard sanction.
- The failure to address inadequate staffing levels.
- A dependence on casual staff to cover leave arrangements during the summer months.

Hydebank Wood Young Offenders Centre

We heard evidence from four applicants who were admitted to Hydebank Young Offenders Centre between 1983 and 1990. The witnesses we heard from had negative experiences in Hydebank, and did not consider their time there in a positive light. Having carefully considered the evidence provided to us we decided that the complaints we received did not amount to evidence of systemic abuse in Hydebank. However, it is probable that some officers took the approach of intimidating boys at the committal stage in order to enforce obedience and discourage any resistance to the regime.

Millisle Borstal

We heard from seven applicants in person, and received statements by two further applicants which were read due to ill health, as well as the evidence of a tenth witness based on the account he gave to the Acknowledgement Forum. Sadly he died before he was able to prepare a witness statement.

Millisle Borstal had both an open and a closed unit and we accept that there was on occasion low level violence in the closed unit between 1977 and 1980, and on occasions in the open borstal, all of which amounted to systemic abuse.

St Joseph's Training School

St Joseph's Training School for Girls at Middletown, Co Armagh, was run by the Sisters of St Louis. We received evidence from sixteen former residents, five of whom gave evidence in person, three of whom wished to tell us of their positive memories of the care they received in the training school. We were satisfied that during the period of SR 237's directorship between 1957 and 1971 she was physically abusive to girls to the extent that it amounted to systemic physical abuse.

Institutions run by Welfare or Health Authorities

We investigated five institutions which were run by either Welfare or, in the case of Lissue, Health Authorities.

Lissue

Lissue Hospital was the only hospital we investigated. Its functions included medical and nursing care. It was not the Inquiry's role to evaluate the medical care provided, and if there remain medical issues which require investigation the task will need to be allocated to another inquiry undertaken by professionals with the appropriate qualifications and experience. That only ten witnesses came forward to the Inquiry suggests that there are unlikely to be many more people who still wish to make allegations. Any further inquiry into Lissue would be subject to diminishing returns; the additional information which might be gained could well be very limited, and it would not justify the time and expense entailed.

However, much of the work of Lissue concerned residential care of children who were displaying behaviour or conduct disorders, and who might well have been cared for in other types of children's home or residential school if they had been available. Furthermore, most of the allegations made by witnesses were concerned with aspects of childcare and were therefore within our terms of reference.

We heard the evidence of ten applicants who had been patients in Lissue Hospital.

- The governance structure of the hospital from 1973 onwards was a systemic failure, and it is fortunate that it did not engender serious management problems. The successes of the Psychiatric Unit at Lissue were thanks to cooperation between the individual professionals involved, but the managerial structure within which they worked was faulty and systemically unsound.
- We were satisfied that there were a number of other aspects of Lissue that demonstrated systemic failings or systemic abuse.
- For example, although there were only a few occasions when physical restraints were used, their use was unacceptable.
- The implementation of the "time out" policy at times constituted systemic abuse, as did the use of injections to sedate children to render the nursing task easier.
- Some staff were unduly rough in their treatment of the children.
- Some children were subjected to systemic abuse by being sexually abused.

- They were emotionally abused by staff who were unfeeling and failed the children who required their support.

Fort James Children's Home and Harberton House Assessment Centre

Fort James Children's Home and Harberton House Assessment Centre were both run by the Western Health and Social Services Board, and were considered together because of allegations made by three applicants, two of whom were former residents of Fort James and the third a former resident of Harberton House. We were also prompted to investigate these homes by police material about investigations they carried out in relation to both homes.

We found that there were three systemic failings by the Western Board to ensure that Fort James provided proper care.

- It failed to effectively address strategic issues in relation to the provision of residential child care and lack of foster care which were clearly having an adverse effect on the appropriateness and level of care that could be given to children in Fort James.
- It failed to address the excessive overtime work by staff, in particular FJ 5 who was the officer in charge, and to address the implications that such work patterns would have for the quality and safety of the care provided to the children in Fort James.
- It failed to question the appropriateness the close relationship between FJ 5, the head of the home, with FJ 30, a male resident, and to respond seriously to comments from children in the home about that relationship, and about FJ 5 and FJ 30's sexuality.

The WHSSB failed to ensure that it provided proper care in Harberton House Assessment Centre in two respects.

- It failed in its strategic planning of Harberton House to ensure the complementary services were in place that would allow its remit as an assessment centre to be realised and protected, so that it could assess the

needs of children, and make arrangements for them to receive planned care appropriate to their assessed needs.

- It failed to instigate a fundamental review of its childcare services despite the findings of the Bunting Review, and failed to increase its scrutiny of its children's homes in response to the concerns expressed by Miss McGowan, a member of the Community Care Committee.

Bawnmore Boys' Home

Bawnmore Boys' Home should not be confused with another children's home of the same name in South Belfast. The Bawnmore we investigated was the home at Mill Road, Newtownabbey, and was one of the homes investigated by the Hughes Inquiry because of the offences involving the abuse of children at that home. As a result of a police investigation two men were convicted in 1981 of offences relating to Bawnmore. Peter Bone and Robert Elder were two of the six men sentenced by the Lord Chief Justice on 16 December 1981 at the same time that Mains, Semple and McGrath were sentenced for offences relating to Kincora, and Eric Witchell was sentenced for offences relating to Williamson House, another children's' home.

We found the following systemic failings by the Belfast Welfare Authority which ran Bawnmore at the relevant time.

- It failed to vet Peter Bone.
- There was a failure by BM 1 to report the abuse of HIA 532 by Bone to his seniors.
- So far as the allegations made against Elder by HIA 532 to BM 3 were concerned, BM 3 did not make a written record of the allegation, or of Elder's response, he did not ask to see the pornographic photographs referred to, and he did not refer the matter to his superiors.
- The number of boys subjected to sexual abuse by staff members was a systemic failing.

Failings by Other Bodies

We have so far summarised our findings of systemic abuse in the homes to which we have referred, and the failings on the part of those organisations or bodies

directly responsible for these homes. However, we did not confine our scrutiny of the abuse and failings to those responsible for the day to day running and management of these homes. There were others who also had responsibilities towards the children in these homes, for example, in the case of Rubane and St Patrick's Training School the Roman Catholic Diocese of Down and Connor and the De La Salle Order were involved in the governance structures of the institutions in various ways.

The Northern Ireland Government also provided part of the funding for some homes in the voluntary sector, and provided central government funding for county welfare committees in the 1950s and 1960s. After the reorganisation of local government in Northern Ireland in the early 1970s when the child care functions of the former local authorities were taken over by the Health and Social Services Boards, the government, through the Department of Health and Social Services, was involved because it provided funding and guidance to the Boards, as well as inspecting both voluntary and statutory homes.

From the start of the period of our remit the Ministry of Home Affairs was responsible for inspecting voluntary children's homes. Its responsibilities were extended under the Children and Young Persons Act 1950 to include registration of voluntary children's homes and the authority to remove such registration if it found a home was being conducted in a manner that was not in accordance with regulations made or directions given under the Act. The legislation also placed requirements on those providing voluntary homes to ensure they were run in the best interests of the children, and to comply with specific regulations concerning matters such as the administration of corporal punishment and the monthly monitoring of homes.

The 1950 Act placed a specific duty on welfare authorities to provide accommodation for children in their care where it was not practicable or desirable for a child to be boarded out. The Ministry was given the power to inspect statutory children's homes and to close a home if it found it was "unsuitable for the purposes or if the conduct of the home failed to comply with regulation."¹ In 1973 its regulatory responsibilities for children's homes were transferred to the Department of Health and Social Services,

¹ HIA 229.

and the Social Work Advisory Group, and then the Social Services Inspectorate, undertook these responsibilities on its behalf.

We found that this legislative focus on the care and well-being of children in residential care was not fully realised until the early 1980s due in large part to the under resourcing of inspection activity. It was clear that inspectors were aware of the adverse conditions in home. For example in April 1953 Miss Forrest, who was a children's inspector with the Ministry of Home Affairs, wrote this about the children's homes run by the Sisters of Nazareth in Londonderry and Belfast:

“I find these Homes utterly depressing and it appalls me to think that these hundreds of children are being reared in bleak lovelessness.”

Despite this awareness, the inadequate conditions and lack of staff in these and other voluntary homes, such as Rubane, were allowed to persist, and in some cases worsen, for a considerable number of years.

