

# Chapter 1:

## Introduction

### Contents

### Para

|  |           |
|--|-----------|
| <b>Part One .....</b>  | <b>1</b>  |
| The Acknowledgement Forum..  | 5         |
| The Statutory Inquiry ..   | 11        |
| The research and investigative team ..                               | 17        |
| Applications ..  | 18        |
| Number of applicants ..  | 21        |
| Assistance to applicants ..  | 24        |
| The form of hearings ..  | 28        |
| Gathering documents and evidence ..                                  | 31        |
| Assessment of evidence ..  | 37        |
| Role of the Inquiry ..   | 40        |
| Standard of Proof. ....  | 43        |
| The standards against which historic practices should be compared .. | 44        |
| <b>Part Two .....</b>  | <b>45</b> |
| Reports to the police..  | 50        |
| Other investigations. ....   | 51        |
| Kincora and the non-devolved Departments and Agencies. ....          | 52        |
| The economic and social background ..                                | 53        |
| <b>Part Three .....</b>  | <b>59</b> |
| Changes in residential childcare ..                                  | 60        |
| Sexual abuse. ....   | 63        |
| Physical abuse..   | 68        |
| Emotional abuse..  | 76        |
| Neglect ..   | 79        |
| Unacceptable practices ..  | 80        |
| Underlying Issues  |           |
| Governance and Finance ..  | 81        |
| Size of homes ..   | 84        |
| Sound standard residential childcare. ....                           | 86        |

**Part Four**

The format of the Inquiry and the Report . . . . . 89  
The cost of the Inquiry .. . . . 93

## Part One

- 1 On 29 September 2011 the Northern Ireland Executive announced that it intended to set up an Inquiry into abuse in residential homes in Northern Ireland, and on 31 May 2012 the First Minister and deputy First Minister announced the agreed Terms of Reference for the Historical Institutional Abuse Inquiry (the HIA Inquiry) and advised the Northern Ireland Assembly of the appointment of the Chairman of the Inquiry and the panel members for the Acknowledgement Forum.
- 2 The Terms of Reference originally provided that the HIA Inquiry would examine the period between 1945 and 1995. Representations were made to the First Minister and deputy First Minister that the start date of 1945 would result in the exclusion from the Inquiry of a number of those who were resident in residential institutions within the Inquiry's Terms of Reference before 1945, and so the remit of the Inquiry should be extended. After consultation with the Chairman of the Inquiry, the First Minister and deputy First Minister announced that the Terms of Reference would be amended to extend the ambit of the Inquiry to start in 1922 and to finish in 1995.
- 3 During the early stages of the HIA Inquiry's public hearings in 2014 it became apparent that it would not be possible for the Inquiry to hear oral evidence from every applicant unless the Terms of Reference were extended to give the Inquiry an extra year to complete its work. The Inquiry therefore applied to the First Minister and deputy First Minister to grant an extension of an extra year to the Inquiry. The First and deputy First Minister agreed to the application, and the Terms of Reference of the Inquiry were formally amended by The Inquiry into Historical Institutional Abuse (Amendment of Terms of Reference) Order (Northern Ireland) 2015, which came into operation on 11 February 2015.
- 4 The effect of this amendment was that the three year period given to the Inquiry to carry out its investigations and deliver its Report was extended to four years from 19 January 2013, three and a half years of which was to allow the Inquiry to conduct its public hearings and investigations, and a further six months to deliver its report.

## The Acknowledgement Forum

- 5 The Terms of Reference provided for a separate Acknowledgement Forum to  
to  
“... provide a place where victims and survivors can recount their experiences within institutions. A 4 person panel will be appointed by the First Minister and deputy First Minister to lead this forum. This Forum will provide an opportunity for victims and survivors to recount their experience on a confidential basis. A report will be brought forward by the panel outlining the experiences of the victims and survivors. All records will be destroyed after the Inquiry is concluded. The records will not be used for any other purpose than that for which they were intended. If necessary the Forum will have the authority to hear accounts from individuals whose experiences fell outside the period 1922 – 1995. The Acknowledgement Forum will operate as a separate body within the Inquiry and Investigation accountable to and under the chairmanship of the Inquiry and Investigation Panel Chair.”
- 6 As the Terms of Reference made clear, the Acknowledgement Forum provided an opportunity for applicants to the Inquiry to recount their experiences of their time as children in residential homes within the Inquiry’s Terms of Reference on a confidential basis. The panel members almost always sat in teams of two, and their role was to enable applicants to the Acknowledgement Forum to describe their experiences in a completely confidential setting. The function of the Acknowledgment Forum was not to interrogate or question the applicants about their experiences, although where necessary panel members asked questions in order to help the applicant to describe his or her experiences. Because the Inquiry and the Acknowledgement Forum recognised that this could be a very difficult experience for applicants, an applicant could, if he or she wished, be accompanied by a companion of their choice whilst they recounted their experiences.
- 7 As the Acknowledgment Forum did not require statutory authority to carry out its work, the Inquiry devoted its initial efforts to putting in place the necessary administrative staff and processes to enable the Acknowledgement Forum to start its work as soon as possible. By a public notice of 1 October 2012 applications were invited from those who wished to speak to the Acknowledgement Forum, and the first interviews were conducted by the Acknowledgment Forum on 22 October 2012.

8 Altogether the Acknowledgment Forum heard from 428 applicants between 22 October 2012 and the completion of their hearings in November 2014. Most of the applicants spoke to the Acknowledgment Forum at various locations in Northern Ireland. Whilst interviews were conducted by the Acknowledgment Forum in the Inquiry Headquarters in Belfast, many interviews took place in Derry/Londonderry (names that we use interchangeably throughout this Report) and other locations throughout Northern Ireland, in the Republic of Ireland, in Great Britain and in Australia. Apart from those applicants who gave evidence by live link from Canada and the United States, all the meetings were conducted on a face-to-face basis. Although the great majority of meetings which took place outside the Inquiry’s Headquarters in Belfast took place in hotel rooms rented by the Inquiry for that purpose, there were a number of occasions when Acknowledgement Forum panel members spoke to applicants in prison or in the applicant’s home.

9 Although the Inquiry made it quite clear that the Acknowledgement Forum was a confidential process that was never intended to be used as a vehicle for gathering evidence for civil proceedings, there were applications to the Inquiry by solicitors representing applicants who sought access to the transcripts of the meetings in order to gather evidence for civil proceedings. The Inquiry declined to produce such transcripts and its position was upheld by the High Court, and on appeal by the Court of Appeal in LP’s Application [2014] NICA 67. As Lord Justice Gillen explained when giving the judgment of the Court of Appeal at [35]

“The AF is a unique provision. It is intended to operate as a confidential and private service where victims and survivors can recount their experience of their time in institutional care with total confidence in the integrity and confidentiality of that stage of the process... It is vital to the integrity of the Inquiry to ensure that there is a public perception that this will remain the case. The grim truth is that if it were to become common place for such recordings to be provided, with all the attendant risks of such material innocently or otherwise getting into the public domain, we can readily see the deleterious effect this might have on the process as a whole.”

And at [36]

“The record of the AF process is not to be used for any purpose other than those for which it was intended. For example it was never intended that it was to be used as a vehicle for gathering evidence for civil proceedings.”

