Chapter 19:

Module 8 – Barnardo’s

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Introduction

1 The Inquiry devoted Module 8 to the examination of evidence relating to two homes run by the organisation now known as Barnardo’s, but for most of that time as Dr Barnardo’s, in Northern Ireland. These homes were known as Macedon and Sharonmore, and were dealt with in the same module because Sharonmore succeeded Macedon, and many of the applicants, and much of the evidence, related to a period when some of the applicants were in one or other of the two homes. As will be apparent from the evidence we consider, some at least of the issues and the evidence relating to these issues overlap both homes.

2 The Inquiry devoted two weeks covering eight sitting days between 7 December 2015 and 17 December 2015, during which we heard oral evidence from three applicants and received the written statement from a fourth. We also received oral and written evidence from Lynda Wilson, the Director of Barnardo’s Northern Ireland, and from five former employees of Barnardo’s. The Inquiry tried unsuccessfully to locate BAR 2, but on 17 December 2015 he made contact with the Inquiry. He was then provided with the relevant evidence, and ultimately provided the Inquiry with a statement dated 24 February 2016. He was offered the opportunity to give oral evidence but declined to do so.1

3 Our investigations have not been limited to the matters raised by the evidence of the four applicants, because we also considered material obtained by the Inquiry from Barnardo’s and from other sources, particularly from the police, relating to the care provided by Barnardo’s to the children in both Macedon and Sharonmore.

4 A substantial part of the material considered by the Inquiry during this module related to allegations that resulted in a major police investigation into the actions of two former staff members of Barnardo’s who were employed at either Macedon or Sharonmore. These two individuals, to whom we shall refer as BAR 1 and BAR 2, were the subject of a Crown Court prosecution in 2004 based upon the evidence of ten individuals, nine of whom were former residents - the tenth being the child of a former staff member. Following the convictions of BAR 1 and BAR 2 on many, but not all, of the charges against them, both appealed to the Northern Ireland Court of Appeal. In 2005, after considering new evidence, the Court of Appeal quashed their convictions and decided not to order a retrial on those charges in respect of which they had been convicted at the Crown

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1 BAR 2546-2548.
Court. The effect of the acquittals at the Crown Court, and the quashing of the charges in relation to which they had been convicted, was that BAR 1 and BAR 2 were acquitted of all of the charges against them.

Because of the nature of the allegations it was necessary for us to consider afresh the evidence relating to the allegations which led to the police investigation and the subsequent prosecution. Although the allegations we considered mostly related to the period 1977 to 1981, we have also considered events that are alleged to have occurred outside that period, and for that reason we have followed a broadly chronological approach when considering these allegations.

We had written submissions from a number of those who were the subject of allegations, as well as submissions on behalf of Barnardo’s, the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MOHA) and the Department of Health and Social Services (DHSS), which had statutory responsibility for these homes during the period with which we are concerned. We also received written submissions on behalf of the Health and Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children they placed in Barnardo’s. We have considered all of this evidence and paid careful attention to the various submissions made to us. However, in accordance with our general approach, we do not propose to refer to every allegation that was made, whether against an individual or against Barnardo’s, although we have taken all of the evidence and the submissions into account.

**Macedon**

Macedon was a large Victorian house set in substantial grounds at Whitehouse on the north-side of the shores of Belfast Lough. It was bought by Barnardo’s and registered by the Ministry of Home Affairs as a voluntary children’s home on 29 June 1950. It accommodated children between the ages of 16 and 18 years, and in its early days had a feeder home called Manor House in Ballycastle, Co Antrim (not to be confused with Manor House, Lisburn, which we consider elsewhere in our Report). Manor House was approximately 55 miles from Macedon, and was a home for babies and toddlers. It accommodated approximately 50 children at any one time, who then progressed to Macedon.

Barnardo’s built two purpose-designed cottages in the grounds of Macedon.
In later years there were generally 30 children resident in Macedon at any one time, with ten in the main building, and ten in each of the cottages. Initially Macedon was registered to accommodate 35 boys and girls, and although it was originally intended to be a single sex facility, in order to meet the needs of the time and to facilitate family groups, both boys and girls were accepted, with flexibility as to admitting children of different ages. Altogether 598 children passed through Macedon in the 31 years of its existence, and by June 1981 all the children in residence had moved from Macedon to Sharonmore.

During its existence Macedon offered long, medium and very short-stay placements, although in the years leading up to its closure in 1981 the placements were predominantly long-term in nature. Described by Barnardo’s as a “traditional Children’s Home”, as the years went by Macedon increasingly catered for children who were from a very disturbed and difficult background, many of whom would otherwise have been placed in a training school if Barnardo’s had not undertaken to care for them.

In January 1958 it was registered for 52, but by 1979 the numbers had been reduced to 32.3 It appears that in the early 1970s two factors coalesced that led to Macedon being closed and being replaced by what was known as the Sharonmore Project. One was that in 1971 Dr Bywaters, Barnardo’s Medical Officer, visited Macedon and raised queries as to whether it was appropriate to have as many children on site as the 52 who were in Macedon at that time.4 It is clear that the numbers had increased from the original permitted maximum of 35.

This questioning of the justification for such a large institution reflected a change in mainstream childcare thinking at that time. BAR 14, who became Barnardo’s Divisional Director for Northern Ireland in 1974 shortly after he had joined Barnardo’s, explained in his evidence that when he joined Barnardo’s a replacement home for Macedon was being planned for a location at Ballyhanwood at Dundonald on the outskirts of East Belfast. The plans had reached the stage at which they were about to go out to tender, but he and the chief architect of Barnardo’s agreed that the new facility would be what he called a “white elephant” and the plan was scrapped. This facility may well be what Dr Bywaters meant in 1971.
12 The other factor was that the projected M5 motorway would result in the compulsory purchase of Macedon and its closure.

**Sharonmore**

13 BAR 14 explained how the scrapping of the proposed replacement home for Macedon at Ballyanwood resulted in a process of Barnardo’s thinking through what was required to replace Macedon. BAR 24 prepared a document called “The Sharonmore Project”, based upon discussions he had with local staff. This eventually emerged as Macedon’s replacement. The Sharonmore Project, as it was known, (although for simplicity we refer to it simply as ‘Sharonmore’), was a response to the Black Report, and by and large catered for more disturbed children than Macedon.

14 Sharonmore had a number of components. Ballyduff House in Newtownabbey was purchased from Newtownabbey District Council. It was called the Parent Unit and contained the administrative functions of Sharonmore. In addition there were two separate, purpose-built, living units: Ballyduff and Ravelston. Ballyduff accommodated eight young people in four single and four double rooms. It closed in February 1985 and the children and staff in Ballyduff transferred to Ravelston. The Ravelston Unit accommodated eight young people in eight single rooms. Both Ballyduff and Ravelston had a “sleeping in” room for staff whose turn it was to be on call at night, and a spare room that could be used for parents and friends.

15 In addition there were two satellite units at Ballysillan and Derrycoole. Each satellite unit was an ordinary dwelling house, both within five miles of Ballyduff, with four young people each in single bedrooms. Derrycoole was closed and deregistered as a children’s home in January 1996.

16 Unlike Macedon, Sharonmore was community based. Each unit was physically much closer to ordinary neighbours than many traditional children’s homes at that time, with children attending schools, churches and recreational facilities in the community, and medical facilities were

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6 BAR 624.
8 BAR 22034.
9 BAR 690.
provided by a local GP at the local health centre. Each child had a key worker, and the individual units were intended to provide a range of social work interventions for the children in their care, as may be seen from the following extract from a statement to the Inquiry by Lynda Wilson, Director of Barnardo’s Northern Ireland:

“Initially, the Ballyduff Unit was intended to provide a residential social work service, which was task-centred, for children who presented with social, emotional and behavioural difficulties. The social work interventions were designed to help these children reflect on their difficulties and to understand better the reasons underlying them, in order to gain control over their actions and begin to take responsibility for them.

“The Ravelston Unit was designed to help young people presenting with social, emotional and behavioural difficulties through the provision of a residential social work service, which provided individualised care with focus on specific tasks including preparation for independent living.

“The Satellite Units aimed to provide residential social work interventions providing individualised care with their focus on specific tasks to children who would benefit from living in a small unit in the community. In the Satellite Unit, care was on a domestic scale to replicate some aspects of substitute family care, while maintaining a professional approach to problem-solving.”

HIA 417

17 The first allegation we considered was that of HIA 417 who was in Macedon between 1967, when she was thirteen, to 1973, when she was nineteen. She was the only applicant from this period to make allegations of abuse. She was placed in Macedon by Tyrone County Welfare Committee and said that she did not remember visits by a social worker. Whilst Barnardo’s records only refer to one such visit, there was substantial correspondence relating to her between Barnardo’s and the Tyrone welfare authorities, and there were also efforts to maintain links with her family.

18 She described how she witnessed the then superintendent of Macedon BAR 5, dragging other girls by the hair, and Barnardo’s concede that there were concerns in 1969 about his leadership and management skills; his

10 BAR 690.
11 BAR 690-691.
skill in dealing with staff was regarded as problematical, as was notably, his limited capacity to handle girls. We accept that HIA 417 was pushed and shoved by BAR 5 as she alleges. However, as hers is the only allegation of such behaviour relating to this period we do not consider that sufficient to amount to a finding of systemic abuse.

19 She also complained of being bullied and sexually abused by older girls. We accept this occurred, but she did not tell staff what was happening to her, and as there is no other evidence of bullying and sexual abuse of other children at this time, we do not consider the abuse she suffered amounts to systemic abuse.

20 She alleged that she was not given sufficient encouragement or opportunity to achieve her full potential academically. We note that at the time she was felt to be very intelligent. Concerns were noted about the standard of her homework at the time, and it was to be more closely supervised in future.\(^\text{12}\) Although we sympathise with HIA 417’s frustration at her lack of academic achievement while she was in the care of Barnardo’s, we consider that Barnardo’s ensured that she had as good an education as many other children who were not in residential homes at that time. We are satisfied that Barnardo’s did as much as they could to point children towards occupations that could be expected to provide a realistic opportunity for them to acquire the necessary skills to enable them to become financially independent once they left the home. We do not regard Barnardo’s efforts in her case as indicative of any systemic failing on the part of Barnardo’s.

**Allegations relating to BAR 3**

21 BAR 3 was employed at Macedon as an assistant house parent from 23 April 1979 until 9 January 1980.\(^\text{13}\) His employment was terminated because it came to light that he had borrowed money from petty cash and from children’s pocket money.\(^\text{14}\) BAR 8 described to the Inquiry how he had borrowed money from her and from other staff. On one occasion she had to pay £40 to the child because he was unable to pay money back to allow a child to buy clothes, and it seems that it was her report about this that led to his employment being terminated after he repaid the money.

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12 BAR 591.
13 BAR 5922.
14 BAR 5924.
22 It is clear that this was not the only aspect of his conduct that was suspect. In her evidence BAR 8 described to us how he wore a large cross around his neck as if he were a priest. BAR 9 confirmed that BAR 3 represented himself as a member of a Roman Catholic religious order. BAR 8 said how he called himself doctor and carried a doctor’s bag and stethoscope. She was told he was treating staff and children for headaches, and giving the staff powders. BAR 14 later described BAR 3 as having “an effeminate manner and one is inclined to the view that he is most certainly homosexual”, and BAR 9 referred to BAR 3 as wearing eye shadow.