We also found that when inspections did take place there was a lack of enforcement of statutory requirements, such as the statutory requirement that voluntary homes put in place a system of monthly visitors whose function it was to inspect the home. Also there was at times a lack of clarity about and engagement with the Administering Authority of homes.

We now turn to the failings we identified on the part of these and other bodies in respect of the homes and institutions we examined.

Failings by the Ministry of Home Affairs and the DHSS.

- The statutory requirements that voluntary homes put in place a system of monthly visitors whose function it was to inspect the home and speak to the children, was almost universally ignored by those homes for decades.
- The inspectors from the Ministry of Home Affairs, and later from the DHSS in the form of the Social Work Advisory Group, failed to notice this and therefore to enforce this system of inspection. This lasted until the early 1980s.
- In the mid-1970s the Social Work Advisory Group stopped inspecting statutory homes because it had insufficient resources, and chose to concentrate on voluntary homes because it thought standards in the statutory sector were

higher. As a result homes in the statutory sector such as Bawnmore and Kincora were not inspected for several years. Indeed Lisnevin Training School was not inspected at all between 1973 and April 1988.

- There were also failings by the Ministry of Home Affairs, and subsequently by the DHSS, in respect of individual homes.
- They failed to ensure that the Sisters of Nazareth had adequate funding, suitable premises, sufficient staff, and suitably selected and properly trained sisters and lay staff in both Termonbacca and Nazareth House in Bishop Street.
- There were several failings by the Ministry of Home Affairs in relation to Rubane.
- It failed to insist that the home was developed on the smaller children's house model in line with existing government policy.
- It allowed overcrowding to increase, and the facilities and staffing levels to become more inadequate and unsatisfactory, by allowing discussion about the type of redevelopment needed, and how it should be funded, to drag on for a decade.
- It failed to clarify with the Roman Catholic Diocese of Down and Connor and the De La Salle Order the nature and aim of the home, as well as the governance and management arrangements.
- It allowed the number of boys to more than double within six years, without requiring the necessary improvements to facilities, or increases in staffing levels, whilst continuing to register Rubane as a children's home.
- The DHSS failed to respond to concerns raised by the EHSSB in 1981, and to maintain information about an investigation into sexual abuse.
- Manor House was not inspected by the Ministry of Home Affairs for over two and a half years after its initial registration.
- When one of its inspectors did raise criticism of the home the Ministry of Home Affairs failed to raise these with the Management Committee.
- In the 1960s the Ministry of Home Affairs inspectors failed to take steps to prevent children under school leaving age, such as HIA 107 and her companions, from being in the Good Shepherd on a long-term basis.

- In relation to Harberton House the Social Service Inspectorate and the DHSS failed to effectively engage with the WHSSB to support it to consider how best to implement the Bunting Report, although the SSI was aware adverse conditions were continuing to affect the care that children were receiving in Harberton House.

Local and Statutory Authorities

Local and statutory authorities were also guilty of systemic failings in respect of some of the homes we have so far considered.

- So far as Termonbacca and Nazareth House were concerned, neither the County Borough Welfare Committees nor the Western Health and Social Services Board which placed, or assumed responsibility for, children in care of either home took adequate steps to monitor the care given to individual children in either home.
- Nor did they take adequate steps to monitor the facilities for, and the standards of care provided to, children in either home.
- None of these statutory bodies took adequate steps to inform themselves of the provision made by the Sisters of Nazareth for the care of children placed privately in either home whose circumstances might have brought those children within the responsibility of the statutory bodies concerned.
- None of the statutory bodies provided adequate financial or administrative support for the children they placed in the care of the Sisters of Nazareth in either home.
- In relation to Rubane, in the period before chalets were opened in 1968 welfare authorities which placed children there failed to address the problem that it had inadequate facilities and was poorly staffed.
- In 1980 the EHSSB failed to alert social workers to the police investigations into physical and sexual abuse in Rubane.
- In relation to Manor House, in 1980 the decision by a member of the SHSSB staff that an informal approach should be used to deal with a member of staff who hit a child in the care of the SHSSB with a stick was a systemic failing.

Kincora Boys' Hostel

Before we announce our conclusions as to what did or did not happen in respect of the Kincora Boys' Hostel we wish to make a number of preliminary observations. As early as 4 September 2013 we announced that Kincora was one of the institutions we intended to investigate. Under the devolution settlement the Assembly could not give the Inquiry powers to compel Westminster departments such as the Northern Ireland Office, or agencies such as the Security Service, to produce documents and compel witnesses from those departments to attend. That meant that unless those departments or agencies voluntarily agreed to help the Inquiry we could not effectively investigate matters relating to what those departments knew or did not know about the sexual abuse of residents in Kincora. It was as if one of the doors marked Kincora would remain closed to us.

When the Home Secretary announced that she was setting up the Independent Inquiry into Child Sexual Abuse in July 2014 there were calls for that Inquiry to investigate Kincora. However, following discussions with this Inquiry in October 2014 the Secretary of State for Northern Ireland announced that she and the Home Secretary believed that as this Inquiry was already investigating Kincora this Inquiry was the appropriate forum to investigate all aspects of Kincora. She gave a number of assurances which had been required by this Inquiry, the most important of which was that;

“All government departments and agencies who receive a request for information or documents from the Inquiry will cooperate to the best of their ability in determining what material they hold that might be relevant to it on matters for which they have responsibility in accordance with the Terms of Reference of the Inquiry”.

On the basis of these assurances we recognised that the door which had hitherto been closed to us had been opened. We immediately embarked upon our investigations, and these continued despite the application for judicial review to stop us from doing so brought by Gary Hoy who was an applicant to the Inquiry. This application was dismissed by the High Court, which described it as “premature and misconceived”, and that decision was upheld by the Court of Appeal last year.

The assurances we were given by the Secretary of State, including the assurance that departments and agencies would confirm all relevant documents would be provided to us, have been honoured. We have been able to examine in full every file and every document in every file disclosed to us, or which we requested. We have examined hundreds of files held by the Northern Ireland Office, by the Ministry of Defence, by the Cabinet Office, by the Home Office, by the Foreign and Commonwealth Office, by the Security Services, by the Secret Intelligence Service, by the Metropolitan Police, and by the National Crime Agency which had any relevance to Kincora, however slight that relevance turned out to be. We also received full cooperation from the Police Service of Northern Ireland. We examined RUC Special Branch files, as well as the files of five major police investigations relating to Kincora, four of which were carried out by the RUC and one by the Sussex Constabulary. We have also examined the transcripts relating to evidence given in respect of Kincora in the proceedings of the Hughes Inquiry Transcripts which were not previously publicly available.

The assistance we received from these departments and agencies was in marked contrast to the unwillingness of some individuals who have been vocal in the past about their purported knowledge of sexual abuse relating to Kincora, but when the opportunity was offered to them to assist this Inquiry refused to do so. A number of excuses were offered, including the assertion that the IICSA should carry out the investigation.

Richard Kerr accepted the Inquiry's invitation to be a core participant, but pulled out of the public hearings relating to Kincora hours before he was due to fly from the United States at our expense to engage with the Inquiry. His solicitors then issued a lengthy statement on his behalf, most of which rehearsed arguments rejected by the courts in the five unsuccessful judicial reviews brought by their clients against the Inquiry. Brian Gemmell and Roy Garland both refused our invitation to be core participants and provide witness statements. Roy Garland sent a submission to the inquiry in October 2016, more than three months after the public hearings finished, and in November 2016 offered to be interviewed by the Inquiry when it was much too late.

Between 9 September 2016 and 18 December 2016 Colin Wallace sent the Inquiry 275 pages of letters, submissions and documents, again long after the public hearings had finished. Despite the amount of material he sent, the greater part of which was irrelevant and some of which was positively misleading, as he has consistently done in the past when asked to provide details of his claims about Kincora, Colin Wallace avoided answering the questions the Inquiry had asked him to address.

Because of the nature of their allegations in the past it was essential that we examine their accounts in order to establish what did or did not occur, and despite their unwillingness to assist in this process we were able to do so because of the volume of material relating to them we were able to gather.

As a result of our examination of all of the material we gathered we believe that we have stripped away the overgrowth of decades of ill-informed comment, half truths and deliberate misrepresentations which have all too often masqueraded as established facts. These had been constantly repeated without critical analysis by, or real knowledge on the part of, those who have offered public comments about the nature and extent of the sexual abuse of residents in Kincora, and what state agencies did or did not know about that abuse during the 1970s and afterwards. We have established that the sources of many of the allegations were untruthful, inaccurate or mistaken in what they said had happened.