- 10 In order to allow as many as possible to apply to the Acknowledgement Forum it was not until 6 March 2014 that the Inquiry announced that the closing date for such applications would be Wednesday 30 April 2014.

## The Statutory Inquiry

- 11 The Inquiry Terms of Reference also provided for “An Inquiry and Investigation Panel” with the task of producing “a final report taking into consideration the report from the Acknowledgement Forum, the Report of the Research and Investigative team and any other evidence it considers necessary.”
- 12 For convenience we describe the Inquiry and Investigation Panel as the “Statutory Inquiry” or “The Inquiry”, and when we refer to the Statutory Inquiry or to The Inquiry in this Report this is a reference to the Investigation and Inquiry Panel.
- 13 Unlike the Acknowledgment Forum, the Statutory Inquiry was created by, and operated under, the provisions of, an Act of the Northern Ireland Assembly. On 12 June 2012 the Inquiry into Historical Institutional Abuse Bill was laid before the Assembly. The Bill passed through a number of stages and was passed by the Assembly on 11 December 2012, and following Royal Assent the Inquiry into Historical Institutional Abuse Act (Northern Ireland) 2013 (the 2013 Act) became law on 19 January 2013. Statutory Rules made under Section 21 of the 2013 Act were laid before the Assembly on 24 June 2013 and took effect from 25 July 2013.
- 14 In order to provide for various procedures relating to the operation of the Statutory Inquiry the Chairman published three protocols.
- 1 A Procedural Protocol
  - 2 A Cost Protocol
  - 3 A Redaction, Anonymity and Restriction Orders Protocol

Under the Redaction, Anonymity and Restriction Orders Protocol the Chairman subsequently made seven Restriction Orders. The Protocols, and the Restriction Orders, can be found on the Inquiry’s website.

- 15 The Inquiry also published guidelines and other relevant procedural documents. These included the definition of abuse used by the Inquiry, undertakings given by the Director of Public Prosecutions for Northern Ireland and the Attorney General for England and Wales in respect of witnesses providing evidence to the Inquiry, application forms for grants of

legal representation by the Inquiry at public expense, and a template to be used by legal representatives submitting an invoice for payment of costs awarded by the Inquiry.

- 16 The Inquiry was not provided with a definition of “abuse” by the Terms of Reference and we therefore adopted the following definition, which recognised that abuse could take the form of sexual abuse, physical abuse, emotional abuse, neglect or unacceptable practices which were against the interest of the children. We set out the full definition of abuse and systemic failings in Appendix 1 to this chapter, and it is sufficient for present purposes to set out paragraph four of the definition.

““Abuse” was behaviour which either (a) involved improper sexual or physical behaviour by an adult with another child towards a child; or (b) in the case of emotional abuse, was improper behaviour by an adult or another child to undermine a child’s self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or (c) resulted in neglect of the child; or (d) took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships, which ignored the interest of the children.”

## The research and investigative team

- 17 In our work the Inquiry was greatly assisted by the work of the researchers in our Research and Investigative Team. Before and during the public hearings they were embedded in the Public Record Office of Northern Ireland (PRONI) where they worked in close conjunction with the Inquiry legal team and PRONI staff. Their excellent working relationship with PRONI meant they were able to trace and examine huge numbers of departmental files, as well as files deposited by former public bodies such as welfare authorities. In several instances it was due to their researches that the Inquiry decided to investigate a particular institution or topic. In the future other inquiries of a similar type might well find that embedding their research staff in PRONI in this way would be valuable.

## Applications

- 18 From the beginning of our work the Inquiry realised that it was necessary to publicise our work as widely as possible so that as many of those who might be able to assist our work would be aware of our existence and would come forward to describe their experiences so that we would gather

as large a volume of evidence of experiences as possible. We organised a poster campaign at sites throughout Northern Ireland in February 2013. Rather than engage in conventional and costly newspaper advertising we decided to utilise other means to reach those who we felt would be able to assist us. The Chairman, Secretary and members of the Acknowledgement Forum made themselves available for press, radio and television interviews, including interviews given to radio stations in Australia and New Zealand.

- 19 The Inquiry also contacted a very large number of organisations throughout the rest of the United Kingdom, in North America and in Australia, which provide various means of contact for people who emigrated from Northern Ireland. These organisations were extremely helpful in publicising our existence and making material available through their websites, newsletters and other means of communication, and we are very grateful to them.
- 20 The Chairman also wrote to the leaders of the four main Christian denominations in Northern Ireland and the Republic of Ireland asking them to publicise the Inquiry's material through their respective church structures and publications. We are grateful to them, to the media and to the many organisations that helped publicised our existence.

### **Number of applicants**

- 21 Altogether 526 individuals applied to the Inquiry and the Acknowledgement Forum. The total of 526 includes two late applications that were admitted by the Inquiry, but excludes seven duplicates received in cases where an application had already been made.
- 22 Not all those who applied were within the Inquiry's Terms of Reference. Also a number of those who applied to the Inquiry subsequently withdrew their applications. Others did not maintain contact with the Inquiry. Despite a number of reminders by the Inquiry, fourteen did not continue to engage with us. In each of the fourteen cases the Inquiry closed the file, but was prepared to reopen it if the applicant subsequently wished to re-engage with us. Consequently, when duplicates and those outside our Terms of Reference are excluded, 493 individuals engaged with the Inquiry as applicants.
- 23 As the table below indicates, of the applicants who were within our Terms of Reference, 62.5% of applicants lived in Northern Ireland, of whom 22.1% lived in Belfast and 40.4% in other parts of Northern Ireland (approximately 12% of these lived in the North West of the province).



### Location of Applicants\*

| Location           | No.        | %          |
|--------------------|------------|------------|
| Belfast            | 109        | 22.1       |
| NI outside Belfast | 199        | 40.4       |
| ROI                | 22         | 4.5        |
| Scotland           | 7          | 1.4        |
| Wales              | 2          | 0.4        |
| England            | 82         | 16.6       |
| Europe             | 5          | 1.0        |
| USA Canada         | 4          | 0.8        |
| Australia          | 63         | 12.8       |
| <b>Total</b>       | <b>493</b> | <b>100</b> |

\* These figures do not include applications which were duplicates or were outside the Inquiry Terms of Reference.

As can be seen from the table below, 31% of applicants were age between 55 and 64, 24% were age between 65 and 74 and 10% were over 75.

### Age Profile of Applicants\*

| Age band     | No.        | %          |
|--------------|------------|------------|
| Up to 34     | 3          | 1          |
| 35-44        | 49         | 10         |
| 45-54        | 120        | 24         |
| 55-64        | 155        | 31         |
| 65- 74       | 118        | 24         |
| 75+          | 48         | 10         |
| <b>Total</b> | <b>493</b> | <b>100</b> |

\* These figures do not include applications which were duplicates or were outside the Inquiry Terms of Reference.