23 We consider that BAR 3’s behaviour in describing himself as a priest and doctor (neither of which appears to be true judging by the absence of references to any such qualifications in his application form), and borrowing money, could have led to his services being dispensed with before the report from BAR 8 that he had taken money from a child’s pocket money. His behaviour was bizarre, and in itself was sufficient to call into question his suitability to work with children because he was clearly not who he purported to be. The failures to detect these matters, and then take appropriate action, represented systemic failures because they demonstrated either a lack of knowledge or an unacceptable tolerance of what was happening among the staff on the part of management at Macedon.

24 In 1981 it came to light that allegations had been made by BAR 46 that BAR 3 (who left Barnardo’s in January of that year) had tried to kiss him on a number of occasions. It appears from a memorandum made some months later that these allegations were originally made to BAR 2. He reported them to his supervisor BAR 8. She does not appear to have reported what BAR 2 said to her for some time, to judge by the note made by the Superintendent BAR 24. In that memorandum BAR 24 recorded that BAR 8 told him that BAR 2 had told her about these matters “some months ago”. The memorandum is dated 21 April 1980 and implies that he was told on 11 April 1980.

15 Day 169, p.124.
16 Day 172, pp. 110 and 115.
17 Day 169, p.124 and following
18 BAR 5944.
19 Day 172, p.115.
20 BAR 4237.
21 BAR 4242.
22 BAR 4242.
In a statement which she made to the police BAR 8 claimed that when BAR 24 did not get back to her she took her complaints to BAR 14, who was then Barnardo’s Divisional Children Officer/Director of Childcare in Northern Ireland. A memorandum written by BAR 14 on 17 April 1980 makes no reference to the allegations made by BAR 46, although (as stated above) he did record that BAR 3 “has an effeminate manner and one is inclined to the view that he is most certainly homosexual. However, this was never a problem, as far as his work was concerned, except that some children made reference [to it]”.

In his statement and oral evidence to the Inquiry BAR 14 said that he had no recollection of BAR 24 speaking to him about this. When BAR 8 gave evidence to the Inquiry she accepted that although she recalled mentioning a number of the things about BAR 3 to which BAR 14 referred in his note, she did not think that she had mentioned the kissing incident to him, because she thought that as she had spoken to BAR 24 about it and he had said that he would go to BAR 14 about the matter, that would be sufficient. We accept that BAR 14 was not told by BAR 8 that BAR 3 was alleged to have kissed BAR 46. BAR 14’s memorandum is entirely consistent with his not being told. We are satisfied that if BAR 14 had been told of the kissing he would have recorded it.

The memorandum of 21 April 1980 contains the following passage:

“As these reported incidents took place some months ago, the member of staff has now left our employment (9.1.80)...on considering the situation in my judgement any well intentioned cross-examination at this late stage might do damage to all concerned, especially in view of the climate in the province at present.”

The reference to the “climate in the province at present” appears to be a reference to the recent disclosure in the media that a number of members of staff at the Kincora Boys Home were alleged to have committed serious sexual offences against the children in their care, allegations which were subsequently found to be well-founded in view of the pleas of guilty of the three men concerned, although that did not take place for some considerable time after the writing of this memorandum.
We are satisfied that the allegation that BAR 46 had been kissed by BAR 3 was not passed on by BAR 24 to BAR 14 as it should have been. Had it been passed on, then it would have been essential for Barnardo’s to report these allegations to the police and to the Eastern Health and Social Services Board (EHSSB) in whose care the child was and who had placed the child in Macedon. The failure to report the allegations meant that no steps were taken to investigate whether BAR 3 had made sexual approaches to any other child, and, if he had, to do whatever was necessary to assist the child. Had the matter been reported to the EHSSB that would have allowed the Board to consider whether it was satisfied that the children it had placed in Macedon were free from any risk of abuse. Had the matter been reported to the board and to the police it would have enabled both to try to investigate the actions of BAR 3 with a view to his being prosecuted and thereby prevented from abusing other children. BAR 3 died aged 47 on 13 September 1993 in the Republic of Ireland.

From the medical evidence presented to the Inquiry on his behalf, we were satisfied that BAR 24 was not capable of assisting the Inquiry in relation to his recollection of these events and why he acted as he appears to have done.

BAR 14 said in his witness statement to the Inquiry:

“I do not know what BAR 24 had in mind in making this judgement, but I do not think that he was referring to the political climate or the troubles in Northern Ireland. It seems more likely that he had in mind the turmoil that existed amongst residential care staff as a result of the Kincora saga and the range of allegations and disclosures that were emerging at that time at a number of other homes. Residential staff felt under-valued and mistrusted and low morale was widespread.”

And at paragraph 28:

“Having read his File Note for the first time within the last few weeks, I cannot fully understand how he came to the conclusion that he did. Nor do I understand why he did not make me aware of what had been brought to his attention regarding BAR 3. I am content that he made his decision in good faith, motivated by his desire to do what he felt at that time was in the best interests of a young person.”

26 BAR 1143.
27 BAR 4242
28 BAR 1143.
The Inquiry put to BAR 14 the possibility that a factor was that,

“To draw these matters to the attention of their proper authorities might result in unfavourable attention being directed towards Barnardo’s?”

He accepted that was certainly a possible implication but he did not think that BAR 24 would have concealed the matter in that way. He accepted that he was influenced by the man whom he knew and whom he made it clear he held in very high regard as someone whom he respected and whose professional and moral integrity he valued.29

Another possible reason may have been a desire to protect the reputation of Macedon and its staff, and the reputation of Barnardo’s, in the media, because we recognise that once allegations such as these are aired publicly, whether there is any substance to them or not, they can have a severe impact on staff morale and on staff retention and recruitment.

The view of Lynda Wilson about this was set out in her witness statement when she said that, “the first task of the Superintendent was to find out the facts. This did not happen and as a result, Barnardo’s failed to address potential child abuse”.30

Whatever the reason may have been, we are satisfied that BAR 24 took a deliberate decision not to report the full nature of the allegations to his superiors, not to report the allegations at all either to the police or the EHSSB, and not to investigate the allegations further. His failure to do any of these things was wholly unacceptable. His duty as Superintendent was to find out the facts so that Barnardo’s could establish whether or not BAR 3 had made sexual advances to any other children in their care and he failed in that duty.

His failures had another extremely important consequence. The Hughes Inquiry appears to have only been made aware of one episode of sexual abuse of a child in the care of Barnardo’s during its terms of reference, namely that involving BAR 44 which we consider later in this chapter. We are satisfied that had BAR 24 reported these matters to his superiors at the time Barnardo’s would then have reported them to the EHSSB and to the police. Had a conviction followed that would have resulted in these matters being investigated by the Hughes Inquiry. Because these matters were not reported, the Hughes Inquiry could not be made aware of them, and Macedon was not investigated by the Hughes Inquiry in the way that Sharonmore was.

29 Day 172, p.33.
30 BAR 048.
More than 30 years later we cannot be sure what would have come to light had the EHSSB, the police and the Hughes Inquiry learnt of the allegations about BAR 3’s conduct in Macedon. Nevertheless, we are satisfied that the opportunity to uncover and investigate the allegations about BAR 3, and quite possibly the allegations made many years later about BAR 1 and BAR 2 as well, was missed because of BAR 24’s failure to report the allegations about BAR 3 to his superiors as he should have done.

It emerged during the Macedon Inquiry, which we consider later in this chapter, that after BAR 3 left Barnardo’s employment BAR 46 said to BAR 75 that BAR 3 “was a real fruity boy” and “had tried to touch him up”. By this time BAR 46 was in either Macedon or Sharonmore. Because BAR 3 had left Barnardo’s employment at that stage, BAR 75 does not seem to have reported the remark to his superiors at Barnardo’s.

The way BAR 3’s behaviour was dealt with by different individuals within Barnardo’s was unsatisfactory in the ways that we have identified. Nevertheless, we should record that although BAR 14 was not told of matters about BAR 3 that he should have been, in his memorandum of 17 April 1980 to the personnel manager, to which we have already referred, BAR 14 said that:

“he had grave doubts as to [BAR 3’s] reliability, and certainly would not recommend him for a position of trust, or for any post in a social work setting.”

This was clearly designed to prevent BAR 3 being given a favourable reference from Barnardo’s should he apply for a job with another employer in this field. That was an effort to protect any children with whom BAR 3 might otherwise have been able to work in future.

Barnardo’s accept “the failure to take appropriate steps in response to the [BAR 46] allegation about [BAR 3] constitutes a systemic failing”.

We are satisfied that there were several systemic failings in the way in which this matter was handled by Barnardo’s staff at the time:

- BAR 75 does not seem to have reported the remarks by BAR 46 to his superiors.

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31 BAR 8619.
32 BAR 5924
33 BAR 21090
• They were not reported for some months by BAR 8 to BAR 24. BAR 24 made a deliberate decision not to report the full facts to his superiors or to anyone else.

**Barnardo’s handling of other sexual allegations by children in Macedon or Sharonmore**

43 BAR 47 is a sister of HIA 516. She did not apply to the Inquiry, but the Inquiry considered events relating to her because of material it obtained in respect of a number of matters with which she was concerned. The first of these events occurred on 20 February 1981 when she told BAR 8 that whilst on a home visit to her father BAR 30 he attempted to pull down her underpants and touched her about her chest below her sweater. She was almost fifteen at the time. The matter was promptly reported to the police who investigated the matter, although it appears that no prosecution resulted.

44 Her complaint in 1981 is relevant because:
• BAR 47 felt able to disclose a sexual assault to Barnardo’s staff.

We are satisfied that on this occasion Barnardo’s dealt appropriately with this allegation.

45 The second event involving BAR 47 occurred on 17 May 1982, when she informed BAR 9 that she had had sexual intercourse with her then boyfriend a few days before during a period when she had absconded from Sharonmore. This was also promptly reported to the police by Barnardo’s staff. During the investigation BAR 47 told the police that intercourse had been consensual. She also told the police that before intercourse had occurred she had been a virgin, something that will be significant when we consider other allegations she made subsequently. This matter was also dealt with by Barnardo’s in an appropriate fashion.