We have devoted two of the volumes of the report solely to Kincora. What we are going to say now about our conclusions has to be read in conjunction with our detailed examination of the relevant material to which we refer, and which we intend to place on our website later today. Some may find our conclusions unpalatable because their preconceptions have not been confirmed, or because we have not accepted the allegations they have repeated over the years.

Kincora opened in 1958 and closed in 1980. During that time 309 boys resided in the hostel. Of the 245 boys who resided in Kincora between 1963 and 1980, 104, (42% of the total), were traced and interviewed by the police. We now know that 38 boys were abused at some point during Kincora's existence. Although not all the surviving former residents could be traced, or have since come forward, it can be

seen from these figures that the great majority of those who were traced were not sexually abused during their time in Kincora.

The great majority of residents of Kincora who were interviewed by the police were unaware at the time of what was happening in the hostel, and were very surprised to learn of the allegations that emerged afterwards. For example, even though some of them described how they themselves were abused, or had engaged in homosexual activity with others, whether with McGrath or other residents, of 92 former residents of Kincora between 1966 and 1980, 76 (that is 88.33%) told the police they were surprised by the allegations of the extent of sexual abuse that took place during their time in Kincora.

Awareness of abuse

It may seem strange that so many of those who were residents, domestic staff and visitors, were unaware of what was happening, but there was a consistent pattern of concealment of their behaviour by Mains, Semple and McGrath, who were the only permanent care staff throughout Kincora's existence. They approached boys who were vulnerable, or who they thought might be easily intimidated. If their initial approaches were firmly rebuffed they generally did not approach that person again. If they did, they went to considerable lengths to approach the boy when others were not around.

During McGrath's time at Kincora he appears to have often worked in the evenings and in the mornings, when Mains or Semple was not about, because the duties involving the supervision of the residents were distributed between all three. Mains had other administrative duties as well, and our impression was that more of the direct supervision of the residents in the 1970s was carried out by Semple or McGrath, and because of the way their duties were arranged McGrath was often on duty on his own.

The knowledge by Mains, Semple and McGrath of each other's sexuality

Whilst Mains and Semple knew each other before Semple was appointed as deputy warden, and Mains definitely knew of Semple's sexual abuse of residents before

Semple was reappointed, there is no evidence either knew McGrath before he was appointed. The evidence suggests that by the time McGrath was appointed Mains had stopped sexually abusing residents, and was engaged in a long term homosexual relationship with an ex resident. Semple did not engage in sexual abuse of residents after he was reappointed, and found outlets for his sexual urges elsewhere. This meant that McGrath was the only member of staff who abused residents during the period between his appointment in the summer of 1971 until the home was closed in 1980.

Failings by Belfast Welfare Authority

- Kincora was never adequately staffed, and this meant that for significant periods only one member of the care staff was on duty in the building.
- It was a hostel for boys who had reached school leaving age, but too many children were admitted to Kincora when they were under school leaving age. These children were too young to be placed in such an environment, and too many of them spent too long in that environment when they were admitted.
- There were insufficient staff with appropriate training or experience to deal with such young children.
- Understaffing also meant that staff had to work very long hours, particularly in the case of Mains during the early years, when he was the only member of the care staff for a very long period of time. This meant that he was effectively expected to be on duty all the time. This was very poor practice, and the long hours and low pay put significant pressure on staff, and meant that recruitment of suitable staff was very difficult.
- The insufficient levels of staff provided Mains, Semple and McGrath with opportunities which they exploited to target their victims when no one else was about to see what was happening, or to suspect what was happening.
- The way the adolescent boys in Kincora were looked after meant that far too much was done for them by the domestic staff. We consider this created an attitude of dependence by the boys on the staff, and this dependency was exacerbated by inadequate preparation of the residents for independent living when they left Kincora.

The Ministry of Home Affairs and the DHSS

- The Ministry of Home Affairs, and then the DHSS, failed to maintain an adequate inspection regime of the hostel.

The handling of complaints by the Belfast Welfare Authority and the EHSSB

- When complaints were made by residents, first of all to the Belfast Welfare Authority, and later to the EHSSB, these were not properly dealt with.
- When the first complaints were received in 1967, Mr Mason decided that Mains's conduct did not amount to a prima facie indication of wrongdoing. We consider that he was wrong to do so.
- The Town Clerk's Department was wrong not to implement Mr Mason's recommendations that clear procedures be put in place to ensure that any further complaints about Kincora were properly reported to the City Welfare Officer.
- Written and clear instructions should have been given to relevant managers for the closer supervision of Kincora in the future.
- In 1971 the Town Clerk and Town Solicitor did not report the allegations to the police as they should have done.
- Following the decision not to report the allegations to the police, instructions were not given to Mains that he should avoid doing anything that could lead to allegations of impropriety.
- Instructions were not given to keep a very close eye on both Mains and Kincora.
- Procedures were not put in place to ensure further allegations about Kincora were properly collated and then referred to the City Welfare Officer, or to his deputy, for immediate attention.
- Throughout the remainder of the 1970s anonymous phone calls and rumours that appear to have circulated about Kincora amongst staff and other social workers were not made known to senior staff in the EHSSB as they ought to have been.

- When the RUC told the EHSSB in 1976 of the allegations against McGrath, the EHSSB did not give clear written instructions to ensure that there would be increased supervision of Kincora, of Mains and of McGrath, and staff did not pass to the EHSSB management important information about allegations against McGrath.
- EHSSB management did not take sufficient steps to press the RUC to find out what was happening with the RUC investigation.

The RUC Cullen/Meharg Investigation

- When the RUC became aware in 1974 of the allegations made by Roy Garland against McGrath, and which he reminded them about in 1976, the Cullen/Meharg investigation was inept, inadequate and far from thorough.
- The response by D/Supt Graham in 1974 to what he was told by Valerie Shaw about McGrath was wholly inadequate.

There was a catalogue of failures by the Belfast Welfare Authority, by the EHSSB and by the RUC. Had the 1971 allegations been reported to the RUC, as they should have been, or if an effective investigation had been carried out by the RUC in later years, it is reasonable to infer that a thorough and competent investigation by trained detectives may have been successful in exposing the abuse in 1976, and possibly even in 1974. This would have meant that those who were sexually abused after 1976, and possibly after 1974, would have been spared their experiences.

Kincora and the security agencies

- We are satisfied that the RUC Special Branch first learnt of William McGrath in July 1966 when he was reported as present as one of the platform party at a rally led by the Reverend Ian Paisley in the Ulster Hall in Belfast. McGrath was otherwise an unknown figure.
- In 1971 MI5 learnt that a man named McGrath was reported to be the OC of Tara, a clandestine Loyalist organisation. However, despite efforts to establish who this person was, and gathering much information about him that was inaccurate, it was not until April 1973, 20 months later, that RUC Special Branch identified the Commanding Officer of Tara as the William McGrath seen on the platform in 1966.

- It seems that it was not until November 1973 that MI5 learned that the Officer Commanding of Tara and McGrath were one and the same person, probably as the result of a letter sent to MI5 in November 1973 by RUC Special Branch.
- The security agencies soon concluded that Tara was not a significant force, and they only paid intermittent attention to it and to McGrath in succeeding years.
- By May 1973 both RUC Special Branch and other RUC officers knew that McGrath was reputed to be homosexual, but they had no proof of this. At this time homosexual acts between males was still illegal in Northern Ireland. It was not until Roy Garland spoke to Detective Constable Cullen on 1 March 1974 that the RUC received an allegation that McGrath had engaged in homosexual conduct of a grooming nature in the past with Roy Garland when Roy Garland was a teenager. For understandable reasons Roy Garland was not prepared to come forward to give evidence at that time, and the result was that the RUC had a witness who would not appear in court, and who was describing events involving homosexual acts that had occurred a considerable number of years before.
- Although in 1973 the RUC Special Branch were aware of the allegation that McGrath was homosexual from what appears to have been another source, they did not pass the information relating to the other source to their RUC colleagues as they should have done. Had Special Branch passed on that information then their RUC colleagues, whether in CID or in uniform departments, could have added it to the information that they had already received from the anonymous Robophone message of 23 May 1973.
- Despite Roy Garland's commendable efforts to alert Social Services and the RUC to the risk he accurately identified that McGrath might be taking advantage of his position in Kincora to sexually assault residents there, just as he had sexually assaulted Roy Garland when a teenager, Roy Garland's efforts to do so were unsuccessful through no fault of his own.
- Although the RUC, MI5, SIS and Army Intelligence were all aware of allegations that McGrath was homosexual, such allegations were common at the time against various political and other figures. In the absence of positive evidence of homosexual acts there was little that could be done by these

agencies because no one other than Roy Garland had come forward with a definite allegation that would allow the matter to be pursued.