## Assistance to applicants

- 24 From the beginning, the Inquiry was acutely aware of the need to make the process of engaging with the Inquiry as straightforward as possible for those who wished to tell us of their experiences as children in residential homes or other institutions within our Terms of Reference. We made considerable efforts to reduce the amount of distress or strain experienced by those who wished to tell us about their experiences. We appointed a number of Witness Support Officers (WSOs) whose task it was to act as the point of contact for an individual applicant with the Inquiry. The intention was that each applicant would, wherever possible, deal with the same WSO when arrangements had to be made to speak to the Inquiry, whether that involved coming to speak to the Acknowledgement Forum, speaking to the Inquiry legal team or to give evidence during the hearings which were held at Banbridge.
- 25 Because we recognised how upsetting it could be for many of those who wished to describe their experiences to us we informed every applicant that, if they wished, they could be accompanied by a companion of his or her choosing when they spoke to the Inquiry, whether that was to the Acknowledgement Forum, during meetings with the legal team, and before giving evidence or while they were giving evidence in the Inquiry chamber. We also paid their travel, accommodation and other costs where necessary. The Inquiry paid approximately £145,000 for the travel, accommodation and subsistence of 320 individuals who travelled from all over the United Kingdom, from the Republic of Ireland, and from elsewhere in Europe in some instances. This included the cost of travel, accommodation and subsistence for those who travelled to various centres in Australia to meet the members of the Acknowledgment Forum, our Legal Team and Witness Support Officers who went to Australia in September and October 2013, and again in June and early July 2014, to talk to applicants living in Western Australia and other parts of Australia.
- 26 When it came to the time when individuals who wished to speak to the Statutory Inquiry during our hearings in Banbridge came to give evidence, in addition to providing them with the services of our Witness Support Officers, the Inquiry arranged to have a representative from Contact NI present in the Inquiry chamber in order to provide immediate comfort and reassurance to anyone who found the experience so upsetting that they felt the need for immediate assistance.

- 27 Throughout the life of the Inquiry we provided information to all applicants to help them contact the appropriate agency if they found the experience of recounting their experience to, or engaging with, the Inquiry to be stressful or distressing.

## The form of the hearings

- 28 It was central to our work that the Inquiry hearings were conducted in an inquisitorial fashion by Inquiry Counsel taking each witness through their evidence, whether that person was an applicant to the Inquiry or a witness called by the Inquiry, including witnesses from the institution under examination at the time or giving evidence on behalf of, or in respect of, issues that the Inquiry was investigating. The inquisitorial approach meant that each witness was able to give his or her evidence, and for that evidence to be thoroughly probed in an appropriate fashion, without the witness being subjected to inappropriate or unnecessary cross examination.
- 29 This did not mean that their evidence was taken at face value without being thoroughly probed and investigated. On the contrary, Inquiry Counsel and the Inquiry legal team went to great lengths to ensure that all relevant material was drawn to the attention of the Inquiry Panel and put to each witness. That was the case whether the material was supportive of, or undermined to some degree, the account given by the witness, whether the witness was describing his or her experiences, or speaking on behalf of an institution or organisation. As part of this process the legal representatives of the core participants and individuals, and their representatives where a core participant chose not to be legally represented, asked Inquiry Counsel to put additional points to each witness. Inquiry Counsel then raised the point with the witness in an appropriate fashion.
- 30 A public inquiry is obliged to ensure that the matters which it is considering are examined by it in an independent and thorough fashion. This means that the accounts given to it by organisations and individuals must be thoroughly probed and objectively assessed, whether the evidence comes from an applicant to the Inquiry or comes from the person against whom allegations of abuse, or some other failing, are levelled. Some applicants found it very difficult to accept that this process necessarily involved the views of institutions or individuals being put to them and their then being asked to comment upon whatever contrary view was being put forward. The Inquiry went to considerable lengths to ensure that all who appeared

before it received a calm and sympathetic, but objective, assessment and appraisal of their evidence. This process was greatly assisted by the skilful way in which Inquiry Counsel took all witnesses through their evidence in a sympathetic fashion, whilst still putting to them politely and firmly relevant matters that might be seen by the witness concerned to imply that their recollection was inaccurate in some respect.

## Gathering documents and evidence

- 31 Using its powers under section 9 of the 2013 Act the Inquiry issued notices to each core participant, and to individuals as necessary, requiring them to provide documents and witness statements, and to give evidence where appropriate. As a result of notices issued to institutions which were designated by the Inquiry as core participants, and to the PSNI, the Inquiry gathered a very large number of documents from various sources, including documents deposited with the Public Record Office of Northern Ireland (PRONI). Altogether 355,891 pages were included in the evidence bundles for the fifteen Modules into which the inquiry divided its public hearings. This was only a proportion of the total number of documents submitted to the Inquiry, and represented the documents which the Inquiry believed it should make available as necessary to witnesses and core participants to enable them to assist the Inquiry. The volume of material meant it was a laborious and time-consuming task for the Inquiry legal team to collate and analyse the documents in order to decide what needed to be examined in the public hearings.
- 32 We were well aware that many applicants would find it extremely distressing if their experiences, whether described in public to the Inquiry, or in confidence to the Acknowledgement Forum, were attributed to them by name. Many had never disclosed their experiences to anyone, or only to some, but not all, of their families. We believed that if such individuals were to be publicly identified by name this would act as a considerable deterrent to witnesses coming forward to assist the Inquiry. Some of those who came forward as applicants were themselves the subject of allegations by other applicants that they had also abused applicants whilst resident in institutions within our Terms of Reference. Some of those against whom allegations were made were either dead or in poor physical or mental condition and therefore unable to give evidence on their own behalf in response to the allegations.

- 33 We wish to acknowledge the willingness to answer our requests shown by all the core participants and other institutions or bodies who were asked to produce documents, and to trace witnesses, by the Inquiry, whether these were non-devolved departments and agencies; religious bodies such as Roman Catholic dioceses and religious orders, or the Police Service of Northern Ireland to name only some of those who helped us. We were well aware that our requests to trace documents, and identify whether possible witnesses were still alive and able to help us, imposed considerable burdens on institutions and other bodies, and their legal representatives. Their co-operation meant that we were able to obtain many important documents whose very existence and significance was hitherto unknown.
- 34 As our Terms of Reference covered 73 years many relevant bodies ceased to exist, or their names and functions were changed, sometimes radically. As a result it is not always easy to trace the successor body, if there was one. Particularly after the Macrory reforms of the 1970s there were significant changes to the structure of both local and central government, and to the names of bodies concerned with matters within our Terms of Reference. Thus the county welfare authorities were replaced by the health and social services boards, which then were replaced by a single board and fewer health and social care trusts. During the Inquiry itself, the Department of Health, Social Services and Public Safety (DHSSPS) became the Department of Health (DoH).
- 35 We decided that the majority of those who were describing their experiences, and those against whom allegations were made, should therefore be given designations to protect their anonymity. Core participants and relevant witnesses were made aware of the identity of the person to whom the designation was given so that the institution or individual could respond to what that person was saying as necessary. It was always open to an individual to waive that anonymity if they wished to do so, and whilst a minority waived their anonymity the great majority wished to retain their anonymity. Those witnesses and others who did not waive their anonymity were, and will continue to be, protected by the anonymity conferred upon them by the Inquiry.
- 36 The Inquiry held 223 days of hearings at Banbridge Courthouse, almost all of which were held in public. Eighteen hearings in 2014 and 2015 took the form of closed hearings solely to avoid prejudice to criminal trials that were imminent at that time. Transcripts of the proceedings during the remaining days have been placed on the Inquiry website, although they

have been redacted as necessary to comply with the Inquiry's anonymity and redaction procedures. In the same way, the documents brought up during the Inquiry hearings and publicly displayed in the Inquiry Chamber have been, or in due course will be, placed on the Inquiry website, although those documents will also be redacted as necessary to comply with the Inquiry's anonymity and redaction processes. The redaction process of those documents has proved to be more complex and time consuming than anticipated, and so not all documents will have been placed on the Inquiry website by the time this Report is published. The remainder will be placed on the website in due course.