**The attitude of Barnardo’s and the EHSSB towards the relationship between BAR 12 and HIA 516**

46 Barnardo’s first became aware of BAR 12 when BAR 8 approached BAR 14 because of the interest expressed by police from Newtownabbey in setting up a trust fund for HIA 516. The interest shown by other officers appears to have waned after a time, but BAR 12 was encouraged by
Barnardo’s staff to focus his attention on one child, rather than on all the children in the unit.\textsuperscript{35} At this point BAR 12 should have been assessed as an individual volunteer or as a ‘befriender’, but this seems to have been overlooked. From January 1980 BAR 12 took a considerable interest in HIA 516,\textsuperscript{36} but it was only in February 1981 that Barnardo’s decided to place this interest on a more formal ‘befriender’ basis. Hilary Reid, (now Dr Hilary Harrison), who was at that time a project leader for Barnardo’s at another home, was asked to perform an assessment of BAR 12 because “some concern was expressed about the relationship and the benefits or otherwise of this”.\textsuperscript{37}

She carried out two long interviews of BAR 12. She was uncomfortable about being asked to perform this task when a relationship had already been going on for some fifteen months, and as she did not know the child concerned. However, she sensed that information may have been deliberately withheld from her so that she would approach her task in a completely unbiased way. Whilst on one view it might have been better if she had been fully briefed about HIA 516, and about BAR 12’s failure to follow all the guidance given to him about how to approach HIA 516 by the staff at Macedon, nevertheless it is important to bear in mind that BAR 12 held a responsible position, Barnardo’s were unaware that there had been concern expressed by his senior officers about his attitude to children in the past, and HIA 516 did not make any allegations against BAR 12 until June 1982.

Dr Harrison told the Inquiry that she had nothing to suggest that BAR 12 would have had any interest in HIA 516 sexually when she carried out her interviews with him. She made no recommendations when she submitted her report in April 1981, pointing out that she was unaware of the whole picture.\textsuperscript{38}

In the light of what was to happen subsequently she made a particularly prescient observation in her conclusion when she said:

“...how much he is prepared or willing to accept the guidance of others, however, is difficult to say. I feel his own needs might tend to override his better judgement”.

\textsuperscript{35} BAR 7108
\textsuperscript{36} BAR 7107.
\textsuperscript{37} BAR 11428.
\textsuperscript{38} BAR 11434.
BAR 14 told the Inquiry that while it was unusual to assess a potential befriender after the befriender was allowed to develop that relationship with the child, his opinion was that there seemed to have been thorough consideration of the relationship both by Barnardo’s and by the EHSSB, (which had placed HIA 516 with Barnardo’s), there had been consultation and the matter had been well handled. 39

Lynda Wilson took a different view. While she pointed out that there was no suggestion of interference of HIA 516 by BAR 12 at that time, and BAR 12 was a trusted member of the community, it was at least poor practice to leave the befriending assessment to a point where the issues had become problematic. She accepted that whether or not abuse had occurred the befriending assessment should have started earlier.

Whilst we accept that it was entirely justifiable for Barnardo’s to accept BAR 12’s willingness to befriend HIA 516, who was a boy with a very disturbed and difficult history, nevertheless a formal befriending assessment should have been carried out at the start of the relationship, and not fifteen months later. In addition, the unwillingness of BAR 12 to follow the advice given to him on several occasions during 1980 by Macedon staff should have been dealt with more firmly at the time.

As can be seen from Dr Harrison’s assessment report, and from the detailed report prepared by BAR 111 (then in charge of Barnardo’s in Northern Ireland), in 1980 BAR 12 was putting substantial amounts of money into HIA 516’s post office savings book virtually every month. He had also given him a stereo unit and records at Christmas 1980. By the time Dr Harrison carried out her meetings with BAR 12 in February 1981, he was paying for riding lessons for HIA 516 each week.

On 14 May 1981 BAR 111 Assistant Divisional Director (Child Care) Irish Division, wrote to BAR 12 to record the outcome of a meeting held with him on 6 May 1981 to discuss his relationship with HIA 516. BAR 111 confirmed that Barnardo’s and the EHSSB were prepared to agree to the relationship continuing subject to conditions. These conditions were that BAR 12 accepted the guidance of Macedon staff about the nature and length of time he spent with HIA 516, including his plans for trips out with him, and the value of presents and amounts of money he intended giving him. This letter was copied to BAR 60, Assistant Principal Social Worker, EHSSB and senior members of Macedon staff. 40

39 Day 171, pp.63 to 64.
40 BAR 16115.
In June or July 1981\(^{41}\) (and not October 1981 as stated by BAR 111),\(^{42}\) BAR 12 bought a pony for HIA 516 for £300, and paid for its board and feed until the end of May 1982.\(^{43}\) The farmer who sold the horse told the police that on numerous occasions BAR 12 brought HIA 516 out to ride the pony, and “he was also brought out sometimes by the home”.

It is unclear when Barnardo’s staff knew that BAR 12 was going to buy the pony, but he had indicated to Dr Harrison in February 1981 that he would be willing, if HIA 516 proved interested enough, to buy him a horse.\(^{44}\) Whether Barnardo’s or the EHSSB knew that BAR 12 was going to buy the pony, it seems that Barnardo’s staff allowed HIA 516 to continue to use the pony after it was bought.

That BAR 12 bought the pony so soon after BAR 111 wrote to him was a significant breach of the conditions. We consider that he should not have been permitted to continue the relationship with HIA 516 after the meeting of 6 May 1981. We are satisfied that BAR 12 had clearly shown himself to be unwilling to abide by conditions which Macedon staff sought to impose upon him before that meeting of May 1981. He should not have been permitted to continue his relationship with HIA 516 after that meeting because he had repeatedly shown an unwillingness to abide by the advice of Barnardo’s staff and the willingness of Barnardo’s to allow the relationship to develop. By November 1981 Barnardo’s had come to the conclusion that the conditions that had been made clear to BAR 12 were not being complied with, and that he was to have no further contact with HIA 516.

The length of time that it was allowed to continue after BAR 12 had repeatedly shown an unwillingness to abide by the advice of Barnardo’s staff represented poor practice. Lynda Wilson conceded that Macedon’s systems were not sufficient in terms of how these matters were dealt with,\(^{45}\) and we consider the manner in which this relationship was allowed to develop, and the length of time for which it was allowed to continue, represented systemic failures by Barnardo’s to ensure proper child care of HIA 516.

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\(^{41}\) BAR 7136.
\(^{42}\) BAR 7113.
\(^{43}\) BAR 7136.
\(^{44}\) BAR 11432.
\(^{45}\) Day 172, p.2.
**The allegations by HIA 516 against BAR 12**

59 The next allegation in chronological sequence relates to an allegation relating to BAR 12 by HIA 516. In October 1980 an oral complaint was made to Newtownabbey Police Station (where BAR 12 was stationed at the time) that staff at Barnardo’s were concerned about the relationship between him and HIA 516. The complaint was apparently reported by the detective constable who received the call to the Sub Divisional Commander at Newtownabbey RUC Station but it would seem that no further action was taken at that time.46

60 The next relevant development was that on 6 October 1981 BAR 30 phoned Newtownabbey police and complained that his son HIA 516 was ‘overly friendly’ with BAR 12 who had bought him a stereo and a pony. The reference to the stereo presumably related to the stereo unit and records BAR 12 bought for HIA 516 at Christmas 1980.47 The reference to the pony clearly relates to the purchase of the pony referred to above.

61 Although BAR 30 subsequently withdrew his complaint, it was investigated by Newtownabbey police at that time, and an inspector spoke to Barnardo’s staff and to BAR 30, but not, it seems, to HIA 516.

62 As it happens, as part of his investigation into allegations concerning Kincora, Detective Superintendent Caskey interviewed BAR 12 on 16 April 1982. In the course of that interview BAR 12 was asked about his relationship with HIA 516, and it is clear from the question that Superintendent Caskey was aware of at least some of the details of that relationship, notably that HIA 516 had a pony.

63 On 28 April 1982 Detective Chief Inspector Colgan was directed to carry out investigations into a number of associations giving rise to what he termed as “suspicions” that BAR 12 had displayed:

> “an inordinate and unhealthy interest in certain youths whom he had met in the course of his police duties and whom he had afterwards befriended and associated with”.48

64 One of these associations was with HIA 516, who by that time had been transferred from Macedon to Rathgael Training School. DCI Colgan interviewed him on 25 June 1982 about his relationship with BAR 12.
During the interview HIA 516 became distressed and ultimately made a written statement alleging that BAR 12 had:

- Given him gifts of the stereo and the pony and money – usually £2.50 a time.
- Bought pornographic books.
- Put his arm round him and tried to kiss him.
- Tried to get him to touch BAR 12’s penis.
- Exposed his erect penis and tried to get HIA 516 to touch it.
- Asked HIA 516 to masturbate him.

HIA 516 said he resisted all of these approaches.

BAR 12 was subsequently interviewed on 6 August 1982 about these allegations. He responded by saying he “just simply had no comment or rather no answer”. He denied being homosexual, or having homosexual tendencies.

Later that month, HIA 516 indicated he wished to see DCI Colgan again, and an interview was held on 19 August 1982. HIA 516 told him he had been thinking it over, had told his mother, and that things had gone further than he had said. HIA 516 said he was not prepared to go to court, but would give evidence against BAR 12 at any police disciplinary proceedings.

Two written statements were recorded. In the shorter statement HIA 516 said what he had earlier alleged was correct, except that BAR 12 had stopped about four times at a quarry near the riding stables, and that he had visited BAR 12’s home in Bangor about six times, and not twice as he had earlier alleged.

In the longer statement he described in considerable detail his relationship with BAR 12. So far as sexual abuse is concerned, the salient allegations were:

- On the first day BAR 12 took him out he tried to open his trouser buttons.
- A week after the purchase of the pony BAR 12 had shown him a book with pictures of nude men and women, and offered him three more similar books to keep, but he refused.

49 BAR 7141.
50 BAR 7142.
• On another occasion BAR 12 felt HIA 516’s penis through his trousers.
• On a further occasion BAR 12 tried to open his trouser buttons.
• On the first visit to BAR 12’s home in Bangor, he tried to kiss him on the mouth.
• On subsequent visits BAR 12 had again tried to kiss HIA 516 and get his trousers down.
• On the last visit BAR 12 was able to get HIA 516’s trousers and underpants down to his ankles, then sat on him and masturbated HIA 516’s penis to an erection, before HIA 516 punched him on the back, whereupon BAR 12 stopped.

HIA 516’s mother BAR 112 made a statement to the effect that when her son told her that BAR 12 had been “messing” with him she assumed her son had been anally raped. She went to BAR 12’s house and confronted him. He denied these allegations, and asked her whether she thought his father had put him up to it, to which she replied that he might have. She signed a statement to that effect prepared for her by BAR 12 and his brother-in-law (also a police officer). She said when she called to the house, “I had drink on me, but I was not drunk”. She then went to Greencastle RUC station with BAR 12, his sister and his brother-in-law, but the station sergeant refused to accept the statement because the matter was already the subject of an internal police investigation. The sergeant also considered that she had consumed a considerable amount of drink before coming to the station.

The DPP directed no prosecution. The directing officer, while acknowledging that the relationship of BAR 12 with HIA 516 was suspicious, stated that there was no corroboration, pointed out that there were significant discrepancies in the accounts given by HIA 516, and observed that HIA 516 was clearly disturbed, violently anti-police and anti-authority, and widely reported by responsible people as being, among other things, a liar.
These matters resurfaced in March 1997 when HIA 516 wrote to the Chief Constable of the RUC renewing his allegations against BAR 12, making further allegations about him, his father BAR 30, and BAR 1. In this letter he gave a different version of being indecently assaulted by BAR 12 in his car, and added a new allegation of a violent anal rape during a car journey back from the riding stables to Macedon. He described this in his police statement but did not refer to the incident in BAR 12’s house in Bangor, Co Down.

