

Chapter 23:

Module 5 – Fort James Children’s Home and Harberton House Assessment Centre

	Para
Introduction..	1

Part One:

Fort James Children’s Home	8
Arrangements for Internal Monitoring and External Inspection of Fort James	14
Challenges Fort James faced in meeting its remit	20
Evidence of HIA 108 about her time in Fort James	35
Evidence of HIA 60 about his time in Fort James	44
Alleged Sexual Abuse by FJ 5	53
Conclusions about Fort James	71
Summary of Findings about Fort James..	77

Part Two:

Harberton House	78
Review of the First Six Months of Operation of Harberton House	85
Formal Review of Harberton House in 1984..	91
Governance and Quality Assurance Arrangements	95
Peer Sexual Abuse	107
Involvement of the Department	120
The Review Process	130
The Review Team’s Conclusions and Recommendations	140
WHSSB’s Response to the Review Report..	146
Further Incidents of Peer Abuse in Harberton House	173
Evidence from HIA 233 about her time in Harberton House.	199
Summary and Findings about Harberton House	208

Introduction

- 1 The Inquiry devoted Module 5 to the examination of particular aspects of the operation of two children’s homes in Londonderry: Fort James and Harberton House. Both these homes were managed by the Western Health and Social Services Board (WHSSB), now succeeded by the Western Health and Social Care Trust (WHSCT). Our focused consideration of these homes was prompted by evidence we received from former residents and by police material about investigations they carried out in relation to the homes.
- 2 Two former residents of Fort James, HIA 108 and HIA 60, and one former resident of Harberton House, HIA 233, raised issues about the care they received in these homes as part of the evidence they gave during Module 1 of the Inquiry, which considered children’s homes run by the Sisters of Nazareth in Londonderry.
- 3 The material we received from the police concerned their investigations into an allegation that FJ 5, the officer in charge of Fort James from September 1980 to August 1983, sexually abused a male resident in the home and into incidents of peer sexual abuse in Harberton House in 1989-1990, 1992 and 1994.
- 4 The Inquiry devoted eight sitting days spread over two weeks to this module, commencing on 8 June 2015 and finishing on 18 June 2015. HIA 108’s evidence about her time in Fort James in 1980 and HIA 233’s evidence about her time in Harberton House in 1991-1992, and responses to their evidence, were heard in Module 1. Therefore, HIA 108 and HIA 233 were not required to go through the pressure of giving evidence in person again in Module 5. Transcripts of relevant parts of the evidence they gave in person in Module 1, and responses to it, were considered during Module 5. HIA 60’s evidence about his time in Fort James in 1980-1981 was not heard when he gave evidence in person in Module 1 and therefore he did attend and gave evidence during Module 5.
- 5 In addition to the evidence from these former residents, we heard evidence from staff who worked in the homes, HH 5, FJ 33, HH 22 and FJ 7, and from senior managers responsible for the operation of the homes, Dominic Burke and Gabriel Carey. Dr Kevin McCoy, Denis O’Brien and Marion Reynolds gave evidence about the inspection and regulation of the homes and Dr Hilary Harrison gave evidence on behalf of the Department of Health, Social Services and Public Safety (DHSSPS).¹

1 FJH 60077-60081.

- 6 We also considered written statements from previous senior WHSSB managers such as Thomas Frawley, who was the Area General Manager of the WHSSB from 1984 to 1995², and from the current Director of Women and Children’s Services and Executive Director of Social Work of the WHSCT, Kieran Downey.³
- 7 We are grateful for all the evidence we received, which assisted our understanding of the development and operation of these homes within the wider childcare services provided by the WHSSB.

2 FJH 599-770.

3 FJH 771-791 and 838 -859.

Part One:

Fort James Children’s Home

- 8 Fort James children’s home opened in 1973 and accommodated children from the Londonderry, Limavady and Strabane district (later Unit), until it closed on 31 March 1995. The home was originally built as a private residence in 1862, and was set in wooded grounds in Ardmore Road around three miles from the centre of Londonderry. It was a three-storey property with additional outbuildings at the rear. When it opened in 1973 it was located between two Housing Executive estates, Tullyally and Currynierin.
- 9 The Health and Social Care Board (HSCB) explained in its submission to the Inquiry that only limited records are available in relation to the early years of operation of Fort James. The available records show that the majority of children accommodated in the home between 1973 and 1978 were babies and young children up to the age of five, although one or two older teenagers were also accommodated in the home during this period. Initially the senior staff member of the home was called matron and the other staff were called nursery nurses.
- 10 HH 22 commenced work in Fort James in 1975 and by that time the title houseparent was being used for staff. HH 22 was appointed to the post of senior house parent. She told us that when she commenced work in the home there was a nursery on the ground floor with cots for three babies and that the oldest resident was seventeen-years-old. She explained that the staff received little information about the circumstances that led to children being admitted to the home and that although the practical needs of the children were met there was little therapy or care planning provided. She commented, “it was all about group living, with little opportunity for individual time, because of the small staff team and wide age range”, and that it was “very difficult to observe or monitor the children’s whereabouts both in the badly laid out house and the large grounds”.⁴
- 11 The HSCB informed us that in and around 1978 the nursery in the home was closed and the intention was to develop a home for older children. When Harberton House opened in 1980, Fort James’ remit was confirmed as being specifically to provide medium or long-term care for sixteen children, aged between five and seventeen years. The stated aim of the