## Assessment of evidence

- 37 As will be apparent from the Terms of Reference which required the Inquiry to examine residential institutions for children over a period of 73 years between 1922 and 1995, many of those who gave evidence to us, whether as applicants or other witnesses, were being asked to describe events that occurred many decades in the past, most were being asked to recall events between 30 and 60 years ago, and some events more than 70 years ago. The passage of time naturally created considerable difficulties for many of those who were asked to recall events that occurred so long ago. Some of those against whom allegations were made were dead, others were too physically frail to give evidence in person, or their mental health or memory had failed to such a degree that they were not able to give reliable evidence. Where medical evidence was produced on behalf of a witness the Inquiry considered that evidence. If we were satisfied the witness was unfit to provide a statement, or to attend to give evidence in person, their statement was admitted without them giving evidence in person, or they were excused from providing evidence to the Inquiry. For example, in the case of HIA 128 where the Inquiry was satisfied that he was extremely vulnerable, very suggestible and would have difficulty in answering questions, the Inquiry felt it was inappropriate to put him through the ordeal of giving evidence and his statement was read and noted by the Inquiry.
- 38 The Inquiry was well aware that the passage of time may render recollections inaccurate, or those recollections may be coloured to a greater or lesser degree by discussions with others, or by accounts that the individual has been made aware of in later years. Another factor was that adults describing events which occurred when they were children may not always

have appreciated at the time all of the relevant circumstances surrounding the actions of the adults, such as the post-war shortages of food and other items that may have affected the way in which they were looked after as children. Equally, events that may seem routine at the time, and hence not memorable, may be forgotten in adult life, such as routine trips to see a doctor or a dentist. In contrast, despite the passage of very long periods of time, some events may have been of such significance at the time that they can be vividly and accurately recalled many years later, for example where a child was repeatedly beaten in front of others or humiliated in front of others for some reason, such as being made to carry wet bed sheets past others to a laundry when they had wet the bed.

- 39 Where contemporary documents and records survived, and many records had either not been compiled in the first place, or had long since been disposed of by institutions and government departments and agencies as the result of normal document disposal procedures, the documents often threw light on the recollections of those who were being asked to recall events of many years before. The collection of documents, and analysis of their content, was therefore central to our work. All those institutions and organisations who were asked to produce documents went to great lengths to comply with our requests. We recognise that this meant the expenditure of a great deal of time and effort, and consequent expense, on the part of those who received such requests and we are very grateful for their co-operation.

### Role of the Inquiry

- 40 The Inquiry was not a court and was expressly precluded by Section 1 (5) of the 2013 Act from (a) ruling upon, or (b) determining, any person's civil or criminal liability. This meant the Inquiry could not make a finding that rendered an individual or an institution guilty of a criminal offence, or subject to civil liability. That is the responsibility of the civil and criminal courts. However, this does not mean that the Inquiry could not identify acts or omissions which, if the same evidence were given in civil or criminal proceedings, might result in the award of damages or some other remedy, or a conviction. If the Inquiry could not make such findings it would be severely hampered in performing the task imposed upon it by its Terms of Reference within the statutory framework created by the legislature.
- 41 The Terms of Reference of our Inquiry required us to identify whether there were systemic failings on the part of an institution, which meant any body,

society or organisation with responsibility for the care, health or welfare of children in Northern Ireland which provided residential accommodation and took decisions about and made provision for the day-to-day care of children under 18 between 1922 and 1995. Conclusions as to whether or not systemic failings existed can only be made once the Inquiry has identified acts or omissions that could be considered to amount to a systemic failing on the part of the institution, body or individual concerned. For example, if A says he or she was physically or sexually assaulted by B, it is necessary to decide whether or not that happened. Only if the Inquiry is satisfied that there was a relevant act or omission on the part of an individual or an organisation can the Inquiry then proceed to consider whether, in those circumstances, and in the light of that finding, there was a systemic failing on the part of the body or institution concerned.

- 42 In general the Inquiry sought to avoid reaching conclusions of fact in relation to specific acts or identifiable individuals where it was possible to arrive at conclusions as to systemic failings without identifying an individual or a specific incident. For example, if ten individuals alleged that one person assaulted them in some way, and if the Inquiry was satisfied that some of those allegations were credible then it was unnecessary for us to specify which of the accounts were reliable and which were not. However, there were a small number of situations where the Inquiry had to identify whether a specific individual did or did not do something in order to determine whether or not there was a systemic failing. If, for example, an individual was alleged to have repeatedly committed sexual offences against children in his or her care, the Inquiry had to reach a view as to whether or not those events occurred in order to determine whether or not there was a systemic failing by an individual or an institution.

### **Standard of proof**

- 43 The 2013 Act is silent as to the standard of proof to be applied by the Inquiry when reaching our findings. The 2013 Act mirrors the provisions of the Inquiries Act 2005, and the standard of proof to be adopted by inquiries under the 2005 Act and other types of inquiry has been considered on several occasions in recent years. We do not consider it necessary to engage in a review of these authorities because we adopt the approach identified by Sir William Gage in the *Baha Mousa* Inquiry where he explained that he was not obliged to adopt the criminal standard of proof, that is proof beyond reasonable doubt. He concluded:



“In order properly to report who is responsible, in my judgment, I must reserve to myself the right to state, were I find the evidence sufficient, that I find a fact proved on a balance of probabilities. To do otherwise would necessarily be to limit my findings of responsibility to the high criminal standards.”

We have applied the same test to the evidence before us and in our assessment of the evidence.

## **The standards against which historic practices should be compared**

- 44 Our Inquiry was obliged to consider matters stretching over many decades. Over that period of time there have been changes in what is regarded as acceptable or unacceptable behaviour towards children, and in what are regarded as proper standards of accommodation and childcare for children in residential care. If we were to judge what happened many years ago by the standards of today that would mean imposing today’s standards on the past with the advantage of hindsight. We did not consider that that was the correct approach to take. Throughout, we approached the evidence we heard on the basis of what we believed to be the appropriate standards of care that should have been applied by the residential institution at the time we were considering. That required us to take into account the economic and social circumstances at the time, the level of professional training and competence to be expected at the time, and other relevant factors that related to the period under consideration.

## Part Two

- 45 When deciding which institutions to examine we took into account a number of factors. The first was the number of applicants who complained about an institution. The second was the nature of the complaints, and the third was the type of institution. As will be apparent from the various chapters, the largest numbers of applicants wished to speak about their experiences when in four homes run by the Sisters of Nazareth, the next largest number being those who wished to describe their experiences in Rubane House or in St Patrick's Training School, both of which were run by the De La Salle Order. We decided to investigate the following homes.