It appears that he was asked by the investigating police inspector why he had not mentioned the alleged anal rape during the 1982 allegations, to which HIA 516 offered no explanation. The police pointed to the absence of corroboration, the passage of time since the alleged anal rape (fifteen years) before the complaint was made to the police, and the problems with the credibility of HIA 516 because he was serving a ten-month sentence in the Republic of Ireland for indecent assault on a fifteen-year-old female, and was awaiting trial on a charge of rape of his niece for which it seems he was subsequently convicted and sentenced to twelve years imprisonment. The DPP directed no prosecution.

HIA 516 was only fifteen and in Rathgael Training School when he made the original allegations against BAR 12. Although he did not advance any explanation fifteen years later as to why he did not mention the alleged violent anal rape in 1982, it is unclear how closely he was questioned in 1997 as to why this was the case. It is possible that in 1997 the police and the DPP may not have given any, or sufficient, weight to what is now a well recognised tendency for victims of sexual abuse to be reluctant to disclose all, or the most serious, abuse to which they were subjected when they first disclose some allegations.

Looking at the evidence as a whole relating to HIA 516’s allegations of abuse against BAR 12, the relationship of BAR 12 with HIA 516 is strongly indicative of a pattern of grooming by BAR 12 of a young, vulnerable child by lavishing gifts and attention on the boy, and having the opportunity to sexually abuse the boy when HIA 516 was away from Macedon where he was living.

However, we have not had the benefit of oral evidence from HIA 516 or BAR 12, although both submitted written statements to the Inquiry. On
the evidence presently available to us we do not feel able to reach a definite conclusion as to whether HIA 516 was subjected to sexual abuse by BAR 12 while HIA 516 was in the care of Barnardo’s, although the relationship of BAR 12 with HIA 516 gives rise to considerable suspicion.

These allegations were unknown to Barnardo’s at the time because they were not made until after Barnardo’s and the EHSSB believed that the relationship between BAR 12 and HIA 516 had been brought to an end in November 1981, although later there were grounds to believe that BAR 12 and HIA 516 continued to have contact with each other in March 1982. That was because HIA 516 arrived back in Sharonmore from school with cigarettes, sweets and money. On 17 March 1982, when he did not return, a staff member contacted BAR 12 who said he would look for him. BAR 12 brought HIA 516 back to Sharonmore at approximately 5.30 pm; it seems that HIA 516 had been at a roller disco.

It is also important to bear in mind that at that time Barnardo’s were not aware of the police suspicions about BAR 12. On the basis of what Barnardo’s knew, or ought to have known, in 1981, we cannot be satisfied that if HIA 516 was subject to sexual abuse by BAR 12, Barnardo’s was guilty of a systemic failure in not preventing any abuse that may have occurred.

The allegations relating to BAR 44

BAR 44 was a thirteen-year-old boy with a very disturbed history who was admitted to Sharonmore from Rathgael Training School in October 1981. He was truanting from school and was picked up in Belfast City Centre by a delivery man on his rounds. The man persuaded the boy to join him on his delivery rounds and sexually assaulted him. Some days later BAR 44 told his uncle what had happened, and his uncle informed Barnardo’s. It promptly informed the Southern Health and Social Services Board (who had placed the boy in Sharonmore) and the police. The matter was investigated by the police, the perpetrator was traced and questioned, and admitted the offences. He was prosecuted, pleaded guilty and sentenced.

This episode came to the attention of the Hughes Inquiry, and as a result it investigated Sharonmore and the way it was run in considerable detail. The Hughes Inquiry was satisfied that Barnardo’s took all necessary steps to assist the police fully in relation to this matter. We agree. They promptly
reported the allegations to the police, and a member of staff accompanied BAR 44 when he was interviewed by the police.

79 The Hughes Inquiry also examined Barnardo’s policy and practice in a number of areas, such as record keeping, recruitment and training of staff, strategic planning and compliance with the 1975 Voluntary Homes Regulations, and we will comment on these matters later in this Chapter.

**The 1985 complaint by HIA 216 against BAR 4**

80 HIA 216 was in Macedon from 1967 (when she was aged five) until she left in March 1981 aged eighteen and a half. She remained friendly with BAR 8 who visited her from time to time. On 24 April 1985 BAR 8 visited her at her home; by then HIA 216 was aged 22. A note made of that visit by BAR 8 records that the purpose was to discuss something that HIA 216 had told her in confidence, “some time ago”.\(^{60}\) When that was is unclear, the note saying that HIA 216 had given information to BAR 8, “at a much earlier date”. In any event, the note makes it clear that although HIA 216 had not wished to pursue the matter, BAR 8 had discussed it with her project leader and a decision had been made to approach HIA 216 again. BAR 8 persuaded HIA 216 to discuss what happened to her in greater detail, and HIA 216 told BAR 8 she had been sexually assaulted by BAR 4. We will consider the details of the allegations later.

81 It is clear from a note made by BAR 8 of a further visit to HIA 216 on 10 July 1985 that in the interim Barnardo’s had been gathering information. The matter was then reported to the police by BAR 79, Barnardo’s Divisional Director, (Child Care).\(^{61}\)

82 While this account might suggest that thus far Barnardo’s dealt appropriately with this disclosure by HIA 216, there is evidence to suggest that that was not in fact the case. BAR 8 said that when she discussed the position with BAR 79, his reaction was to say that as HIA 216 had left Barnardo’s a long time ago, there was nothing Barnardo’s could do about it, and it was for HIA 216 to contact the police. BAR 8 responded:

> “Well I know that, but there is [sic] other children who were working/living down in Macedon and something could have happened then”.

\(^{60}\) BAR 227.

\(^{61}\) BAR 17630.
To which she alleges he replied:

“you are not to go to any child to ask them about anything. They must come to you first and make a statement”.62

However BAR 8 disobeyed this direction and went back to HIA 216, as BAR 8 recounted to Lynda Wilson in 1999.63

We are satisfied that BAR 79’s initial reaction was not to follow up the implications of these allegations, despite the risk to children elsewhere that might arise if the alleged abuser was not investigated, as well as the possibility that any investigation might reveal that other children in Macedon had been abused by the alleged abuser. As we have stated, the allegations were later reported to the police in August 1985. **We consider the reluctance on the part of some Barnardo’s staff in Northern Ireland at that time to report such matters to the proper authorities was a systemic failing.**

We now turn to consider whether HIA 216 was the subject of sexual abuse by BAR 4. When she made her statement to the police in 1985 she alleged that when she was thirteen or fourteen two types of incident occurred. The first occurred in one of the cottages at Macedon when he put her hand down the front of his trousers. The second occurred some weeks later and involved him stopping the car on the way back to Macedon from his house in Lisburn. She alleges that he touched her on the breasts and below her waist, but stopped when she told him to stop.64 The DPP directed no prosecution, it would seem because there was no corroboration and because of the delay in reporting the matter.65

In 1999, by now aged 37, HIA 216 made further allegations against BAR 4 in the course of a further statement she made to the police during an investigation that resulted in the prosecution of BAR 1 and BAR 2. On this occasion HIA 216 considerably expanded her allegations.

• She said she was abused by him in the cottage, “at least 10 times”.

• In the cottage, in addition to putting her hand down the front of his trousers, he pulled up her nightie, felt around her breasts and vagina, inserted his finger in her vagina, and on a couple of occasions made her masturbate him.

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62 Day 169, p.90.
63 BAR 17791.
64 BAR 7614.
65 BAR 8470.
• On the car journeys back from Lisburn he kissed her, made her masturbate him, inserted his finger into her vagina, and on maybe three or four occasions made her perform oral sex on him.

• On at least three occasions on such journeys he forced her into the back seat and held her by the throat while he vaginally raped her, as well as anally raping her on one or two occasions.

• On two or three occasions while in BAR 4’s house in Lisburn, and while his wife was watching, he took his penis out of his trousers and made her touch it. He also put his hand inside her underwear and rubbed around her vagina, again while his wife was watching.66

86 At the beginning of the 1999 statement HIA 216 explained that when she made the 1985 statement she felt that the police woman who took the statement was just not interested. She felt that she had been thrown in at the deep end and was expected to tell the police woman everything the first time HIA 216 had met her. She also said that BAR 8 was not allowed to come into the room at the police station when the statement was being taken.

87 In her evidence to the Inquiry HIA 216 said that although she had told a friend at the time that BAR 4 had put his hand around her privates (and she also referred to telling her friend in the 1999 police statement), she had not told her or the police about the rapes “because I just felt ashamed”, and that “…even getting out that first part about BAR 4 was hard enough without anything else”.67

88 BAR 4 and his wife were interviewed by police in 2002 in Wales where they were living by that time. Both denied all the allegations. By this time BAR 4 had been convicted in September 1992 of five charges of indecent assault, three involving males and two involving females, one of whom was his daughter. In the course of that investigation he admitted touching his daughter and getting her to masturbate him,68 but denied that sexual intercourse had occurred. He admitted in engaging in mutual masturbation with a teenage boy, and that he and his wife and this boy had engaged in sex together.69 He also admitted that he was sexually interested in both male and female children.70 His wife was convicted in

66 BAR 7615-BAR 7621.
67 Day 170, p.22.
68 BAR 7706.
69 BAR 7691.
70 BAR 7707.
In 1991 of the offences of having intercourse with two under-age teenage boys.

89 Whilst the DPP directed no prosecution in relation to HIA 216’s allegations against BAR 4, there are two other matters that are of some significance in respect of these allegations. The first is that she told the police that BAR 4 had a mole or birthmark or something like that, a brown colour, definitely not a tattoo on the top half of his body, although she could not remember where, or if it was on the front or back of his body. BAR 4 admitted that he had a small mole less than one quarter of an inch in size just above his belly button, although he claimed HIA 216 could have seen it when he washed or came downstairs while looking for a shirt or something.

90 The second matter is that HIA 216 said that while she was still at Macedon she went into the office of BAR 23, who was the superintendent of Macedon at the time, intending to complain to him about BAR 4. Although we are satisfied that HIA 216 is mistaken when she says that BAR 8 was present, we accept that there was such an occasion. In May 1985 BAR 28 typed a note for the record, her memory having been jogged while typing BAR 8’s note about her discussions with HIA 216. In 2001 BAR 28 made a police statement in which she said she remembered very clearly HIA 216 coming into BAR 23’s office and saying that she wished to speak to him, but then turning red and leaving the room when she realised that BAR 4 was also in the room. BAR 28 said that BAR 23 went after HIA 216 to speak to her, and when he came back asked BAR 4 how she had been during their meeting, why was she upset and did he know what HIA 216 wanted to speak about. BAR 4 said that he had no idea what was wrong with HIA 216. BAR 23 was described as being perplexed by this incident.

91 Elsewhere we have considered other allegations made by HIA 216, and have taken all of the evidence relating to those other allegations into account when assessing her evidence about BAR 4. We are satisfied that HIA 216 was sexually abused by BAR 4 in the manner she described to the police in 1985, but we are not persuaded to the required standard that the abuse she described as suffering at the hands of BAR 4 in her later accounts to the police went beyond the matter she originally alleged.