- We are satisfied that it was not until 1980 that the RUC Special Branch, MI5, the SIS and Army Intelligence became aware that McGrath had been sexually abusing residents at Kincora, and they learnt of that when it became the subject of public allegations and a police investigation was launched. All four agencies, whilst aware that McGrath was alleged to be homosexual, had no proof of that. They were aware that he worked in a boys' hostel where he was in a position of authority. They were aware of allegations that he had abused Roy Garland a long time before McGrath went to work in Kincora.
- However, by November 1973, MI5, unlike the other three agencies, were also aware that the person who had by then been identified as William McGrath had been accused of "assaulting small boys". By virtue of Section 5 (1) of the Criminal Law Act (Northern Ireland) 1967 MI5 officers were subject to the same legal obligation as everyone else in Northern Ireland to report the commission of an "arrestable offence" to the police where they knew or believed that such an offence, or some other arrestable offence, had been committed. An alleged assault on small boys could, depending on the nature of the alleged assault, have been an arrestable offence which ought to have been reported to the police.
- With the benefit of hindsight, and in the light of what is now known about McGrath's abuse of residents in Kincora, it might be argued it was the duty of MI5 to bring to the attention of RUC Special Branch that MI5 had received a report that McGrath had been accused of assaulting small boys, and that by not doing so the MI5 officers who had this information were in breach of that duty. However, we consider that to take that view would be unjustified for several reasons. First of all, although the information was known to MI5 because it had been received eighteen months before, eighteen months separated the receipt of that information and the information confirming the identity of William McGrath as the leader of Tara. Secondly, the information came to MI5 in a letter from James Miller who was simply reporting what an unidentified source said at a time when unsubstantiated allegations of discreditable behaviour by Tara members about each other were

commonplace, and the report was therefore assessed as being of dubious reliability. Thirdly, the MI5 officers were concentrating on establishing what sort of organisation Tara was, and whether it could be a possible Loyalist terrorist group in the context of the extremely volatile political and security circumstances of that time. In all of those circumstances we do not criticise them for failing to appreciate the significance of this information.

- We consider that if this information had been passed to the RUC Special Branch, and by it to their CID and uniformed colleagues, that information may still not have made a significant difference to the approach of the RUC. The RUC had received, and was to receive, much more detailed allegations from the Robophone message of 23 May, 1973; from Valerie Shaw's conversation with D/Supt Graham, and from Roy Garland's conversation with Detective Constable Cullen that brought about the Cullen/Meharg investigation. An anonymous allegation of assault on small boys in an unspecified context and at unknown point in time that had been passed by MI5 might not have added much, if anything, to that information. On the other hand, we consider that if it came from MI5 it might have prompted the RUC to look at the existing information it held about McGrath and to investigate it more robustly.

William McGrath

- Based on our extensive examination of a very large number of files held by RUC Special Branch, by MI5, by SIS and by the Ministry of Defence, we are satisfied that McGrath was never an agent of the State, although he may have enjoyed creating an air of mystery about his activities, part of which may well have involved him hinting at, or implying in an oblique fashion, that he was an agent of the State.
- Not only have we found no evidence to indicate that McGrath was an agent of any of the four security agencies, we have found many documents and references which very strongly indicate that he was not an agent.
- William McGrath was a sexual pervert who had political and religious views of an extreme and bizarre type who managed to trick gullible young men who were interested in political matters into regarding him as an important political figure. William McGrath was never more than a minor player on the wider political stage who managed to create a spurious air of self-importance

through Tara at a time of great political instability, communal violence and terrorist activity. Tara was never more than an organisation of occasional interest to the security agencies.

Were prominent individuals involved in the sexual abuse of residents of Kincora?

There have been frequent allegations that various individuals, including Sir Maurice Oldfield, a former head of the Secret Intelligence Service who was later the Security Coordinator in Northern Ireland, and a number of named and unnamed Northern Ireland Office Civil Servants, and unnamed business men and other prominent figures, resorted to Kincora for sexual purposes. We are satisfied there is no credible evidence to support any of these allegations. Kincora was a small hostel and for most of its existence had only nine or fewer residents at any one time. The great majority of all of those residents who were interviewed by the Sussex Police were very surprised at such allegations and did not believe them to be of any substance.

There were a small number of former residents of Kincora who returned to Kincora as visitors and who engaged in consensual homosexual activity with Mains, or on a small number of occasions with some of the residents. A number of residents engaged in consensual homosexual activity with each other, or did so with others away from Kincora in circumstances which were completely unconnected with Kincora. We are satisfied that Kincora was not a homosexual brothel, nor used by any of the security agencies as a “honey pot” to entrap, blackmail or otherwise exploit homosexuals.

Allegations of a cover up

Both the Belfast Town Clerk and the Town Solicitor died before the Hughes Inquiry investigated the sexual abuse at Kincora. The reasons why the Town Clerk and the Town Solicitor decided not to accept the recommendation made by Mr Mason in 1971 that the complaints against Mains should be reported to the RUC were never recorded. There are a number of possible reasons why they took this step. One was that they did not agree that the information contained in Mr Mason’s report was sufficient to justify the matter being reported to the police. Another reason may have

been to protect the Belfast Welfare Authority from the embarrassment that would flow from a police investigation into a boys' hostel under its control. Another explanation may have been that either or both were determined to protect Mains from exposure as a homosexual. That would only be a possible consideration were there evidence to show that either the Town Clerk or the Town Solicitor knew that Mains was a practising homosexual. In the absence of any evidence each of these possible reasons is no more than speculation.

Apart from that unexplained decision, we are satisfied that there were no attempts by the Belfast Welfare Authority or the EHSSB to engage in a "cover-up", that is concealing from relevant individuals or authorities their knowledge of, or information about, wrongdoing by Mains, Semple or McGrath.

Allegations by Colin Wallace and others

- We are satisfied that Mr Wallace was moved from his post in the Army Information Service at HQNI, and subsequently dismissed, solely because there was very strong circumstantial evidence that he had been engaged in, and was still engaged in, the unauthorised disclosure of classified documents to journalists. We are satisfied that whatever he claims to have known about Kincora had nothing whatever to do with his posting to Preston or his subsequent dismissal.
- We are satisfied that Mr Wallace was treated unjustly in two respects connected with the subsequent appeal he brought against his dismissal to the Civil Service Appeal Board. First of all the MoD did not reveal to the CSAB the full job description which had been prepared showing the true nature of his work. Secondly, the MoD briefed the Chairman, and then the Deputy Chairman, of the CSAB with information that was not made known to Mr Wallace, to his representative, or to the other members of the Board who sat on his appeal. That they did so, and that the gentlemen concerned received the information, was thoroughly reprehensible and should never have happened.
- These injustices were accepted by David Calcutt QC in his report to the MoD in which he recommended that Mr Wallace be paid £30,000 compensation. We understand that Mr Wallace eventually accepted this amount.

- For the reasons we have given in considerable detail in Chapter 28 of the Report we do not regard Mr Wallace as truthful in his accounts of what he knew about sexual abuse in Kincora, or of what he did with that knowledge, between 1972 and 1974. In particular, we do not accept that the critical document of 8 November 1974 was created at that date.

MI5

During the Caskey Phase Three investigations MI5 consistently obstructed a proper line of enquiry by their refusal to allow the RUC to interview a retired MI5 officer, and by their refusal to authorise that retired officer to provide a written statement to the RUC answering 30 questions the RUC wished to ask him. We consider these questions were proper and relevant questions to the enquiry being conducted by D/Supt Caskey at that time.

Sir George Terry's report

While the Sussex Police carried out a thorough re-examination of the way the RUC carried out the initial Caskey Phase One investigation into the offences committed by Mains, Semple and McGrath, Sir George Terry was not justified in stating that military sources had been "very frank with me and perfectly open".

The NIO and the limited Terms of Reference of the Hughes Inquiry

The reliance by the NIO on the decision by the DPP that there should be no prosecution, and on Sir George Terry's Report, as adequate reasons for not setting up an Inquiry with Terms of Reference that would have enabled an investigation of the issues relating to the security agencies was not justified at the time. The decision failed to properly take account of the public disquiet at the time about issues which were deliberately excluded from the Terms of Reference of the Hughes Inquiry.