### Local Authority Homes

Lissue Hospital, Lisburn  
Kincora Boys' Home, Belfast  
Bawnmore Children's Home, Newtownabbey  
Fort James, Londonderry  
Harberton House, Londonderry

### Juvenile Justice Institutions

St Patrick's Training School, Belfast  
Lisnevin Training School, Newtownards, County Down  
Rathgael Training School, Bangor  
Hydebank Young Offenders' Centre  
Millisle Borstal

### Secular Voluntary Homes

Barnardo's Sharonmore Project, Newtownabbey  
Barnardo's Macedon, Newtownabbey

### Roman Catholic Voluntary Homes

St Joseph's Home, Termonbacca, Londonderry  
Nazareth House Children's Home, Londonderry  
Nazareth House Children's Home, Belfast  
Nazareth Lodge Children's Home, Belfast  
De La Salle Boys' Home, Rubane House, Kircubbin  
St Joseph's Training School for Girls, Middletown, Co Armagh  
Three institutions run by the Good Shepherd Sisters in Derry/Londonderry, Belfast and Newry

### Church of Ireland

Manor House, a children's home near Lisburn.

- 46 We carefully reviewed every one of the remaining homes and institutions in respect of which an individual made a complaint to see whether or not a full public investigation of the type we conducted in respect of the above homes and institutions was absolutely necessary to add further information to the picture of the nature and extent of systemic failings on the part of the homes and institutions, and on the part of the state, that emerged based on the evidence we received from our investigations into the other homes and institutions. We decided that an examination of the homes and institutions listed above was sufficient to provide the Inquiry 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 were within our remit. This was because we believed that our understanding of the nature and extent of the abuse, and of the systemic failings that allowed abuse to happen, would not be improved by conducting full scale investigations into other homes and institutions. There was no home omitted from our investigations in respect of which there was a substantial number of complainants.
- 47 We conducted a small number of targeted paper investigations into six homes or institutions in respect of which there were complaints by individual applicants which we felt required further examination. When considering which homes should be the subject of investigation requiring full documentation and oral hearings, it became apparent that there were some homes where there were specific causes of concern such as serious incidents, possible systemic failings or the actions of a member of staff which warranted targeted paper-based investigations without taking into account the whole of the homes' histories and functioning. Targeted investigations were undertaken concerning individual allegations relating to five homes and one hospital. We have made no finding of systemic abuse or failure in relation to any of the six establishments.
- 48 Altogether applicants made allegations of some form of abuse in respect of 65 institutions or homes. We investigated twenty two in our public hearings, and a further six were the subject of targeted paper investigations, making twenty eight institutions or homes we investigated in all. The remaining thirty seven institutions or homes were each the subject of allegations by two applicants at most, and in some case by only one applicant. In each of the thirty seven remaining cases the panel considered the statements and/or accounts given by each applicant. Having done so we decided that our understanding of the nature and extent of the abuse, and of the systemic

failings that allowed abuse to happen, within all the types of homes and institutions within our remit would not be improved by conducting full scale investigations into any of those thirty seven homes and institutions. As the Chairman emphasised in his remarks of 4 November 2015, this did not mean that we had decided that abuse did not occur in those homes or institutions, nor did it have any effect on our recommendations for compensation and other forms of redress that we make in Chapter 4.

- 49 There were also further homes which we considered where applicants had lived but about which they had made no, or minimal, complaints, and which did not merit any investigation by us.

## Reports to the police

- 50 Almost all of the allegations made by applicants to the Inquiry were capable of amounting to criminal offences if they were substantiated. We referred each such complaint to the relevant police force for investigation, and in almost all cases this was the PSNI. In a few cases where the complaint was made by or about a person living elsewhere in the United Kingdom the matter was referred to the appropriate force.

## Other investigations

- 51 We also conducted investigations into two issues that became apparent at an early stage of our evidence gathering. The first was that a large number of children were sent to Australia as part of what was called the Child Migrants Programme or Child Migrants Scheme. Many of the applicants who were sent to Australia as children complained that this was itself abusive. The second was into the allegations that Fr Brendan Smyth sexually abused children who were in residential children's homes in Northern Ireland that were within our Terms of Reference.

## Kincora and the non-devolved Departments and Agencies

- 52 As we explain in Volume 8 Chapter 25 the Inquiry agreed to the request by the Secretary of State for Northern Ireland to include in our investigations the allegations relating to Kincora and the non-devolved departments and agencies which are the constitutional and legal responsibility of Her Majesty's Government and not the responsibility of the Northern Ireland Executive and the Northern Ireland Assembly.

## The economic and social background

- 53 Whilst it is not for this Inquiry to engage in an extensive historical review of social and economical conditions in Northern Ireland during the 73 years covered by our Terms of Reference, those conditions cannot be ignored when considering the resources available to residential institutions, public authorities and government in the field of residential childcare. The statistics to which we refer are merely some indicators of what was generally a very challenging economic and social background against which the activities of the residential institutions, public authorities and the Government have to be viewed.
- 54 For many years the financial circumstances and living conditions of a substantial section of the population of Northern Ireland were extremely poor. For example, between 1923 and 1926 the unemployment rate remained between 20% and 23%.<sup>1</sup> Despite a number of public work schemes that were provided in an attempt to reduce unemployment, in the early 1930s unemployment in Belfast reached almost 30%.<sup>2</sup> Whilst unemployment rates were lower after the Second World War, in 1946 the average percentage of male unemployed was 10.7%, although this declined to 7.6% in 1948.<sup>3</sup> In the 1950s and 1960s unemployment remained stubbornly high, particularly male unemployment. Thus as late as 1958, the average yearly percentage of male unemployment was 10.1%, whilst that for females was 7.8%, giving an average yearly percentage of 9.3%.<sup>4</sup>
- 55 The decline of employment in traditional industries such as linen and ship building was to some degree offset by an influx of large employers in the synthetic fibre industries during the 1950s and 1960s. In the post-war period the Northern Ireland Government made considerable efforts to attract new industries to Northern Ireland in an effort to reduce unemployment and improve overall prosperity. The Industries Development Act (Northern Ireland) 1945 enabled an estimated additional 31,000 jobs to be created by the provision of two million square feet of government-owned factory

---

1 Moreau, Piere-Vincent, 'Poverty Relief and the Economic Crisis in the Region of Belfast from 1921 – 1939 (The Workhouse – workhouses.org) <http://www.workhouses.org.uk/Belfast/moreau2.pdf> p.5.

2 Piere-Vincent Moreau, 'Poverty Relief and the Economic Crisis in the Region of Belfast from 1921 – 1939 (The Workhouse – workhouses.org) <http://www.workhouses.org.uk/Belfast/moreau2.pdf> p.6.

3 *Ulster Year Book* 1950 (Belfast: HMSO, 1950) p.194.