71 BAR 7620.
72 BAR 7742.
73 BAR 8462.
74 BAR 7645/46.
Although we are satisfied that HIA 216 was sexually abused by BAR 4 to the extent we have just described, we are not satisfied that this was due to any systemic failing on the part of Barnardo’s. At the time Barnardo’s had no reason to believe that BAR 4 was behaving inappropriately towards HIA 216, or that he posed a danger to her or any other child at Macedon. He was with Barnado’s in the summer of 1977 as part of a scheme that enabled him to work there on placement for some months before he left the Army.

Although a more rigorous vetting procedure of the type that is standard practice today might have revealed what appears to have been a highly sexualised environment in BAR 4’s home, such a rigorous vetting procedure would not have been good or standard practice at that time. Whilst we consider BAR 79’s initial reluctance to report the matter when it first came to his attention in 1985 was poor practice, the situation was rectified without excessive delay, although in large measure this was due to the persistence of BAR 8 in pursuing the matter.

Nevertheless, the amount of unsupervised access BAR 4 was permitted to have to HIA 216, and the failure of Barnardo’s to check the home environment, were unacceptable by the standards of the time. It is noteworthy that in 1972 Mr Bunting of the EHSSB told all voluntary homes that even if children were only going out for a day this had to be approved by the Board. Barnardo’s have told the Inquiry that they think the Board was not informed. We consider the amount of unsupervised access by BAR 4 to HIA 216, and the failure of Barnardo’s to inform the EHSSB that this access was taking place, represented systemic failures by Barnardo’s to provide proper childcare.

The decision by Barnardo’s to retain BAR 1 in their employment

BAR 1 was 41 when she joined Barnardo’s staff on 1 April 1977 as a nursery officer at Barnardo’s Day Care Centre at Windsor Avenue, Belfast. As was standard practice she was placed on a six month probationary period.

It is clear that she was not regarded as a satisfactory employee when dealing with small children, and on 9 November 1977 she was notified
that a decision had been made not to confirm her appointment. However, she appears to have persuaded Barnardo’s that, notwithstanding her poor record when dealing with children of nursery school age, she would nevertheless be suitable to work with older children. On 18 November 1977 Barnardo’s decided to accept her application to transfer to work at Macedon because she had experience of working with older children, and because she held a recognised residential childcare qualification. She was appointed as a residential social worker at Macedon with effect from 1 December 1977, again subject to a six month probationary period.76

97 Seventeen months later she was promoted to the position of third senior, effectively the third in command in her unit, with effect from 1 April 1979, again subject to a six month probationary period. As we shall see, this promotion took effect a short time after what we later refer to as ‘the wooden spoon incident’ in February 1979.

98 On 29 June 1981, three and half years after she had been appointed to Macedon, and 26 months after she had been promoted to third senior, she transferred to Sharonmore. By that stage all the children at Macedon had moved to Sharonmore77, but by 1 March 1982 her performance was considered unsatisfactory, and disciplinary action and demotion were suggested.78

99 It seems that there was no improvement in her work, and disciplinary proceedings in September of that year resulted in her being given a formal warning.79 In March 1983 her work was still regarded as unsatisfactory, and the highly unusual sanction of the deferral of an annual increment to which she would normally have been entitled occurred for the second time.80

100 Although it appears that she then tendered her resignation on 26 April 1983,81 for some reason which cannot now be established she was allowed to remain in post. Her work was regarded as unsatisfactory, and on 21 July 1983 the warning period was extended for a further year and she was warned about her lack of ability to work with and to control children.82

76 BAR 5880.
77 BAR 4329.
78 BAR 5884.
79 BAR 5893.
80 BAR 5896.
81 BAR 5901.
82 BAR 064.
On 1 December 1983 she was transferred to another project run by Barnardo’s at Tara Lodge House in Belfast as a disciplinary measure. On 1 January 1984 she struck a child with a Scholl-type wooden shoe or sandal, disciplinary proceedings were instigated and she then resigned.

Despite a highly unsatisfactory employment record over the previous two years, BAR 79, then the Divisional Director of Barnardo’s in Northern Ireland, told her that if she ever needed a reference she should contact him.

Her employment record has to be viewed against a number of issues which were known about at the time.

The wooden spoon incident in 1979

BAR 1 left £100 in her handbag in the sleeping-in room at Macedon. Some two weeks or so later she discovered that £30 was missing from her handbag, and on 6 February 1979 she accused HIA 101 of stealing the money. The events that then occurred were subsequently recorded by BAR 14 in a lengthy file note.

The initial reaction of one of Barnardo’s staff, BAR 35 was to smack HIA 101 on each hand with a wooden spoon, and then she went to report the matter to BAR 7 who was the Acting Superintendent of Macedon at that time. After BAR 35 left to make this report another staff member, BAR 76 and BAR 1 also struck HIA 101 with a wooden spoon. BAR 76 slapped him on the legs, and BAR 1 struck him on the bottom, both also using a wooden spoon.

As BAR 14 observed in his note, the three members of staff each punished HIA 101 without consultation with each other, or without reference to the Superintendent, actions he described as “completely indefensible”. He also noted that HIA 101 was punished in a number of other ways. He was not allowed to go home to his grandmother, and he was told he was not allowed to use a bicycle he had been given by BAR 8. As BAR 14 commented to the Inquiry, HIA 101 was effectively being punished several times for the same offence, something that was “totally unacceptable”.

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83 Day 172, p.70.
84 BAR 5905.
85 BAR 148.
86 BAR 134.
87 Day 171, p.46.
107 The theft was reported to the police and to her superiors by BAR 7. She required each of the three staff to enter what they had done in the punishment book. The matter was investigated by BAR 14. While all three staff members who struck HIA 101 were admonished, and a note placed on their personal file, no formal disciplinary action was taken against them.\footnote{Day 171, pp 45 and 47.} BAR 14 was asked by the Inquiry whether he felt this was the appropriate way to deal with the matter and he stated that he felt that the line taken was probably proportionate. We accept that when this episode came to the knowledge of the Acting Superintendent at Macedon it was promptly and thoroughly investigated by her and management.

108 In July 1977 Barnardo’s issued a circular to all its staff throughout the United Kingdom and Ireland relating to Care and Control.\footnote{BAR 22272.} This expressly stated that the only form of corporal punishment that was permitted was an occasional smack on the hand for children who were under the age of ten (and who were not handicapped).\footnote{BAR 22273.} Any other form of corporal punishment was forbidden, including the use of any implement.\footnote{BAR 22274.} No doubt to emphasise the importance of adherence to this policy, and the gravity with which a breach would be regarded, the document stated that “Any breach of these rules by a member of staff may lead to disciplinary action which could include dismissal” (emphasis added).\footnote{BAR 22274.}

109 We consider that the episode, and the way it was dealt with, reveal a number of systemic failings on the part of Barnardo’s.

• There was no preliminary investigation of the theft by staff before the child was punished.

• The three staff who struck HIA 101 acted in breach of Barnardo’s policy prohibiting the use of any implement by way of corporal punishment.

• That each resorted to the use of a spoon in such an impulsive fashion suggests to us that this was not the only occasion that staff resorted to a wooden spoon to administer minor corporal punishment.

• We consider that to admonish the three staff, and to place a note on each of their personal files, was an inadequate and inappropriate response. They had individually and collectively...
behaved in a very unprofessional manner, and we consider that the proper course to have taken at that time would have been for each to have received a formal written warning.

**Ghost stories and the “evil eye”**

110 There was considerable evidence before the Inquiry that BAR 1 was in the habit of telling children ghost stories in thoroughly inappropriate circumstances, and grimacing at them in a way which led them to think that she was giving them the “evil eye”. BAR 1 told the police that the children called her “evil eye” and that she had told them ghost stories, although she maintained that the lights were always on on such occasions.

111 However, we are satisfied that BAR 1 was in the habit of telling children very frightening ghost stories, and on many occasions did so in the dark. For example, BAR 55 (who was in Macedon from the age of nine in 1973 until 1977 when she was thirteen) described BAR 1 as playing games in the dark, moaning like a demon and trying to catch the children.

112 These accounts were not limited to children, because several staff described what happened during a police investigation in 2001. BAR 35 described how BAR 1 would tell ghost stories with the lights out and “seemed to get the children excited which was the last thing needed around bedtime. It must have been done regularly because I can remember them”, and “there was a mixture between kids being frightened and enjoying it”. Other staff such as BAR 76, BAR 91, BAR 113 and BAR 92 gave similar descriptions, BAR 92 describing the children being chased around at bedtime and saying that BAR 1 “was unsettling the kids around that time”. BAR 75 told the police that he had instructed her in 1981 not to tell ghost stories.

113 No doubt, as a number of the staff maintained, some at least of the children in Macedon enjoyed having ghost stories told to them and on some occasions this may have been done in the dark. We are satisfied from the various accounts given by children and others to the police in 2001 that it was well known that BAR 1 regularly chased children in the grounds and told ghost stories involving her moaning and jumping

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93 BAR 4910.
94 BAR 4914.
95 BAR 4540.
96 BAR 4606.
97 BAR 4630.
at children. A number of Barnardo’s staff seem to have seen nothing untoward or wrong in this, but others clearly disapproved of her behaviour because this was resulting in a number of children being frightened whilst others became excited and difficult to settle down before bed.

114 We consider that this went much too far and was a practice rightly stopped by BAR 75 in 1981. It should not have been permitted to the extent that it was. Whilst we accept that a rare treat might have been to tell children ghost stories, to do this on a regular basis in the manner in which it was done was a highly undesirable practice. It frightened and upset many children when they should have been preparing to settle down for bed. We are satisfied that it was a completely unacceptable practice which was well known to Barnardo’s staff who either condoned it or failed to intervene to stop it until BAR 75 stopped it in 1981.

115 We consider that the way in which this was allowed to happen amounted to a systemic failing, and that it went unreported and/or undiscovered for several years by senior managers responsible for the home represented a failure by Barnardo’s to exercise proper supervision.

116 We consider this to be a further sign of BAR 1’s unsuitability in any capacity to work at Macedon. Whilst BAR 1 held a childcare qualification, it is apparent to us that she was unsuitable to work in Macedon, and it is questionable whether she should have been permitted to transfer to Macedon from Windsor Avenue when her suitability there was found to be unsatisfactory. The fact that she was repeatedly permitted by senior management to continue in her employment having been found to be unsatisfactory is something we find inexplicable, particularly in the light of her known conduct in relation to ghost stories and grimacing in a way which led impressionable children to believe that she was in some way exercising power over them. It is particularly surprising that she was promoted so soon after the wooden spoons incident in 1979.

117 Irrespective of the nature of her conduct in other matters which we shall consider in due course, we are satisfied that Barnardo’s was guilty of a series of systemic failings in relation to her employment.