The steps taken by the Ministry of Defence in 1989 and 1990 to correct incorrect statements

The recognition by the MoD in 1989 that incorrect answers may have been given by Ministers to the House of Commons and to others led the MoD to carry out a wide ranging and detailed investigation to establish the correct position. When the correct position was known, the Ministry took the necessary action to place the correct facts

before the House of Commons and to correct the errors that had occurred in the past. It appointed Mr Calcutt QC to consider the injustices suffered by Mr Wallace to which we have already referred. We are satisfied that once the MoD appreciated that incorrect information had been given, and that Mr Wallace had not been treated properly before the CSAB, it acted promptly and properly to establish the correct position, and to ensure that the injustices Mr Wallace suffered in the appeal process were remedied. The injustices were remedied by the payment of £30,000 to him as compensation.

Why the sexual abuse by Mains, Semple and McGrath was not stopped sooner

Those residents of Kincora who were sexually abused by Mains, Semple and McGrath were let down by those three individuals who abused their positions of authority and committed numerous acts of sexual abuse of the gravest kind against teenage children in their care while they were living in this hostel. When their conduct was exposed, they were prosecuted, convicted and sentenced to appropriate periods of imprisonment.

In our investigations into Kincora the Inquiry examined hundreds of files held by Government and by the Police, MI5, the Secret Intelligence Service (MI6), the Ministry of Defence and other departments and agencies. We have also examined the police files relating to the earlier investigations that were carried out by the RUC and then by the Sussex Constabulary into what did or did not happen at Kincora. As we explained, those investigations by the RUC and the Sussex Police were extremely thorough and comprehensive. D/Supt Caskey and his officers went to great lengths to identify every possible person who may have been in possession of information that could lead to the identification and possible prosecution of anyone else who had committed a criminal offence of whatever kind relating to Kincora, whether that was sexual abuse or the suppression of evidence.

Those investigations did not find, and our Inquiry has not found, any credible evidence to show that there is any basis for the allegations that have been made over the years about the involvement of others in sexual abuse of residents in

Kincora, or anything to show that the security agencies were complicit in any form of exploitation of sexual abuse in Kincora for any purpose.

The reality of the situation was that it was because of the multitude of failings by officials of the Belfast Welfare Authority, of the Eastern Health and Social Services Board, and by the RUC, that the sexual abuse of residents at Kincora was not stopped earlier, and that those responsible for perpetrating these grave crimes were not brought to justice sooner.

The Child Migrant Scheme

We now turn to the Child Migrant Scheme, which was the first of the two other matters that we investigated. When we publicised the work of Inquiry overseas we received 65 applications, 12% of the total, from men and women in Australia who had been sent there as children from homes in Northern Ireland. Some alleged they had been abused before they left, others believed that the Child Migrant Scheme as we call it was itself abusive. Although the effects on those who were sent under the Child Migrant Scheme were brought to public notice in the 1990s, largely due to the tireless work of Dr Margaret Humphreys, ours is the first Inquiry in the United Kingdom to examine this in depth, although we note that the IICSA in England and Wales intends to do the same in the near future.

We examined why and how children who were in care in Northern Ireland were sent to Australia. We are very grateful to all those who helped us in our investigation into the way the Child Migrant Scheme operated in Northern Ireland, and the various courts in Australia who provided facilities for live television links when we took evidence from applicants in Australia, and the Royal Commission who provided staff.

We were unable to establish exactly how many children were sent from Northern Ireland, but at least 138 children under the age of fourteen were sent, and possibly as many as 144. 121 were sent by the Sisters of Nazareth, ten by various local authorities and seven by the Irish Church Missions.

Although the Child Migrant Scheme was administered by the Government in London, the Northern Ireland Government was well aware that children from Northern Ireland were being sent to Australia in the 1940s and 1950s. We found a number of systemic failings on its part.

- It was indifferent to the practice of the voluntary sector in Northern Ireland of sending child migrants to Australia.
- It failed to fully inform itself as to what was happening once it became aware that significant numbers of such young children were being sent to Australia by voluntary organisations such as the Sisters of Nazareth.
- It failed to make any enquiries whatever as to the fate of these children.
- It failed to make any representations to the United Kingdom Government about the operation of the Child Migrant Scheme.
- The Minister of Home Affairs was wrong to approve the proposal by Tyrone County Welfare Committee that HIA 354 should be sent to Australia
- There were a number of systemic failings by Tyrone Welfare Committee in the way they dealt with HIA 354.

There were also systemic failings by Manor House Home.

- The home was wrong to send children to Australia who were so young.
- It failed to take sufficient steps to maintain contact with the children after they went to Australia.
- It did not give truthful information to parents of the children who enquired where their child was.

The great majority of the children were sent by the Sisters of Nazareth who were responsible for a number of failings.

- They were wrong to send children to Australia who were so young. 85 of the children sent by the Sisters were ten or younger, two were four years old, thirteen were five years old, and nine were six years old. Only six were over fourteen.
- They failed to make any enquiries to satisfy themselves that the homes run by other Roman Catholic religious orders in Australia were suitable to receive their children.
- They failed to take sufficient steps to maintain contact with the children after they went to Australia.

- They did not give truthful information to parents of the children who enquired where their child was.
- In many cases they did not provide detailed, accurate and timely responses to enquiries by former child migrants for information that would have assisted them to trace their parents and relatives.

All the institutions who sent children to Australia failed to ensure that those who accompanied the children were competent to look after the children during the voyage, and failed to ensure that a suitable case history was sent with each child.

Fr Brendan Smyth

The second matter that we investigated related to Fr Brendan Smyth who joined the Norbertine Order as a novice in 1945, and took the name Brendan, and so he was known as Fr Brendan Smyth for the remainder of his life. He was ordained a priest in 1951 and remained a priest until his death in 1997 while in prison in the Republic of Ireland. Until he was arrested and sentenced in Northern Ireland in 1994 he committed acts of sexual abuse against an unknown number of children in Northern Ireland, in the Republic of Ireland and elsewhere. Although he was convicted of 43 separate offences against 21 children in Northern Ireland for offences committed between 1964 and 1984, and a further 74 separate offences committed against another twenty children in the Republic of Ireland for offences committed there between 1967 and 1993, he admitted on a number of occasions that he did not know how many children he had abused, saying that it could be hundreds.

Amongst the 43 offences in Northern Ireland to which he pleaded guilty in 1994 and 1995 for which he was sentenced to a total of four years imprisonment, three related to children who were in Nazareth House in Belfast, and five related to children in Nazareth Lodge, also in Belfast, both of which were children's homes run by the Sisters of Nazareth. However we accept that he also committed offences against other children, some of whom he also abused in either Nazareth House or Nazareth Lodge. He is also alleged to have abused children in two other children's homes in Northern Ireland. One was the home for boys at Rubane, Kircubbin, Co. Down, run by the De La Salle Order, and the other was the home for girls run by the Sisters of St Louis at Middletown, Co. Armagh.

Fr Smyth committed offences against many more children, and in many other places, as well as against children who were in those four children's homes in Northern Ireland. Because our Terms of Reference required us to examine whether there were systemic failings on the part of those responsible for children in residential homes in Northern Ireland, our focus had to be on how he was able to commit offences against children in those homes.

As Fr Smyth was able to move around and abuse children for so many years, and because the failings of several organisations and individuals contributed to his ability to abuse children over many years in different places, it was necessary for us to consider whether that abuse could have been stopped in those homes in Northern Ireland. The events surrounding his abuse of children in different places over many years were so inextricably interlinked that it was impossible to isolate what happened in the four homes in Northern Ireland within our Terms of Reference from the wider picture of his offending outside those homes, and the failures to protect children from him.

We identified many systemic failings by the Norbertine Order which can be summarised as follows.

- It permitted Fr Smyth's ordination despite a clear warning from the Abbot General that Fr Smyth should not be ordained.
- Throughout the Order failed to properly assess and appreciate the grave risk Fr Smyth posed to children despite being well aware of many episodes of sexual abuse by him.
- Despite what it knew he had done, the Order sent him to different dioceses which gave him the opportunity to abuse more children
- The Order allowed repeated efforts to be made to 'cure' Fr Smyth by sending him for various forms of medical treatment on several occasions, even though it was clear from continuing complaints that, despite earlier treatments, he was continuing to abuse children.
- The Order failed to report Fr Smyth to the police and social services in either Northern Ireland or the Republic of Ireland, thereby preventing him from being prosecuted and convicted, and so enabling him to continue his abuse.
- The Order failed to confine Fr Smyth to the Abbey in Kilnacrott.