4 FJH 40182.

home was to assist children to return to their parents, prepare for a foster placement, or prepare for independent living in the community.

- 12 Given the focused nature of our consideration of Fort James it would not be appropriate to consider the governance, funding and operational arrangements in detail. However, it was clear from the evidence of previous staff and managers of Fort James and contemporaneous documentation that the home faced significant challenges in meeting its stated remit. This was, due in the main, to the number of emergency placements it had to accommodate, which included the placement of younger children with a range of needs. Emergency placements also led at times to a high throughput of children in the home, which hampered the provision of the consistency and stability required for medium to long-term care of older children. The home also had to deal with periods of over-occupancy and staff shortages.
- 13 The impact these circumstances had on the care that could be provided in the home and the pressures on staff were clearly and consistently identified through internal monitoring and external inspection of Fort James. To set the context for our consideration of the home we will briefly note these circumstances as they were identified through contemporaneous monitoring processes.

Arrangements for Internal Monitoring and External Inspection of Fort James

- 14 In accordance with the Conduct of Children’s Homes Direction (Northern Ireland) 1975 the WHSSB had a duty to ensure that each of its children’s homes was conducted in such a manner and on such principles as would further the wellbeing of children in the home. The WHSSB put arrangements in place for the regular monitoring of Fort James and invested significant resources in this monitoring throughout the 1980s and up until the home closed in 1995.
- 15 Part of the monitoring arrangements was the provision of a monthly report on the home by a visiting social worker. This duty was allocated to a senior member of social work staff, TL 4, first in his role as Senior Social Worker (Residential and Day Care) and then in his subsequent role as Assistant Principal Social Worker (Child Care). TL 4 visited Fort James regularly and submitted a monthly written report on the home to his managers using a standard format to record his observations and conclusions.⁵

5 FJH 6812.

- 16 In addition, from 1988 onwards, managers senior to TL 4, Gabriel Carey and then Robert Dunseath, undertook management audit visits to the home approximately every six months. Both these senior managers produced detailed reports of their audit visits to Fort James⁶ which they provided to their management colleagues.
- 17 Directors of Social Services also occasionally visited the home and contemporaneous documentation shows that they tended to follow up these visits with memos to senior colleagues about any matters of concern.
- 18 In addition to monitoring by managers, a member of the WHSSB’s Personal Social Services Committee visited the home on a regular basis and completed a brief proforma recording his/her findings, which were then reported to the Committee.
- 19 The Department of Health and Social Services (the Department) was responsible for the external scrutiny of the home. Records of this external scrutiny are not available for the period 1973 to 1982, but inspections of the home were undertaken by the Social Work Advisory Group (SWAG) in 1982 and 1986, and by the Social Services Inspectorate (SSI) in 1987, 1991 and 1994.

Challenges Fort James Faced in Meeting its Remit

- 20 In spring 1981 the then Director of Social Services, Ronnie Carroll, inspected Fort James to examine the professional functioning within the home. In a memo he sent to Tom Haverty, the then District Social Services Officer, about his visit he acknowledged the aspiration of the staff that the home should concentrate on offering care for periods ranging from six months to three years for older children. However, he pointed out that the wide variation in the ages of children admitted to the home and in the lengths of their stays affected the programmes of care that could be planned and put into operation. He recognised that the shift to caring for older children for longer periods would require an increase in emergency fostering and the number of long-term foster placements. Mr Carroll asked Mr Haverty to undertake a review of fostering resources to ascertain how many foster parents would be willing to accept shorter placements and emergency placements, particularly for pre-school children.⁷