• She should not have been retained as an employee for several years, let alone promoted, when it was clear that she was unsatisfactory in the manner that we have described.
The relationship between BAR 1 and Joseph Mains

118 As appears in that part of our report relating to Kincora, Joseph Mains was in charge of Kincora Children’s Home from when it opened in 1958 until he was the subject of a police investigation in 1980. That resulted in his being charged with sexual offences against a number of children, charges which he ultimately admitted and for which he was subsequently sentenced to a period of imprisonment. The relevance of Mains to this chapter stems from his relationship with BAR 1.

119 BAR 1 said in her Inquiry Statement that they:

“...went out together. After the Kincora scandal broke I broke our friendship off. He contacted me again when he was in prison and I felt sorry for him and visited him. I also visited him when he was dying in hospital in Coleraine”.98

However, the evidence before us establishes that the relationship between BAR 1 and Mains when the Kincora investigation started was a long-standing one and more than one of friendship, and that BAR 1 was formally engaged to Mains. BAR 7 said that she believed that it was a formal engagement,99 and Lynda Wilson recalled that BAR 1 had an engagement ring.100 As part of the Terry Inquiry BAR 1 made a statement to Chief Inspector Flenley of the Sussex Police on 1 April 1982 in which she admitted that Mains had been her steady boyfriend for twenty years, that they had become officially engaged two or three years before (i.e. in 1979 or 1980), and that they went out socially together, including going to dances and dinner dances.101

120 We are satisfied that when it first became known that Mains was being investigated in relation to alleged sexual offences against children in his care it was well known to Barnardo’s staff at Macedon that there was a close relationship between Mains and BAR 1.

121 We must emphasise that the Inquiry has found no evidence to suggest that Mains had any improper connection with Macedon, or with any child whilst that child was in the care of Barnardo’s. Nevertheless, when it became known that Mains was alleged to have sexually abused children in his care, Barnardo’s should have taken steps at that time to investigate

98 BAR 2533.
100 Day 172, pp.160 to 61,
101 KIN 40609.
the extent of the relationship between Mains and one of their staff to try to establish whether that relationship involved any risks to the children in Barnardo’s care. No consideration appears to have been given by anyone at Barnardo’s at the time to taking such steps.

122 In her evidence to the Inquiry, Lynda Wilson conceded this was a failing on the part of Barnardo’s, because Barnardo’s recognised that there should have been management consideration of the situation, and as a point of good management practice there should have been consideration and a proactive plan put in place at that stage.102

Barnardo’s accept that “the failure to address, by way of risk assessment and management, the engagement of a member of staff to a person charged with sexual offences against children is...a failing”.103

123 **We agree that the failure of Barnardo’s management to investigate the nature of Mains’ connection with BAR 1 and Macedon represented a systemic failing on the part of Barnardo’s.**

124 Lynda Wilson felt that it was surprising that BAR 1 was kept on by Barnardo’s as long as she was. She explained that at that time in particular a lot of effort would have been made to keep giving people a chance to do better. Nevertheless, she felt that in BAR 1’s case that was a mistake.104 While it is understandable that Barnardo’s wished to support staff, we feel that indicated a willingness to put the interests of staff above the well-being and protection of children.

125 **We consider that BAR 1 had shown herself to be a completely unsatisfactory employee to be placed in the care of children for a considerable period of time before she finally resigned. Barnardo’s failure to terminate her employment at an earlier stage represented a systemic failing on its part to ensure that suitable staff were in place to look after the children in its care.**

**HIA 50**

126 HIA 50 spent two periods in Sharonmore, the first for eight months in 1985 when he was fifteen, and the second for six months in 1986. HIA 50 alleged that during his time in Sharonmore he was anally raped by HIA 516 in a launderette in Ravelston. HIA 516 has denied this. He
was a former resident of Sharonmore, and Barnardo’s accept that he probably did return from time to time after he left in 1982. It is noteworthy that in 1985 he was banned from entering Sharonmore because he had threatened a young boy there, and in December 1986 police had to be called to remove him from Ravelston. We also note that HIA 516 has a substantial criminal record including convictions for common assault, attempting to pervert the course of justice, two offences of unlawful carnal knowledge, as well as convictions for rape in the Republic of Ireland and England. Barnardo’s paid £5000 compensation and his legal costs to HIA 50 in respect of this incident.

127 HIA 516 responded to the Inquiry Warning Letter and denied the allegations. However, we accept that HIA 50 was sexually abused, but we also accept that at the time Barnado’s had no reason to believe that he was at risk from HIA 516. Given that Barnardo’s had no reason to believe that, and that they tried to keep HIA 516 away from Sharonmore when HIA 50 was there, we do not consider that the sexual abuse suffered by HIA 50 was due to any systemic failing on the part of Barnardo’s.

128 HIA 50 has also complained that on one occasion he was taken in a Barnardo’s staff car by BAR 8 when she went to pick up another child living in Sharonmore from her home on the Shankill Road in Belfast. This is a Protestant area but HIA 50 is a Roman Catholic, and he felt extremely frightened when two brothers of the girl tried to get into the car. He alleges that BAR 8 locked the car doors, and slapped him on the face. He believes that she deliberately set up this incident, and part of his complaint is that she did not report the incident afterwards.

129 BAR 8 gave evidence that no such episode occurred involving her and HIA 50. Barnardo’s disclosed to the Inquiry a report of a different incident involving another staff member collecting the same girl from her home when the girl was late and had been drinking.105

130 Having considered all of the evidence relating to this matter, in the absence of conclusive evidence we are not persuaded that there were any systemic failings on the part of Barnardo’s.
The Macedon Police Investigation

Background

In March 1997 HIA 516 wrote to the Chief Constable of the RUC. As a result he was interviewed by officers of the RUC in the Republic of Ireland where he was serving sentences imposed on charges of unlawful carnal knowledge, as well as awaiting trial on charges of rape and indecent assault. In his police statement at 6 May 1987 HIA 516 made allegations that he had been subjected to abuse by three individuals. One was his father BAR 30. Another was BAR 12 and we have considered the allegations made against BAR 12 earlier in this chapter. The third person was BAR 1. These allegations were investigated, and in September 1997 the DPP directed no prosecution against each of these three individuals.

Whilst these matters were being investigated, the police learnt of further allegations by BAR 46 that he had been sexually abused by BAR 3 on an overnight trip to Dublin. It subsequently transpired that BAR 3 died in the Republic of Ireland in 1993, although the police were unaware of that when they carried out this investigation.

In June 1998 allegations were made by BAR 47 a sister of HIA 516 and by HIA 101 his brother, that they too had been sexually abused during their time in Macedon.

The Police Investigation

As a result of these additional allegations the police launched a wider investigation into Macedon covering the period from 1 December 1977, when BAR 1 started to work at Macedon, and 30 May 1984 when she stopped working for Barnardo’s. This investigation also dealt with allegations against BAR 2 who worked at Macedon during part of that period.

With the assistance of Barnardo’s, the police identified 51 people who had been in either Macedon or Sharonmore as children between these dates. Thirteen of the 51 could not be located, were confirmed to be deceased, or were unwilling to speak to the police. Twenty-seven said that they were not abused and were unaware of abuse. Thirteen of the 51...
ex-residents made allegations of abuse. One withdrew his allegation, one would not confirm his verbal allegation in writing, the third was murdered and there was no corroborative evidence of his allegations. As well as the ten remaining ex-residents, two children of a former staff member at Macedon also made allegations of abuse, making twelve people in all who alleged that they were abused during this period.

136 The allegations pursued by the police related to four individuals, namely BAR 1, BAR 2, BAR 3 and BAR 52. The DPP subsequently directed no prosecution of BAR 52. As we have already stated, at this time the police were unaware that BAR 3 had died, and because he had not yet been traced only BAR 1 and BAR 2 stood trial.

137 An unusual feature of the proceedings was that before the trial Barnardo’s settled claims for compensation by nine of the ten individuals who alleged that they had been sexually and/or physically abused by BAR 1 or BAR 2 for amounts ranging from £15,000 to £25,000. Seven of the nine claims were settled within a few days of each other early in January 2003. The only one of the ten individuals who had not brought a civil claim against Barnardo’s at that time was HIA 516.

The Trial

138 A lengthy trial of BAR 1 and BAR 2 took place in 2004. BAR 1 was charged with 105 offences against ten individuals, nine of whom were ex-residents of Barnardo’s and one who had been a child of a former staff member who worked for Barnardo’s. The trial judge directed that she be acquitted on thirteen charges, and that twelve charges be “stayed” (meaning that the prosecution was not allowed to proceed with the charges, but no verdict was taken). BAR 1 was convicted on 52 charges relating to eight of these individuals, and was sentenced to a total of eleven years imprisonment.

139 BAR 2 was charged with 60 offences against six ex-residents. He was convicted on seventeen charges relating to four of them. He was acquitted by direction of the trial judge on 33 charges, and found not guilty on the remainder. BAR 2 was sentenced to fourteen years in prison.

140 Two matters relating to the trial and its outcome are worthy of particular note:
   • BAR 47 did not appear to give evidence in support of the allegations relating to her, and so her evidence on which these charges were based was not considered by the jury who were directed by the
trial judge to acquit both BAR 1 and BAR 2 where those charges depended upon the evidence of BAR 47.

- Although HIA 516 gave evidence at the trial, at the end of the prosecution case the trial judge ordered that the twelve charges against BAR 1 that depended on his evidence should be “stayed” because the charges were an abuse of the process of the court as BAR 1 had been informed by the DPP that she was not to be prosecuted in respect of those charges. The effect of this ruling was that the jury did not have to reach a verdict on the allegations made by HIA 516.

Events before the hearing of the appeal

Both BAR 1 and BAR 2 appealed against their convictions. Prior to the appeals being heard by the Court of Appeal, BAR 37, who had given evidence for the prosecution at the trial, wrote a series of letters which were to prove highly significant. One of these was to BAR 2. In this letter, which appears to have been written on 26 January 2005, BAR 37 made several important assertions.

- He had undergone a religious experience.
- BAR 1 was innocent and he would not be surprised if BAR 2 was innocent as well.
- A great injustice had taken place and he would come forward and tell the truth.
- HIA 216 and BAR 29 were lying about BAR 1, and so he believed they were lying about BAR 2 as well.

In March 2005 BAR 37 wrote another letter to BAR 89, a social worker. He again said that he had undergone a religious conversion and that he wished to put right the injustice he had caused. In this lengthy letter he made the following assertions.

- BAR 1 was innocent of any of the sex charges against her.
- BAR 1 had frightened him and had given him the evil eye.
- That was why he gave evidence against her.
- BAR 1 had only nipped him while bathing him.
- He would now tell the truth although the others may stick to their lies.

109 BAR 4218.
110 BAR 9477.
• It would not surprise him if BAR 2 were innocent as well.
• That he had told his sister BAR 38 what to say about an incident that he had described involving BAR 1 and his sister and himself whilst both children were in the bath together.

143 As a result of these disclosures the police interviewed BAR 37 and he made a statement on 3 June 2005. In this statement BAR 37 purported to recant what he had said in the various letters, and in particular that at BAR 9477. He asserted that he had said these things because he was angry at not being visited in prison by BAR 89, or by anybody else from Barnardo’s, and because BAR 3 had been acquitted on a charge of buggery of him. He explained that his reason for saying that he had lied during the trial was the belief this would mean someone would come to visit him in prison, and that what he had said about others lying at the trial was untrue. He also said that he had not told his sister what to say about the bath incident.