4 *Ulster Year Book* 1957 – 1959 (Belfast: HMSO, 1959).

space. This enabled 200 firms to be assisted. One commentator has suggested that:

“The promotion of government-funded advanced factories rather than social housing was to get preferential treatment in the post-war reconstruction of the 1940s and 1950s. ...On the negative side, the [1945 Act] hindered raising the quality of the Province’s housing stock because resources used in building these factories could have been invested in housing”.<sup>5</sup>

- 56 Although the Northern Ireland Government’s drive for new industries created almost 72,000 new manufacturing jobs after 1945 – over 44% of total employment in manufacturing industry<sup>6</sup> – the rising oil prices and excess capacity in synthetic fibre production in Europe, and increased competition from low-wage developing countries, had a very severe effect on Northern Ireland industry by the 1980s.
- 57 Housing conditions for many remained extremely poor, particularly in Belfast. The German bombing raids of Belfast in April and May 1941 resulted in the destruction of 3,200 houses, and a further 53,000 were damaged. A sample of rural life in five areas of Northern Ireland involving 1018 houses carried out in 1944 revealed that just 8% of the houses had mains water supply, and only 6% had mains sewerage or satisfactory private water-borne disposal. Some areas, particularly in the west of the province, were found to be very much worse than average. It was estimated in 1947 that “96% of all houses in County Fermanagh have no running water.”<sup>7</sup>
- 58 Whilst the 1960s and early 1970s were marked by major slum clearance and redevelopment schemes, particularly in Belfast, the 1974 *House Condition Survey* showed that less than half of Belfast’s 123,000 homes were sound, around 30,000 were unfit, and a further 32,000 were in need of improvement or major repair. Over 40,000 of the total housing stock lacked one or more of the five basic amenities of a water closet, fixed bath or shower, wash-hand basin, kitchen sink, hot and cold water.<sup>8</sup>

---

5 Brownlow, Graham, ‘The causes and consequences of rent-seeking in Northern Ireland, 1945-72’, *Economic History Review* 60:1 (2007) p.77.

6 *Ulster Year Book* 1975 (Belfast: HMSO, 1975) p.110.

7 Melaugh, *Majority Minority Review 3: Housing and Religion in Northern Ireland* (Centre for the Study of Conflict, University of Ulster, 1994) <http://cain.ulst.ac.uk/issues/housing/docs/mm31.htm> (webpage, no page reference).

8 *Ulster Year Book* 1980 (Belfast: HMSO, 1980) p. 115.

## Part Three

- 59 In this Part we set out observations on residential childcare practice in relation to our findings, largely grouped under the headings of the main types of alleged abuse.

### Changes in residential childcare

- 60 It is important to first acknowledge that there were very significant changes in residential childcare during the seven decades covered by the Inquiry's Terms of Reference, which stretched from 1922 to 1995. The oldest witness who gave evidence to the Inquiry was in a children's home in the late 1920s, almost ninety years ago. Compared with care provided at that time, the conditions in which children were accommodated had improved greatly by the 1990s. For example, physical standards of care were much better, staffing levels were increased and staff training was improved. Children were cared for in smaller groups and there was an emphasis on siblings being cared for together. Children received greater individual attention with the introduction of key workers, and field social workers visited children in homes more regularly. Formal reviews were introduced and increasingly children and their families were involved in care planning.
- 61 The reasons for children being in care also changed over the decades. In the early decades of our remit many children were placed in care on a private basis because they were illegitimate or their parents were unable to provide for them. These children tended to stay all of their childhood and early youth in residential care. By the 1970s and 1980s more preventive measures and greater practical support to help maintain children within families and less stigma about illegitimacy meant that fewer younger children were admitted to care. Where it was considered necessary to accommodate young children outside their families, fostering was seen as the most appropriate form of care. Older children continued to be admitted to residential care although in smaller numbers and mainly because they were deemed to be beyond the care and control of their parents and in some cases were getting involved in petty crime and/or anti-social behaviour associated with the Troubles. These young people tended to stay in care for shorter periods and the focus was on returning them to their families.

- 62 We are also aware that further improvements have been introduced in the twenty-one years since 1995, and in particular, social workers and residential childcare workers are now registered and regulated by the Northern Ireland Social Care Council and they and their employers are required to adhere to Codes of Practice.

## Sexual abuse

- 63 The sexual abuse of children and young people by staff was one of the two main areas of complaint we received. There were some instances in which female staff were alleged to have sexually abused either boys or girls. However, by far the majority of the alleged abuse was by male staff, and because of the historical patterns of staffing, the predominant type of abuse alleged was of male staff abusing boys. The alleged abuse ranged from inappropriate touching and fondling of boys who were fully dressed to anal rape. While there was some evidence about grooming behaviour, in many cases intimidation and physical abuse occurred in tandem with the sexual abuse.
- 64 In some of the homes we investigated there were multiple sexual abusers. We are aware that this phenomenon has also occurred in children's homes and boarding schools in other countries. In one case there were two abusers who knew each other prior to taking up post; in another case all the care and teaching staff were of the same gender as the children; in another instance the head of the home was an open abuser, which will have reduced any chance for the children to report abuse and may have encouraged other staff who were inclined to also abuse. But none of these factors was apparent in every instance or sufficient to explain the numbers of abusers in these homes. We consider that this is an area that would benefit from further research.
- 65 We found that from the mid-1980s there were significant improvements in the awareness of managers and staff of the risk of sexual abuse in residential care, complaints processes for children and investigation of complaints and use of disciplinary procedures. However, we still found examples of a lack of rigour in selection procedures, a lack of regular supervision of staff, poor use of disciplinary processes including examples of staff who were suspected of sexual or physical abuse of children being moved to a different establishment or allowed to leave their post without the completion of proper disciplinary processes. Therefore, we would emphasise that rigorous recruitment practice and regular supervision of staff are essential elements in keeping children safe in residential care.



- 66 We heard many allegations of sexual abuse by peers. These related mainly to boys, though there were some instances concerning girls. Strictly speaking, it may be inaccurate to term the abusers ‘peers’, as they were mostly a few years older than their victims. Many of the witnesses who faced allegations of the sexual abuse of their juniors told us they had been abused by older boys when they were younger. It was also the case that some of this learnt behaviour manifested itself as part of wider bullying by older boys. Some appeared to have genuinely forgotten they initiated any such behaviour but it was clear it was still a source of painful memories to the victims. The complaints about peer sexual abuse mainly dated back to times when children were being accommodated in large dormitories in over-crowded and poorly staffed children’s homes.
- 67 Where sexual activity occurred between those of approximately the same age it generally did not lead to complaints, as it was seen by the participants as normal and not a source of concern, and it could sometimes be attributed to adolescent exploration.

## Physical abuse

- 68 Physical abuse by staff was the other main sources of complaint. In the early decades of our remit the use of corporal punishment was generally accepted within families and schools and the statutory regulations governing the provision of residential childcare included directions about how corporal punishment should be administered and recorded. However, there were periods in certain homes when a culture of informal physical punishments was pervasive. Witnesses clearly distinguished between the administration of formal and informal physical punishment as a direct consequence of their misbehaviour and the random application of excessive physical abuse which they experienced as staff exercising power and control over them. We heard evidence of some staff who clearly lost their temper and applied uncontrolled physical punishment. In some institutions staff were said to have used a variety of implements to beat children, including canes, belts, sticks, slippers and other items which came to hand such as curtain rods.
- 69 The actions of these staff were not only counter to the statutory regulations about administration of corporal punishment but also counter to their organisations’ policies about the discipline of children. The impact of the culture of informal punishments, especially when underlined by more serious violence on the part of staff, was significant. Many witnesses told

us they were terrified, not knowing when they might be the subject of punishment. It was clear that for many witnesses the experience of seeing excessive physical force used against other children coupled with the fear of being subject to random violence was almost as, and in some cases more, damaging than the actual physical chastisement they received.