- It failed to take steps to have him expelled from the priesthood and so prevent him from exploiting his position as a priest to continuing abusing children.

The Diocese of Kilmore

Although Kilnacrott Abbey was not under the authority of the Roman Catholic Bishop of Kilmore Fr Smyth's activities led to the Diocese being involved with him, and there were several failings by the Diocese which can be summed up as follows.

- The Diocese consistently failed to notify the police and social services in Northern Ireland and in the Republic of Ireland of allegations against him.
- The Diocese did not take all the steps open to it to thoroughly investigate each allegation relating to Fr Smyth that came to its notice and to report the matter to the proper civil and ecclesiastical authorities on each occasion.
- The Diocese did not inform the civil and ecclesiastical authorities in Belfast that there was reason to believe two Belfast children were involved with Fr Smyth.
- The Bishop allowed him to continue to function as a priest outside the confines of Kinacrott Abbey.
- When the allegations relating to Brendan Boland and FBS 39 were investigated by the Diocese, it failed to have Brendan Boland's father in the room with him whilst Brendan was questioned, and it did not notify the parents of FBS 39 of the alleged abuse, or have his parents present when he was questioned.
- In both cases there was also a failure to follow up with the parents of each child how the child was reacting to the abuse afterwards.
- It failed to warn other dioceses, and in particular the Diocese of Down and Connor, about the allegations so that they could take steps to protect the children in homes in their diocese from being abused by Fr Smyth.

The Diocese of Down and Connor

Fr Smyth's activities came to the attention of the Roman Catholic Diocese of Down and Connor which was also responsible for a number of failings.

- It failed to disseminate to other bishops and institutions the concerns known to the Diocese about, and later the knowledge of, the sexual abuse alleged against Fr Smyth.

- It did not report the allegations against Fr Smyth to the social services and the police in Northern Ireland when they were received by the Diocese.
- It failed to institute a penal investigation or process against Fr Smyth in the Diocese of Down and Connor on the basis of the allegations of his abuse in that Diocese.
- It failed to exert greater pressure upon Abbot Smith in 1971, by not asking for urgent and immediate information, and for that to be confirmed; and by not threatening to institute the church inquiry process in Down and Connor against Fr Smyth as had been done in Kilmore by Bishop McKiernan.

The Sisters of Nazareth

SR 31 and SR 46 of the Sisters of Nazareth in Nazareth Lodge failed to report what they had been told to the mother superior.

Rubane House

Fr Smyth visited Rubane House and abused children there. There was a systemic failing by the De La Salle Order because it failed to notify the police and social services in Northern Ireland of the allegations against Fr Smyth made to BR 1.

Recommendations

An Apology

Our Terms of Reference expressly require us to consider a number of possible recommendations, the first of which is an apology. During the different modules many core participants took the opportunity to make formal apologies to those children who were failed in different ways, but many applicants made it clear that they did not regard an apology as worthwhile. However, we consider that a public apology is important because it is a formal recognition of past mistakes or wrongdoing.

We therefore recommend that the Northern Ireland Executive, and those who were responsible for each of the institutions where we found systemic failings, should make a public apology. The apology should be a wholehearted and unconditional recognition that they failed to protect children from abuse that could and should have been prevented or detected. We also recommend that this should be done on a single occasion at a suitable venue.

A Memorial

Physical structures such as sculptures or plaques are valued as visible reminders of past events or individuals whose memory should be commemorated. As in the case of an apology, there were differing views expressed by applicants, many of whom were very strongly of the opinion that a memorial was not appropriate because they did not want to be reminded of their experiences as children in residential institutions. Whilst we respect that view, we are of the opinion that a memorial should be erected to remind legislators and others of what many children experienced in residential homes. We recommend that a suitable physical memorial should be erected in Parliament Buildings, or in the grounds of the Stormont Estate.

Additional provision for those who were abused

From the beginning of the public hearings we offered each applicant the opportunity to say what recommendations they felt the Inquiry should make. To give them the opportunity to add to what they may have said, and to allow the same opportunity to those who only spoke to the Acknowledgement Forum, we took what we believe to be the unprecedented step of sending every applicant a questionnaire asking for their views on a number of matters. 541 were issued, and 330 were returned, a very high return rate for a survey of this type.

A common theme of the comments by applicants during their evidence during the public hearings, and in their responses to the Questionnaire, was that their experiences as children who were abused had a lasting effect on their lives, and that services should be available to them to enable them to cope with these problems. The areas that were most frequently identified as still causing difficulties for those who were abused were those we identified in the Questionnaire.

- Mental health problems.
- Other health problems.
- Literacy and numeracy problems.
- Counselling.
- Addiction problems.
- Employment problems.
- Access to education.

No single agency can deal effectively with such a multiplicity of issues, but steps to address these issues will need to be co-ordinated to ensure that existing facilities are made readily available to those who need them, and where there are gaps in the services already available these can be identified and remedied. We consider that the best means of addressing the specific needs of those who experienced abuse as children would be by the creation of a post whose holder would act as an advocate for those children who were subjected to abuse whilst under 18 and resident in institutions within our Terms of Reference. We therefore recommend that a designated person should act as an advocate for such children, and should be responsible for ensuring the co-ordination and availability of services, and identifying suitable means whereby such services can be made available to those who need them. This person should be called the Commissioner for Survivors of Institutional Childhood Abuse (COSICA).

The Commissioner (who should be assisted by the necessary staff) should be entirely independent of government and the organisations that ran the institutions, but should be funded by government. The Commissioner would have a number of responsibilities.

- (a) Act as an advocate for all those who were abused as children in residential institutions in Northern Ireland between 1922 and 1995.
- (b) Encourage the co-ordination and provision of relevant services free of charge for those who were so abused.
- (c) Provide a central point of contact; for providing advice on the services and facilities available; and provide assistance to those who suffered abuse to contact those services. This would include providing a hotline and internet advice.
- (d) Be responsible for monitoring the matters referred to below.
- (e) Assist in the provision of advice and information to those who wish to apply for compensation to the HIA Redress Board.
- (f) Assist people to access records about the time they spent in homes including admission and discharge dates to enable them to apply for compensation to the HIA Redress Board.

(g) Monitor the operation of the HIA Redress Board.

We recommend the Commissioner should be assisted by an Advisory Panel consisting of individuals who as children were resident in residential homes in Northern Ireland. The members of the Advisory Panel should be chosen by the First Minister and deputy First Minister in accordance with the normal processes for public appointments in Northern Ireland. The operation of, and need for, COSICA should be reviewed after five years.

We understand that the Executive Office has funded a number of groups of former residents of residential homes for children, and we recommend that such funding should continue on a transitional basis until such time as the members of the Advisory Panel have been appointed.

Our Terms of Reference were limited to abuse that occurred in those institutions that came within our Terms of Reference, but we heard some evidence of abuse of children in other circumstances, such as schools or foster care. It is not for us to say whether there should be other inquiries into allegations of abuse and systemic failings in such areas. However, if our Recommendations are implemented, we suggest that consideration be given to expanding the functions of COSICA as necessary to include other forms of abuse suffered by children, such as clerical abuse, abuse in schools or abuse suffered whilst in foster care.

So that the Commissioner would be, and would be seen to be, independent, and to ensure that the office would be adequately resourced, the office of Commissioner should be:

- (a) created by statute;
- (b) allocated a separate budget; and
- (c) required to report once a year to the NI Assembly.

Specialist care and assistance

Sufficient funds should be made available by government on a ring-fenced basis for a fixed period of ten years, subject to a review after five years, to establish dedicated

specialist facilities in Belfast, Derry and, if necessary, at other suitable locations across Northern Ireland to provide:

- (a) general counselling services for those who have suffered abuse as children in residential institutions in Northern Ireland, supported by appropriate links to the health service and to other relevant housing, education and employment services; and
- (b) practical help with literacy and numeracy, education, employment, housing and benefits advice tailored to the needs of individual victims of institutional abuse.