The evidence given to the Court of Appeal

144 Before the Court of Appeal dealt with the appeals against the convictions by BAR 1 and BAR 2 it heard evidence from a number of those who had given evidence at the trial, namely BAR 37, BAR 39, BAR 38 (sister of BAR 37), and the investigating officer in the case, Detective Sgt Boyce. BAR 89, the social worker who had been closely connected with some of the witnesses, also gave evidence. Several, notably BAR 39 and BAR 89, were rigorously cross examined by defence counsel over an extended period of time. The Court of Appeal later expressed its opinion upon some of the witnesses who had given evidence before it, and on some of those who gave evidence during the trial.

The outcome of the appeal

145 After the appeal, the Court of Appeal delivered three judgements. The first was an ex tempore, oral, judgement quashing the convictions. This was followed by a written judgment confirming and amplifying the reasons already given. Finally, on 16 September 2005 the court delivered a second written judgment giving its reasons for not ordering a retrial of

111 BAR 9491.
112 BAR 4120.
113 BAR 4112.
BAR 1 and BAR 2 on the various charges in respect of which they had been convicted.\textsuperscript{114} As we have already indicated, the outcome of the trial and of the appeal was that BAR 1 and BAR 2 were acquitted of all of the charges against them.

\textbf{146} It is essential to remember that the acquittal of any defendant on a criminal charge does not necessarily mean that some or all of the evidence upon which the criminal charges were based was untrue, only that the prosecution have failed to establish his or her guilt to the high criminal standard of proof beyond reasonable doubt.

\textbf{147} It is therefore perfectly possible that in such circumstances some or all of that evidence may nevertheless satisfy the lower standard of proof on the balance of probabilities applied by a civil court, or by an inquiry such as this Inquiry. Although Barnardo’s payments of compensation made before the trial to a number of the witnesses at the trial shows that Barnardo’s accepted that it was legally liable to those individuals, all of whom gave evidence at the trial, Lynda Wilson explained to the Inquiry that Barnardo’s does not take issue with the decision of the Court of Appeal, and it recognises that it is not for Barnardo’s but for the Court or this Inquiry to determine the allegations to whatever extent is necessary.\textsuperscript{115}

\textbf{148} Our Terms of Reference require us to determine whether there were systemic failings on the part of those responsible for residential homes for children, in this case by Barnardo’s. We have to take account of all the evidence now available to this Inquiry to establish whether on the balance of probabilities abuse occurred which could give rise to findings that there were systemic failings on the part of Barnardo’s towards the children in its care. This includes us giving proper weight to any material that affects the reliability of some, or all, of the evidence of witnesses during the trial of, and during the appeal by, BAR 1 and BAR 2.

\textbf{149} In particular it requires us to take into account that the evidence of individual witnesses has been exhaustively probed in cross examination, either at the trial or before the Court of Appeal. Where the evidence of an individual witness has been shown to be either untrue or unreliable in important respects at the trial or before the Court of Appeal, then we have to take that into account when deciding to what extent, if any, we can regard the evidence of that witness as reliable.

\begin{itemize}
\item\textsuperscript{114} BAR 4105.
\item\textsuperscript{115} Day 172, p.132.
\end{itemize}
We have concluded that the judicial criticisms of the evidence of several of the witnesses whose evidence was relied upon to support the criminal charges against BAR 1 and BAR 2, criticisms which led the Court of Appeal to quash their convictions on the charges upon which they were convicted, mean that we cannot rely on their evidence alone. We have also considered the evidence of other witnesses relied upon to support the convictions of BAR 1 and BAR 2. We have not had the benefit of hearing oral evidence from the other witnesses, or from BAR 1 or BAR 2, although both provided written statements to the Inquiry denying that they committed any offences.

Because this was a criminal investigation it was concerned with possible offences and was not concerned with probing issues of a childcare nature. As a result, inevitably issues of systemic failings relating to the care provided for children were only touched on incidentally.

Taking all of these factors into account, we consider there is insufficient reliable evidence to satisfy us that the more serious allegations of sexual and physical abuse made against BAR 1 and BAR 2 by witnesses other than BAR 46 and BAR 39 have been established to the civil standard of proof on the balance of probabilities.

For these reasons we consider that we must leave out of account the allegations of abuse against BAR 2, and the greater part of the allegations of abuse against BAR 1, when deciding whether there were systemic failings in the care of children provided by Barnardo’s at Macedon.

As a result, we are left with only the evidence of BAR 46 and BAR 39 relating to BAR 1. We have considered that evidence very carefully. Some of their evidence supports the conclusions we have already expressed about BAR 1 frightening children by telling them ghost stories, chasing them in the dark and pretending she had the evil eye. We are not persuaded by the remainder of their evidence, which was relied upon at the trial to establish the more serious allegations of sexual and physical abuse of children in either Macedon or Sharonmore made against BAR 1 and BAR 2.

Looking at the evidence as a whole we are persuaded that BAR 1 engaged not only in the ghost stories and other related matters to which we have already referred, but also engaged in inappropriate bathing of male children who were of an age when they should have been left completely to bath themselves, as other witnesses alleged in their statements to the police, and not assisted to do so by BAR 1. We regard this as an unacceptable practice which should not have been allowed to occur.
That it was allowed was due to inadequate supervision of BAR 1 by management at Macedon, and amounted to a systemic failing.

Nevertheless, it is also clear from statements made to the police during this investigation that there was corroboration of some parts of the account by BAR 47 of her relationship with BAR 2.

- Several staff members observed that BAR 47 appeared to be very fond of BAR 2. BAR 9 told the Inquiry he warned BAR 2 to be careful.\(^{116}\)
- BAR 47 agreed that she borrowed BAR 2’s ring on occasion. This also is confirmed by BAR 9.\(^{117}\)
- The then Superintendent of Macedon, BAR 23 (since deceased) objected to BAR 2 taking BAR 47 to his flat.\(^{118}\)

We are satisfied that these events occurred, and that they should not have. We consider that management at Macedon were at fault in not taking steps to investigate whether an inappropriately close relationship was developing between a staff member and a teenage girl resident in the home. Whether or not anything untoward in other respects occurred between BAR 2 and BAR 47 (as to which we express no conclusion), the failure to prevent this relationship developing, and then to put a stop to it, represented a systemic failing on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.

The Ruddock Report

When the trial judge sentenced BAR 1 and BAR 2 he made a number of critical observations as to how Macedon was run based on the evidence given during the trial, which had been clearly accepted by the jury. After the trial, and before the developments leading up to and during the Court of Appeal hearing, Barnardo’s arranged for a senior officer at its headquarters in Barkingside in Essex to carry out an investigation and report. Lynda Wilson explained that this was not intended to be an in-depth historical review of the allegations, but an examination of Barnardo’s practices when viewed against the trial judge’s remarks in order to see whether there were systems failures in Macedon during the time with which the trial was concerned, and to check Barnardo’s current

\(^{116}\) Day 172, pp. 99 to 100.
\(^{117}\) See police report at BAR 4278 for other accounts to the same effect.
\(^{118}\) BAR 4282.
practices.119 This report was prepared by Martin Ruddock. Whilst part of the process involved consideration of notes taken with the permission of the judge by Barnardo’s staff during the trial, Ruddock also examined a number of the children’s files.

159 The Ruddock Report was subject to trenchant criticism by BAR 14, who had not seen it before it was provided to him by the Inquiry. He described it as, “a rather shallow piece of work, somewhat partial in its scope, and certainly weak in the evidence”.120 “To me it was a crudely constructed set of conclusions without evidence”.

160 Ruddock commented on a number of matters, in particular BAR 1’s continued employment, and observed that in his view “… management failed to effectively review evidence from children’s records and no doubt elsewhere to show something at Macedon was wrong”. However, he immediately qualified that by continuing:

“This comment is however made with hindsight and knowledge about abusive practice gained through numerous reviews over the last 20 years”.121

161 A key conclusion, and one to which BAR 14 took particular exception, was contained in the following passage:

“My hypothesis is that the level of incident, low staff moral [sic] political environment [letter by BAR 24]122 management failure and lack of strategic leadership left a staff group managing a level of chaos that inhibited reflective practice to identify and address what was going on”.123

162 We do not consider it necessary to comment upon every detail of the Ruddock Report. We accept that to a significant degree it was influenced by hindsight. We also accept that between 1977 and 1981 Barnardo’s senior staff in Northern Ireland engaged in detailed strategic planning that led to Macedon being replaced by the innovative and carefully planned Sharonmore Project. We do not consider that there was a lack of strategic leadership in Barnardo’s at that time in that context.

119 Day 172, p.133.
120 Day 172, p.12.
121 BAR 056.
122 BAR 4242.
123 BAR 057.
However, we are satisfied that management practices at Macedon during the years 1977 to 1981 were deficient in a number of respects that give rise to systemic failings. As we have already indicated, we consider BAR 1 should not have been employed at Macedon. Her assaults, and the assaults of her two colleagues, on HIA 101 and her being allowed to frighten children by telling ghost stories and the related matters should have been dealt with sooner and more robustly. The failure of BAR 24 to report BAR 3’s behaviour to his superiors was a further example of an unacceptable approach. All of these failings contributed towards creating, or perpetuating, risks of abuse to children, whether they were in care of Barnardo’s in Macedon or elsewhere.

Barnardo’s have stated that the Ruddock report meant “Barnardo’s accepted that when the decision was made to close Macedon, management focus shifted to the development of the new Sharonmore service. This shift in service, it was further accepted, had detrimental implications for the robustness of the service to be closed”. 124

We are satisfied the failings we have identified occurred because of poor management at Macedon, something that reflects on the leadership exercised by Barnardo’s staff both in Macedon and at a higher level in Northern Ireland, possibly because oversight of Macedon by more senior staff was reduced due to the attention devoted to bringing the Sharonmore Project into being and to completion, as well as achieving a smooth transition from Macedon to Sharonmore. We regard the poor management at Macedon and of Macedon during BAR 1’s time there as a systemic failing by Barnardo’s.

BAR 52

The fourth person to be investigated by the police during the Macedon Inquiry was BAR 52 who was employed as a gardener or handyman at Macedon for some nine months between November 1973 and August 1974. BAR 55 (who did not apply to the Inquiry) was at Macedon for most of the time between 1969, (when she was aged six or seven), and 1976, when she was sixteen. In 2000 she described to the police how she had been in the handyman’s shed when she was twelve, and how he came up behind her while she was standing at the work bench, put his hands on the bench on either side of her, rubbed himself against the back of her...
legs, and rubbed his hand on her leg on top of her school uniform skirt. Someone called his name and he moved away. Although she thought she told another girl about this, it would seem that she did not report the incident to anyone in authority.

167 When questioned by the police in 2000, he was 80 and the alleged events had occurred more than 26 years before. He denied allowing children into his workshop. As the investigating officer commented, the allegations were uncorroborated. Taking into account BAR 52’s age and the passage of time the DPP directed no prosecution.