- 70 This was an area of abuse where individual staff members were influential; a small number were identified as being seriously abusive, but there were others who, while they were more benign, took no action to report or limit the behaviour of their colleagues. While physical chastisement of children is no longer acceptable and has no place in residential care the exercise of authority by staff still needs to be carefully supervised and monitored, and workers need support and training to deal safely and effectively with the volatile and at times aggressive situations that can be a feature of residential childcare. In addition, workers need to take individual responsibility for managing their behaviour and addressing and/or reporting any inappropriate behaviour by colleagues. While senior staff have a particular responsibility for being alert to abuse, it is also the responsibility of the whole staff team and other professionals who relate to homes such as field social workers. It may well be a junior member of care staff or an ancillary worker whom a child feels comfortable approaching and telling about abuse. Each person who may be approached in this way therefore has the responsibility for listening and reporting onwards as appropriate and persisting until satisfied that the message has been heard and acted upon.
- 71 The values and attitudes of every member of staff are important, but those of the head of the home are particularly significant in setting the tone and expectations for both staff and children. From the evidence we heard there were excellent heads of home who introduced new and enlightened practices and witnesses talked of how their influence greatly improved the quality of their lives. Sadly, there were those who abused children and whose conduct left the children with no one in authority to whom they could complain.
- 72 As with sexual abuse by peers, the majority of the allegations concerning physical abuse by peers were about young boys being bullied and physically abused by older boys who had been left in charge of them. Some witnesses talked about the maintenance of status in “pecking orders” and expressed the view that some degree of bullying was to be expected. However, others described being physically intimidated and beaten by other boys

on a continual basis and indicated that at times this abuse occurred with the knowledge and implied approval of staff. It was significant that when the homes in question were remodelled and modernised, with smaller bedrooms and better staffing, the complaints we received about peer physical abuse and bullying reduced dramatically.

- 73 Some institutions faced major problems of absconding, and secure rooms or suites were used to ensure that unsettled children did not absent themselves and were also used to provide time-out for children who were misbehaving. Such a solution should only be temporary; however, from the evidence we heard it was clear that in some institutions there was overuse of this provision. It was also the case that in some homes without secure rooms children were shut in confined spaces such as brush cupboards or drying rooms. This was strictly against the Regulations.
- 74 A major source of complaints in two homes during the later years of our remit concerned restraint. We recognised that there were times when children and young people had to be restrained, because of the risk of them harming themselves or others, or doing serious damage. However it was clear that not all staff received appropriate training in the use of alternative techniques such as diversion or talking through situations which meant that in some homes restraint was used too often. Also, where staff were not properly trained in safe methods of restraint some witnesses were left feeling frightened and physically abused rather than safely contained.
- 75 In one institution we found evidence that drugs had sometimes been administered primarily to control children. While it is not for us to comment on medical matters, the use of drugs in this way for social care purposes is clearly unacceptable.

### **Emotional abuse**

- 76 It was clear from the evidence that there was a strong link between emotional abuse and sexual and physical abuse. Indeed, often it appears to have been the anguish caused by the sexual and physical abuse which made the sexual and physical abuse memorable. We found, though, that there were also other practices which were emotionally abusive.

- 77 Some staff appear to have used various ways of humiliating children, such as:
- name-calling, perhaps picking on the unattractive features of a child;
  - denigrating the parents or family of a child;
  - suggesting a child had inherited the negative qualities of a parent and would never be of value; or
  - showing a child up in front of the group, in relation to a personal matter, which the child would have wanted to be treated confidentially such as bedwetting, deafness or menstruation.
- 78 This type of abuse was mainly a feature of large children’s homes run by Roman Catholic congregations and appeared at some level to be prompted by a wish to ensure that children did not repeat what was seen as the “sins” of their parents and also a concern that children should not “get above themselves”. Clearly such behaviour was unacceptable and had a profound impact on witnesses. Many told us of how the subsequent low self-confidence and poor self-esteem have adversely affected their ability to establish and maintain successful adult relationships and parent their children. Again, we found that complaints about these forms of cruelty diminished when staffing levels increased and staff training was improved.

## Neglect

- 79 The most serious complaints about food, clothing, bathing conditions and other aspects of physical neglect appear largely to date back to the 1940s and 1950s, at a time when there were also poor conditions in some family homes and widespread poverty in the community at large. Standards were undoubtedly well below the acceptable in some homes. Witnesses described poor food, inadequate toilet facilities and lack of heating in the large homes which were not designed to accommodate large numbers of children. In the later decades, physical standards in homes improved greatly with the assistance of government funding and there were instances where the resources and facilities available to children were beyond those they would have enjoyed in their family homes and local schools.

## Unacceptable practices

- 80 Some of the unacceptable practices reported to us by witnesses included the confiscation of personal possessions, force-feeding, excessive chores, queuing for bathing, the use of Jeyes fluid, and the systems used for the

management of enuresis. These practices were particularly prevalent in the 1950s and 1960s in homes where very few staff were managing large numbers of children. None of these practices would now be considered acceptable.

## Underlying Issues

### Governance and Finance

- 81 We came across a range of issues which were not systemically abusive of children or young people but were systemic failures, sometimes with consequences for the resident group. As we explain in detail in Chapter 2 we found significant weaknesses in governance arrangements including a lack of clarity about the role of management committees and a failure of some committees to monitor the quality of the conditions children were living in and the direct care they were receiving. There were also examples of management committees not being informed about complaints concerning serious sexual and physical abuse of children by staff.
- 82 As with other aspects of residential childcare, governance arrangements improved over the decades and by the 1980s monitoring arrangements were in place, were regularly adhered to and properly recorded and reported. However, we found in some instances that although a significant amount of resources were invested in monitoring and resulted in senior managers and Committee members achieving a good understanding of the challenges facing particular homes they proved less effective in addressing the resource and strategic management issues that were contributing to the challenges.
- 83 In relation to lack of resources we found this affected not only the quality of physical care which homes could offer but more importantly the level of staffing. Low staffing levels were a feature of large voluntary homes, which often were dependent on members of religious communities working very long hours looking after large numbers of children. This led to older children resident in the home and previous residents returning to visit the home being put in charge of younger children and this provided conditions which enabled the physical and sexual abuse of younger children.

### Sizes of homes

- 84 Approximately four out of every five applicants to the Inquiry were in one of the large children's homes, mainly in the 1950s to 1970s. We have referred above to how unacceptable practices, particularly in relation to

bathing and excessive chores, were a feature of such homes. It was also clear that many of the children and young people in these home did not get the individual attention they needed, which led to some misbehaving to gain attention and others feeling uncared for and lacking in self confidence.

- 85 We were interested to note that as early as 1950 the Home Office issued guidance on good quality residential childcare which advocated smaller homes and included an appendix on ways in which larger homes could be broken down internally into smaller family-sized groups. However, it was the case that mainly because of lack of resources, though also because of lack of agreement about what form revised accommodation should take, it took until the late 1960s/early 1970s before such changes were introduced in the larger voluntary children's homes in Northern Ireland.