Financial Compensation

On 4 November 2015 we announced that, based on the evidence we had heard, we would recommend that compensation should be payable to those who had been abused whilst in residential children's homes within our Terms of Reference. The great majority of redress schemes that we have considered throughout the English speaking world provide for lump sum payments to those entitled. Some argue that a more sensible form of redress would be to provide regular payments in the form of a benefit or pension, thereby ensuring that the money is regularly available and is less likely to be dissipated unwisely. Whilst we can see some validity in that argument, we consider that a lump sum payment is preferable for a number of reasons.

- The recipient has the benefit of a lump sum to use as he or she thinks best, for example by giving some or all of the money to their children, by purchasing an annuity, or by paying for the cost of travel to the United Kingdom or Ireland to have contact with relatives.
- It is easier to identify the possible total cost of the redress.
- It is easier to administer, particularly if a redress scheme is time limited, and does not require a permanent organisation to be created and staffed as would be the case were the compensation to take the form of regular payments.

We therefore recommend that compensation should take the form of a lump sum payment.

Although some have argued that the institutions responsible for any abuse should be responsible for compensation, it must be remembered that the Inquiry has not

investigated every institution in respect of which there have been allegations of abuse. As well as those we examined during our public hearings, as we explained on 4 November 2015 there were some other homes that were subject to specific, targeted investigations. There were another 43 homes or institutions where we decided that any further investigations into them would not be justified. We emphasised that this did not mean that we had decided that abuse did not occur in those homes or institutions. Any compensation scheme has therefore to provide for those who may have been abused in homes or institutions that we did not investigate.

In addition, there may well be applications for compensation by individuals who were abused in homes or institutions against which no complaints were made to us. Some of those homes or institutions may no longer exist, nor may the organisations which ran them. Even if they do exist, those responsible for them now may not have sufficient funds to pay compensation, or may not be covered by insurance. If compensation were only payable by those responsible for the homes we investigated, and have the funds to pay, that would mean that many who were abused might not receive compensation.

A further important factor is that we have found that employees of local authorities, health boards and government departments were also guilty of abuse. Those organisations were guilty of systemic failings in the homes or institutions they organised, such as Rathgael, Millisle, Lissue, Kincora and Bawnmore, or were responsible for inspecting in the case of the Ministry of Home Affairs and the DHSS.

For these reasons we believe that only a government-funded compensation scheme can ensure that all of these contingencies are provided for. If such a scheme is not provided, it is likely that many of those who should be compensated will not be compensated. We recommend that the Northern Ireland Executive create a publicly funded compensation scheme.

The HIA Redress Board

We consider the appropriate method of administering the compensation scheme is to create a specific Historic Institutional Abuse Redress Board for that purpose, and we so recommend. The HIA Redress Board should be responsible for receiving and processing applications for, and making payments of, compensation. Whether an individual is entitled to compensation, and if so how much, should normally be decided by judicial members of the Redress Board solely on the basis of the written material submitted by the applicant, and any other written material the judicial member or the Appeal Panel consider relevant.

We consider compensation should not be payable to anyone merely because they were resident in an institution within our Terms of Reference. Many of those who were resident in these institutions were not abused in any way, and we consider there is no justification for awarding compensation to individuals merely because they were in homes where others were abused, but they were not themselves abused, and were unaware of abuse taking place.

We therefore recommend that compensation awarded by the HIA Redress Board should only be payable to, or in respect of, a person who can show (or their estate can show) on the balance of probabilities that they were resident in a residential institution in Northern Ireland as defined by the Terms of Reference of the HIA Inquiry when they suffered abuse in the form of sexual, physical or emotional abuse, or neglect or unacceptable practices, between 1922 and 1995; and were under 18 at the time.

In some, though not all, of the institutions we investigated there was a harsh environment that affected all the children in that institution at that time. Other children who were exposed to that harsh environment, but were not themselves abused, were still affected by the general regime and the impact of what they witnessed, and therefore were also abused. We recommend that such persons also should be regarded as having been abused, and should also be eligible for an award of compensation by the HIA Redress Board

Living persons should be eligible to receive a full payment.

Not all redress schemes allow the surviving spouse or children of a person who was abused, but who died before they could receive compensation, to receive all or part of the amount the person would have had they lived. Payment under a redress scheme is designed to compensate an abused person for the effect of the abuse on him or her. However, many applicants to the Inquiry stressed the adverse effect of their experiences upon their adult lives when it came to being a spouse or parent, and said their families suffered as a result of their parent's experiences. We accept that was the case for many of those who spoke to us.

An additional consideration is what happens to those who were abused but died before they could claim compensation, or before their claim was dealt with. We are aware that so far at least twelve applicants to the Inquiry have died since they made their application, and sadly more may die before the HIA Redress Board could come into operation, or before their claim may be dealt with by the HIA Redress Board.

We believe that it would be just and humane for only those directly affected, namely the spouse or children of a person who died after a prescribed date to be able to claim 75% of the compensation that would have been awarded to their spouse or parent, and we so recommend. The Northern Ireland Executive announced that it intended to set up an Inquiry on 29 September 2011, and we recommend that that should be the prescribed date, and that any person living on that date should be entitled to compensation from the HIA Redress Board.

Where a person entitled to compensation died after 29 September 2011 we recommend that the following provisions should apply.

- (a) The relatives of the person should be able to recover 75% of the award that would have been made to the person had he or she survived.
- (b) Those entitled to the 75% proportion of the award will be the beneficiary or beneficiaries of the person's estate where the victim left a will. If the person died without leaving a will then the entitlement will be decided in accordance with the law of the country in which the person resided at the time of his or her death.

- (c) Where more than one person is entitled to share in the estate of the deceased their respective shares will be decided in accordance with the law of the country in which the person lived at the time of his or her death.

We believe that a person should not be entitled to be compensated twice for abuse they suffered. If a person has already received compensation through civil proceedings for his or her time in a residential institution within our Terms of Reference we recommend that person should not be entitled to a payment from the HIA Redress Board.

A person who has instituted civil proceedings against an institution or a public body or a government department for abuse suffered by that person whilst under 18 in a residential institution in Northern Ireland within our Terms of Reference must decide whether to continue his or her civil action or apply to the HIA Redress Board. They should not be able to do both, and must terminate those civil proceedings in a final manner before they apply to the HIA Redress Board.

We consider that a person who wishes to institute, or continue, civil proceedings instead of applying for compensation to the HIA Redress Board should be entitled to do so, but should not be able to top up any payments they have received, or may receive, by applying to the HIA Redress Board in the hope of obtaining a further payment in respect of abuse suffered in the same institution.

However, for the avoidance of doubt we wish to make it clear that this would not prevent a person who has already received compensation in civil proceedings in respect of abuse suffered whilst a resident in one institution from receiving compensation from the HIA Redress Board for abuse suffered whilst resident in a different institution, provided that institution was not managed by the same organisation against whom the earlier civil proceedings were taken.

To allow applicants to claim in civil proceedings and from the HIA Redress Board would be contrary to the principle that compensation from the HIA Redress Board should be an alternative, and not a supplement, to compensation received as a result of civil proceedings.

To allow applicants who have accepted settlements, or who have instituted civil proceedings that were unsuccessful, to also apply to the Redress Board would be contrary to the principle that litigation should be final; would cause difficulties for the courts and the HIA Redress Board in deciding which case was to be dealt with first, and would cause difficulties for the courts and the HIA Redress Board when deciding what the other had already taken into account and why.

However, in one instance only we consider that those who have been unsuccessful in civil proceedings based on abuse they suffered under the age of eighteen while in residential institutions in Northern Ireland should still be allowed to claim from the HIA Redress Board, and that is where their claim was defeated by the operation of the limitation defence.

We recommend that priority is given by the HIA Redress Board to those applicants who are over 70 or in poor health.

Many have urged that a redress scheme be set up as a matter of urgency, not least because many applicants to the Inquiry were elderly or in poor health, and may not live to receive compensation if it takes a long time to set up a redress scheme. Whether the HIA Redress Board is put on a statutory or on an *ex gratia* basis, we urge the speedy implementation of our Recommendations.

Amount of Compensation

As part of our consideration of the issue of compensation, and who should be compensated, and what the amount of compensation should be, we examined redress and compensation schemes in other countries. We were helped in our deliberations by discussions with colleagues from Germany and the Netherlands, and with Professor Kathleen Daly of Griffith University, Queensland, Australia, whose pioneering study of redress schemes in Canada and Australia deserves to be studied by all interested in this important field.