168 BAR 52 was the brother-in-law of the then superintendent BAR 24. This appears to have been a “one-off” episode. Although there was one other allegation, which may have related to BAR 52, this was not pursued by the complainant and there appears to be no other allegations relating to him, whether at Macedon or elsewhere. Given the nature of his job as a grounds-man/handyman, it is unlikely that at that time in 1973 and 1974 the type of vetting which is now regarded as appropriate would have been considered usual for such a post. In those circumstances we do not consider that there is any evidence of a systemic failing on the part of Barnardo’s in relation to these events.

Staffing

169 Apart from the suitability of BAR 1 to work at Macedon and Sharonmore, which we have already considered, among the criticisms made of Barnardo’s by the trial judge when sentencing BAR 1 and BAR 2 was that “Staff had no or very basic qualifications and seem to have been given far too much unsupervised responsibility”. We have the advantage of having received a great deal of evidence from all quarters about the level of qualifications and quality of staff during the post Second World War period in many more homes in the statutory and voluntary sectors of residential childcare in Northern Ireland than just the limited period at the Barnardo’s homes at Macedon and Sharonmore that were examined during the trial.

170 That evidence, and the experience of those members of the panel with many years experience of the position elsewhere in the United Kingdom, leaves us in no doubt that in the early 1970s all residential institutions

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125 BAR 5109.
126 BAR 4354.
127 BAR 4020.
for children still had to rely to a very significant degree on staff who were either unqualified, or had only basic qualifications, in residential childcare. There was a limited number of professionally qualified staff in the childcare sector generally at that time, something that the Ministry of Home Affairs had recognised as early as the 1950s needed to be improved.

171 Over many years the Ministry encouraged both the voluntary and statutory sectors to send staff on training courses and supported this by providing the necessary finance to pay replacement staff while staff were absent on training courses in England. From the late 1960s various training courses were provided by the Rupert Stanley College in Belfast on both a full-time and day-release basis. However, as BAR 14 pointed out in his evidence, the voluntary sector had difficulty in retaining residential staff in the 1970s as the statutory sector offered more attractive working conditions, such as shorter hours and better pay.

172 It was only after the Hughes Inquiry had drawn attention to these difficulties in its report that a real improvement in the position in the residential childcare sector was achieved, and to such an extent that by the end of our Terms of Reference in 1995 the position in Northern Ireland was considerably ahead of the rest of England and Wales in this respect.

173 Although we have found systemic failings on the part of Barnardo’s in relation to their employment of BAR 1 and in their treatment of the allegations against BAR 3, we consider that if anything, Barnardo’s were better than other institutions in the voluntary sector in Northern Ireland in the quality of staff they employed. In her evidence Dr Harrison said that when she joined Barnardo’s in 1976 its policy was to recruit staff with at least the minimum qualification, and her impression at that time was that there was a much higher number of staff with the basic qualification than maybe existed in statutory homes at that stage.

174 Her recollection is in accordance with the evidence given to the Hughes Inquiry by BAR 79 (then the Divisional Director of Barnardo’s for Ireland), and Barnardo’s written submission to the Hughes Inquiry. BAR 79 emphasised that traditionally, Barnardo’s put a lot of emphasis on staff development and training, and had its own training courses before nationally available courses became available from 1948 onwards.

128 Day 171, p.34.
129 Day 172, pp. 42 and 46 to 48.
130 BAR 22026.
It also paid qualified staff more than their equivalents in the statutory sector so that they could attract and retain qualified staff.\textsuperscript{131} As part of this approach, in 1979 Barnardo’s decided to pay residential social workers the same as field social workers.\textsuperscript{132}

\section*{BAR 79}

BAR 79 pointed out that in its report of its 1983 inspection of Sharonmore the Social Work Advisory Group (SWAG) expressed the view that Sharonmore had:

“...probably the best qualified group in a home in the Province. [And] overall, out of 120 social work staff in the division [that is for the whole of the island of Ireland] we have got 64 with an approved qualification by the Central Council for Education and Training in Social Work, and 34 staff with either the Certificate in Social Service, which is part-job related training, or another allied qualification in teaching or in youth work.”\textsuperscript{133}

176 We are satisfied that Barnardo’s made every effort to recruit suitably qualified staff, and although we have found it to be guilty of a systemic failing in the specific case of BAR 1, we are satisfied there was not a general systemic failing in Barnardo’s recruitment of staff. From the documents we have seen we are satisfied that Barnardo’s had many excellent policies, systems, and procedures, and went to considerable lengths to disseminate these by regular visits by senior staff from Headquarters, individual supervision of staff and staff meetings. We recognise that in many respects Barnardo’s were amongst the leading exponents in the United Kingdom in the demanding field of residential childcare for very difficult children.

\section*{Inspections}

177 As in some other modules, the DHSSPS were unable to find reports of inspections of Macedon by inspectors from the Ministry of Home Affairs due to the normal process of review and destruction of old files. However, there is no reason to believe that such inspections were not carried out as we know they were in other institutions, and that is borne out by the evidence of BAR 14 who was aware of inspections by Miss Forrest and Miss Hill of Barnardo’s in the 1970s.\textsuperscript{134}

\begin{flushleft}
\textsuperscript{131} BAR 22026.  \\
\textsuperscript{132} BAR 22054.  \\
\textsuperscript{133} BAR 22026.  \\
\textsuperscript{134} Day 171, 2015 at p.33.
\end{flushleft}
BAR 14 told the Inquiry that in his eight years with Barnardo’s he never met a SWAG inspector in his professional capacity, although he was aware of informal visits, it remains the position that SWAG did not carry out any formal inspections in the mid-1970s for reasons we address in Chapter 2, but the failure by SWAG to carry out formal inspections of Macedon in the 1970s was a systemic failing on its part.

Compliance with the Visiting Committee requirement of the Voluntary Homes Regulations

BAR 14 explained that although Barnardo’s Council in Essex had ultimate responsibility, a considerable amount of authority was delegated to divisional heads. Because there was no visiting committee in the Barnardo’s structure in Northern Ireland this meant that the Divisional Director in Northern Ireland in turn delegated the responsibility for regular visiting to the Assistant Divisional Director (the ADD) in the divisional headquarters. The ADD was answerable to the Divisional Director, and visited each residential home on a monthly basis and prepared a detailed report. In addition, there were regular meetings of the superintendents and deputy heads of all the homes, which were properly minuted and matters of day-to-day administration and concern discussed, as can be seen from minutes produced to the Inquiry, such as those for the superintendents held on 8 September 1978.

We consider that these arrangements meant that the Divisional Director for Ireland was the “administering authority” within the meaning of the 1975 Voluntary Homes Regulations, and that the visits by the ADD fulfilled the requirement under the Regulations for monthly visits.

The Hughes Inquiry received considerable detail from BAR 14 about the frequency of visits to Macedon and Sharonmore by the ADD during the period relating to the sexual assaults suffered by BAR 44, and Barnardo’s requirements for regular written pro forma reports to be submitted to the ADD by the superintendent. It concluded at 11.20 of its report that:

“As we have said in earlier chapters, we consider the reporting activity to be of secondary importance to the actual visits, and we accept that BAR 111 [the ADD at the relevant time] did visit the Project [Sharonmore] on a regular basis and that monitoring was continuous

135 Day 171, 2015 pp. 16 to 19.
136 BAR 26075/6.
137 BAR 22012
and well-directed. Nevertheless, we consider Barnardo’s record on reporting to have been less than entirely satisfactory in so far as it fell short of full compliance with the letter of the 1975 Regulations. Nevertheless, this had no relevance to the isolated offence against [BAR 4]’.

182 We are satisfied that these arrangements provided a very high level of external oversight of the day-to-day working of Macedon and Sharonmore, oversight which amply complied with the spirit, if not perhaps the letter, of the Voluntary Homes Regulations.

Conclusions

183 We are satisfied that Barnardo’s and the DHSS were responsible for the following systemic failings in relation to Macedon.

Barnardo’s

184 The failure to detect the bizarre behaviour of BAR 3, and then to take appropriate action, were systemic failures because they demonstrated a lack of knowledge of what was happening among the staff on the part of management at Macedon.

185 We consider the amount of unsupervised access by BAR 4 to HIA 216, and the failure of Barnardo’s to inform the EHSSB that this access was taking place, represented systemic failures by Barnardo’s to provide proper childcare.

186 There were several systemic failings in the way in which the allegations about BAR 3 were handled by Barnardo’s staff at Macedon:

• They were not reported for some months by BAR 8 to BAR 24.
• A deliberate decision was made by BAR 24 not to report the full facts to his superiors or to anyone else.
• BAR 75 does not seem to have reported the remark made to him by BAR 47 that BAR 3 was a “real fruity boy” to his superiors at Barnardo’s.138

138 BAR 8619
187 The reluctance on the part of some Barnardo’s staff in Northern Ireland in the 1980s to report allegations about staff to the proper authorities was a systemic failing.

188 The manner in which the relationship between HIA 516 and BAR 12 was allowed to develop, and the length of time for which it was allowed to continue, represented systemic failures by Barnardo’s to ensure proper childcare of HIA 516.

189 The ‘wooden spoon’ episode, and the way it was ultimately dealt with, represented a number of systemic failings on the part of Barnardo’s:

• The three staff who struck HIA 101 acted in breach of Barnardo’s policy prohibiting the use of any implement by way of corporal punishment.

• That each resorted to the use of a spoon in such an impulsive fashion suggests this may well have not been the only occasion that staff resorted to a wooden spoon to administer minor corporal punishment.

• To admonish the three staff, and to place a note on each of their personal files, was an inadequate and inappropriate response. The proper course to have taken at that time would have been for each to have received a formal written warning.

190 The way in which BAR 1 was allowed to frighten children with ghost stories and the ‘evil eye’ practice, and that it went unreported and/or undiscovered for several years by senior managers responsible for the home represented a failure by Barnardo’s to exercise proper supervision.

191 BAR 1’s bathing of male children who were of an age when they should have been left completely to bath themselves was an unacceptable practice which should not have been allowed to occur. That it was allowed was due to inadequate supervision of BAR 1 by management at Macedon, and amounted to a systemic failing.

192 We agree that the failure of Barnardo’s management to investigate the nature of Mains’ connection with BAR 1 and Macedon represented a systemic failing on the part of Barnardo’s.
193 The failure to prevent the relationship between BAR 2 and BAR 47 developing, and then to put a stop to it, represented a systemic failing on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.

194 BAR 1 should not have been retained as an employee for several years, let alone promoted, when it was clear that she was unsatisfactory in the manner that we have described.

195 BAR 1 had shown herself to be a completely unsatisfactory employee to be placed in the care of children for a considerable period of time before she finally resigned and Barnardo’s failure to terminate her employment at an earlier stage represented a systemic failing to ensure that suitable staff were in place to look after the children in Barnardo’s care.

196 There was poor management at, and of, Macedon during BAR 1’s employment.

197 There was a failure on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.

**The DHSS**

198 The failure by SWAG to carry out formal inspections of Macedon in the 1970s.