### **Sound standard residential childcare**

- 86 We received evidence from many witnesses which indicated that, in the earlier decades in particular, the professional standards of care were poor. Some homes kept virtually no records of children's progress. In the case of children privately placed in homes there was little assessment of children's needs and no move to see whether reintegration into their families was possible. In the earlier decades, even when welfare authorities were involved in placing a child in a home, there was often very limited follow-up contact maintained with the children. Consequently, there were no individual care plans, no monitoring of the progress of the children or consideration of their future needs. A number of witnesses described being discharged from children's homes at short notice and being unprepared for life after care and receiving minimal ongoing support. While people who had left homes were often welcomed back for a meal or visit there was no systematic follow-up. This was particularly marked in the case of children who had been sent to Australia who for all intents and purposes appeared to have been forgotten.
- 87 Over time, standards improved and sound professional practices were introduced. There was evidence from the 1970s onwards of: assessment of children's needs; the planning of care programmes; the maintenance of family contact where possible; the availability of systems of advocacy and for making complaints; and, aftercare on returning home or living independently. Many witnesses told us they felt they had no-one to turn to about the abuse they were suffering and some told us they did report the abuse but were not listened to or believed. The evidence we received

suggested that this improved so that by the 1980s and 1990s children's allegations and complaints received proper attention. There is no doubt that greater awareness of the risk of physical and sexual abuse in residential children's homes, particularly in the aftermath of the identification of abuse in Kincora and Rubane, meant that greater emphasis was placed on external monitoring of children's homes and having proper procedures for children and their families to raise concerns and make complaints.

- 88 In this section we have summarised the types of abuse we have heard about and indicated how standards and conditions improved over time. Although we found evidence of systemic failings in every decade of our remit it was the case that in some homes improved staffing levels, better qualified staff, smaller group living and more external governance of homes led to enormous improvements in the care children received. It is also important to acknowledge that throughout the decades some staff provided good care and warmth to children and were genuinely concerned to help them grow and develop and often worked unstintingly with little support to do so. We are of the view some staff abused children both physically and sexually, and even took pleasure in doing so. However, we recognise that there were other staff who responded inappropriately under the extreme pressure of caring for too many children with little training and support and in poorly designed and inadequate conditions.

## Part Four

### The format of the Inquiry and the Report

- 89 The Inquiry divided the institutions and issues investigated into fifteen modules, and, as appropriate, one or more issue or institution was examined in each module. Institutions, organisations and individuals being investigated in a particular module were provided with the documentary evidence gathered by the Inquiry which we felt was relevant to the issue(s) to which the person or organisation could be expected to speak and assist the Inquiry. Individuals, bodies and institutions were asked to deal with relevant issues identified by the Inquiry in their witness statements, and at the end of each module were given the opportunity to make written and oral submissions in respect of matters raised by the Inquiry, or alleged by individuals or other organisations. Most individuals, institutions and other bodies made submissions at this stage, and some took the opportunity to admit systemic failings and express regret for those failings.
- 90 The panel then prepared a draft chapter or chapters dealing with the institution or issues considered in each module. After the public hearings each institution or individual who was subject to a criticism in the draft Report was sent a Warning Letter and invited to respond by a certain date, the time allowed for responses being calculated to allow for the nature of the criticism and the length of the part of the Report provided to them. In those cases where an individual was criticised but had not been asked to give evidence to the Inquiry, or in some cases had been offered the opportunity to give evidence but had declined to engage with the Inquiry, the individual was offered legal representation at the expense of the Inquiry (if their means required this) and the opportunity to make submissions.
- 91 The responses were then considered by the Inquiry panel and the draft amended if necessary as we considered appropriate having taken the submissions into account.
- 92 The Report consists of twenty-nine chapters comprising nine volumes. The tenth volume consists of the Report of the Acknowledgement Forum.



## The cost of the Inquiry

- 93 There will be expenditure by the Inquiry after the delivery of the Inquiry Report, and its publication, associated with winding up the Inquiry and placing the Inquiry Record with the Public Record Office of Northern Ireland. Including these costs the estimated cost of the Inquiry is £13,250,000, of which an estimated £575,000 will be borne by the Northern Ireland Office because it represents the additional cost to the Inquiry of investigating the non-devolved departments and agencies in the context of Kincora. This means that the net cost of the Inquiry to the Northern Ireland Executive is estimated to be in the region of £12,675,000. This represents the costs incurred by the Inquiry, and does not include the costs of Northern Ireland Executive departments or other agencies, which were not the responsibility of the Inquiry.

## Appendix 1

### Definitions of abuse and systemic failings

The Terms of Reference of the Inquiry required it to consider whether “there were systemic failings by institutions or the state in their duties towards those children in their care”, children in this context being children in residential institutions (other than schools). This required the Inquiry to address three questions. (a) What were the duties of the institutions and the state towards the children? (b) What constituted “abuse”? (c) What amounted to “systemic failings”?

The Inquiry applied the following broad definitions when considering the evidence it gathered. These were intended to be broad, general definitions because the Inquiry did not seek to exhaustively define in advance everything that might amount to “abuse” or “systemic failings”, and therefore when the Inquiry came to consider specific circumstances it was sometimes necessary to amplify these definitions in the context of those circumstances.

1. The duty of an institution was to provide an environment in which the children in their care would (a) receive proper physical care in the form of food, clothing, accommodation and medical attention; (b) be free from emotional, physical, or sexual abuse, or from neglect; and (c) develop through the provision of childcare in accordance with standards acceptable at the time
2. The state had the same duty towards children as a voluntary or religious institution where the state directly provided residential institutional care, either by central government in the form of places of detention, hospitals or residential schools for children with special needs or by local government, and later by public bodies such as health and social service boards or health and social care trusts.
3. The state also had a separate duty to ensure that all institutions maintained proper standards of care of the children in the institutions because (a) it was obliged by law to regulate and inspect the institutions, or (b) it funded either all or part of the capital and/or running costs of the institutions.
4. “Abuse” was behaviour which either (a) involved improper sexual or physical behaviour by an adult or another child towards a child; or (b) in the case of emotional abuse, was improper behaviour by an adult or another child which undermined a child’s self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or (c) resulted in

neglect of the child; or (d) took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships, which ignored the interests of the children.

5. A “systemic failing” by an institution consisted of either (a) a failure to ensure that the institution provided proper care; or (b) a failure to ensure that the children would be free from abuse; or (c) a failure to take all proper steps to prevent, detect and disclose abuse, or (d) take appropriate steps to ensure the investigation and prosecution of criminal offences involving abuse.
6. A “systemic failing” by the state consisted of a failure to ensure either (a) that the institution provided proper care; or (b) that the children in that institution would be free from abuse; or (c) a failure to take all proper steps to prevent, detect and disclose abuse in that institution, or (d) take appropriate steps to investigate and prosecute criminal offences involving abuse.
7. “Systemic failings” could also have taken place in one or more of the following ways:
  - (a) where some or all of those who had contact with children in residential establishments, including volunteers and visitors, adopted abusive childcare practices in common;
  - (b) where staff in managerial positions within residential establishments initiated, encouraged or condoned abusive childcare practices;
  - (c) where people in positions of responsibility for the institutions running residential services initiated, encouraged or condoned abusive childcare practices;
  - (d) where those responsible for the inspection, oversight, policy-making or funding of the institutions providing residential services initiated, encouraged or condoned abusive practices, or failed to take appropriate steps to identify, prevent or remedy abuse.”