We gathered information about as many civil claims that have been brought against institutions within our Terms of Reference as we could. We then analysed the awards to see what amounts of compensation had been awarded to, or accepted by

way of settlement, by plaintiffs who had taken civil action against any of these institutions in Northern Ireland. We believe that such an exercise on such a scale has never been attempted before in the United Kingdom because of the difficulty in obtaining information in respect of awards in civil claims against institutions within our Terms of Reference as many have been settled on confidential terms. We exercised our powers under section 9 of the Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013 to require the provision of this information.

Whilst we regard the details of individual awards as confidential, we have been able to gather much relevant information, the results of which are contained in Tables 1 and 2 in Appendix 3 of Chapter 4 in Volume 1.

We know that 147 applicants to the Inquiry have instituted civil proceedings, and 67 individuals who did not apply to the Inquiry have also done so. We have established that of the 214 cases, 34 cases brought by applicants to the Inquiry, and 33 cases brought by individuals who did not apply to the Inquiry, resulted in payments being made to the plaintiff. We understand that 147 cases are therefore still unresolved.

We analysed the amounts that have been accepted in settlement by those who have taken civil proceedings. The figures show that of the 67 cases where compensation has been paid as the result of civil proceedings in Northern Ireland no settlement has been for less than £5,000; and only seventeen settlements exceeded £20,000. Of those seventeen cases, only seven exceeded £30,000. Of the seven settlements over £30,000 the highest settlement figure was £60,000, and that was in only one case. We consider that the amounts to be paid by the HIA Redress Board should be in line with the amounts that litigants who have taken civil proceedings in Northern Ireland have received in respect of abuse suffered whilst they were residents in institutions within our Terms of Reference.

We have also taken into account the recent decisions in the High Court of Justice in Northern Ireland *McKee v Sisters of Nazareth* [2015] NIQB 93 and *Irvine (Una) v Sisters of Nazareth* [2015] NIQB 94. In *McKee* Mr Justice Horner felt that the range of damages would have been between £5,000 and £7,500, and the award would have been £6,500. In *Irvine* Mr Justice Colton would have awarded £7,500 for the physical injuries, and £20,000 because she had been rendered vulnerable to

psychiatric injury, £27,500 altogether. We refer to these cases because the experiences of both plaintiffs claim were typical of many applicants who gave evidence to the Inquiry, although both cases was defeated by the operation of the limitation defence.

We do not consider that there is any reason why awards by the HIA Redress Board should be materially out of line with amounts that have been already been paid as a result of litigation, whether against individual institutions or public authorities, or by the state in the form of Criminal Injury Compensation, or which may be awarded by the courts. We believe that such awards are the appropriate benchmark against which awards by the HIA Redress Board in this jurisdiction should be measured.

We consider that there should be a minimum amount that would be awarded to a person who can show that they have been abused in a residential institution, and that the upper limit of awards should be capped at a figure that would be sufficient to provide fair compensation for the worst cases, taking into account the highest settlements that there have been to date on the basis that there are likely to be few such awards by the HIA Redress Board, whilst leaving a reasonable margin in case a small number of cases are brought that would justify awards between £60,000 and £80,000. In what we believe would be a handful of cases where awards exceeding £80,000 (or £100,000 in the case of Australian applicants) might conceivably arise, the option of civil proceedings with an unlimited award would continue to be available.

Some applicants believe that had they not been abused whilst resident in a children's home that they would have had had more success in life, and so earned more money. We consider that if a person wishes to claim for loss of earnings in adult life then they should pursue such a claim for loss of earnings as part of a claim in civil proceedings, and that claims for loss of earnings should not be allowed under the capped compensation scheme we recommend.

We therefore recommend that every person entitled to compensation should receive a standard award sufficient to cover those forms of abuse that were widespread and suffered by a significant number of children, such as unacceptable living conditions, excessive domestic work, loss of earnings for excessive work done by children in

children's homes, minor physical abuse, or being subjected to emotionally abusive behaviour, but not for any other form of loss of earnings.

Those who may have been more significantly affected, or who were subjected to more serious forms of abuse of any type, such as sexual abuse or serious physical abuse, would be entitled to an enhanced payment from the HIA Redress Board.

Those sent to Australia under the Child Migrants Scheme should receive a special payment in addition to any other payment to which they might be awarded by the HIA Redress Board. The special payment should be of a sum sufficient to recognise the injustice they suffered as young children by being sent to a far away land and losing their sense of identity as a result.

We recommend that the amount of compensation should therefore consist of one or more of the following elements.

- A standard payment of £7,500 payable to anyone who was abused, including those who experienced a harsh environment, or who witnessed such abuse.
- An additional payment of £20,000 in respect of a person sent to Australia under the Child Migrants Scheme.
- An additional enhanced payment to anyone who was more severely abused.
- The maximum amount of compensation payable should not exceed £80,000, except for those who were sent to Australia, where the maximum payment should not exceed £100,000.

We also recommend that social security payments should not be affected by lump sum payments awarded by the HIA Redress Board.

Lump sum payments of damages for personal injury, or by way of criminal injury compensation, are not taxable, and we consider that lump sum payments made by the HIA Redress Board should be treated in the same way. We recommend that payments of compensation should not be taxable, and that the Northern Ireland Executive make representations to the Treasury and to HMRC to achieve this.

Legal Aid

We recommend that applicants should be eligible for legal aid to allow them to obtain legal assistance to make an application for an award.

We consider that the operation of the HIA Redress Board should not continue indefinitely, but should be time limited, with a reasonable period being allowed in which prospective applicants could be expected to make an application for compensation. We recommend that applications must be made within five years from the coming into existence of the HIA Redress Board, which should then close to new applicants after that date. If other forms of abuse such as clerical abuse, or abuse in schools, were to be added to the HIA Redress Board then the five year period might have to be amended accordingly.

Contributions to the cost of the compensation scheme

There is a widely expressed view, which we believe to be valid, that the total cost of compensation awarded to the victims of historical institutional abuse should not fall completely on the taxpayer. We recommend that any voluntary institution found by the Inquiry to have been guilty of systemic failings should be asked to make an appropriate financial contribution to the overall cost of the HIA Redress Board and any specialist support services recommended by the Inquiry.

The amount, and how it would be paid, should be negotiated between government and the institution(s) concerned in the first instance. For example institutions may wish to argue that their funds, or their other obligations, are such that they are not in position to make such a contribution, or, in the case of institutions that have already made payments, that the payments or other outlay, such as travel costs from Australia, should be taken into account and set off against any contribution to which they may be asked to make so that they do not pay twice over for their failings.

If agreement as to the amount(s) to be paid by the institution(s) cannot be reached, we recommend that the Northern Ireland Executive and the institution(s) concerned submit all issues to mediation. If mediation fails then all remaining issues should be

dealt with by the Northern Ireland Executive and the relevant institutions agreeing to submit to binding arbitration.

Conclusion

In conclusion, there are there are six main messages arising from this Inquiry.

The first is that background factors such as poverty, social conditions and government policies had a significant impact in creating the setting in which systemic abuse occurred.

The second is that within that context some institutions providing residential child care were responsible for a range of institutional practices which constituted systemic abuse.

Thirdly, there were individuals who provided excellent care and there were others who were cruel and abusive, sexually, physically and emotionally towards the children for whom they were responsible. This abuse has affected many people for the rest of their lives.

Fourthly, in the last three decades of the Inquiry's remit there were perceptible improvements in physical conditions, staff numbers and training, and case management, and by the 1990s the quality of care was generally good.

Fifthly, although all three staff at Kincora were convicted of homosexual offences against boys in their care, and there is evidence of numerous missed opportunities to detect the abuse and take action, there is no evidence whatsoever of the hostel being used by security forces as a honeytrap, and we believe it is now time to finally lay these unfounded myths to rest.

Finally, when we drafted our Recommendations in December 2016 the Executive was still in being. We have provided a detailed framework for the recommended compensation scheme and for the HIA Redress Board that would administer the compensation scheme. When we finalised our Recommendations we believed that if the Northern Ireland Executive and Assembly addressed the implementation of our Recommendations in a positive and energetic fashion the first payments could be made by the HIA Redress Board by the end of this year.

The Assembly Election inevitably means there will now be a significant delay in considering and implementing our Recommendations. We appreciate the intense disappointment this will cause to all those affected, and we recognise that there may be calls for interim payments of compensation. However, experience in the past has shown that all too often interim payments prolong the final resolution of claims. We therefore urge the new Executive and Assembly to give effect to our recommendations, and to do so as a matter of priority after the Election. We believe that those who have waited so long for their voices to be heard deserve no less.