6 FJH 6751.

7 FJH 6555.

- 21 Despite this intervention, the SWAG team that inspected Fort James in 1982 concluded that the home’s aims and objectives to provide medium to long-term care for older children were being undermined by the need to accept emergency admissions. Inspectors found that between January 1981 and September 1982 a total of 34 children were admitted to Fort James. Twenty of these admissions were unplanned and arranged at short notice and ten of the eighteen admissions received between January and September 1982 were emergencies. The inspectors recorded the view of the officer-in-charge, which echoed that of Mr Carroll, that unplanned admissions and uncertainty about the duration of placements in the home was making it difficult to implement planned programmes of care for individual children. The inspectors recommended that the frequent use of the home for emergency admissions was reviewed urgently.⁸
- 22 Staff shortages were also a problem at times in Fort James. The monitoring of the home by members of the WHSSB’s Personal Social Services Committee and the reporting on this monitoring to the Committee meant that this difficulty was known at the highest level of internal governance. For example, Mr P D McAleer recorded in the report of his visit to Fort James on 4 December 1982 that “there continues to be a severe shortage of staff”.⁹
- 23 To further the remit of caring for older children, the accommodation in Fort James was renovated in late 1984 to provide self-contained flats on the site which were used to assist young people to prepare for leaving care. The addition of these flats increased the total capacity of the home to twenty-one.¹⁰ When the home was inspected in 1982 inspectors recorded that the major problem was shortage of staff rather than the use of the home for emergency placements. By the time of the follow-up visit to the inspection which took place in October 1984 the inspector recorded that the staffing establishment had been increased by two senior house parents and two house parents and the number of emergency placements had reduced.¹¹ However, FJ 33 who was appointed as officer in charge of Fort James in May 1984 told us that during his period as officer in charge the home continued to have to accept a range of emergency and short-term assessment placements. He recalled that staff had to work with children who ranged in age from five to eighteen years, who had a variety

8 FJH 6619.

9 FJH 6561.

10 FJH 40908.

11 FJH 5263-5264.

of care needs, including some learning disabilities, and that the lengths of their stays varied from short to medium to long-term. He explained that this complex mix of children made it very difficult to meet their needs.¹²

24 Throughout the 1980s and into the 1990s these difficulties persisted and were recognised and recorded by senior managers who visited the home regularly. For example, Robert Dunseath, Principal Social Worker (Child Care) recorded in his monitoring report of the home for the period April 1989 to March 1990, that twelve of the total of fifteen admissions in that period had been directly from the community and were due to the lack of available alternative placements. He recorded that three children in the home were aged between five and nine years and four children were aged between ten and fourteen years. He observed that this position reflected the overall increase in the number of admissions of children to care in the area and concluded that if the level of demand for care was sustained there could be implications for the role and function of Fort James.¹³

25 A similar state of affairs was recorded in the 1991-1992 monitoring report, which identified that six of the eleven admissions in that period were emergency admissions direct from the community and that this reflected:

“a trend identified in the last few monitoring reports of Fort James not meeting its core role as a long-stay unit being used for children moving from Harberton House”.¹⁴

The report concluded that while the formal aims and objectives of Fort James remained unchanged, in practice it was being used predominately as an emergency reception centre rather than as a long-stay unit for adolescents preparing to leave care.¹⁵ The impact on Harberton House of not being able to transfer children to Fort James will be considered later in this chapter.

26 Despite its continued inability to meet its stated remit, the home was further developed and restructured on the basis of that remit. By the time of the SSI inspection in 1994 the home had been divided into two units: an Adolescent Resource Team which was expected to provide a service from reception to long-stay care to address the assessed needs of twelve young people

12 Day 124, p.15.

13 FJH 6758-6794.

14 FJH 6966.

15 FJH 6966.

aged thirteen years and over; and, a Leaving and After Care Team which was expected to prepare four young people to leave care and to provide a supportive/crisis intervention service for those who had left care.¹⁶

- 27 However, the inspectors found that despite the redesign of the services being offered in Fort James the home was still not meeting its aim of caring only for children aged over thirteen years. Inspectors noted that eight of the 31 admissions made in the year prior to the inspection were of children aged less than eleven years. Inspectors also noted that in the previous year the home had to cope with a group of young people with very different needs, and that the throughput of children with 31 admissions and 37 discharges had created considerable disruption for the young people requiring long-term care.
- 28 The inspectors recorded that they had heard from staff and residents that there had been major control problems in the home during most of 1993. They suggested that one possible explanation for this unsettled and volatile situation could be the number of admissions and discharges and the resulting disruption this caused to the residential group.¹⁷
- 29 The inspectors also commented that the level of throughput and the practice of caring for adolescents on short-term and long-stay placements within one residential team, raised questions about how the “assessed needs of residents could realistically be addressed”.¹⁸ They noted that a proposal had been made by the team leader to use the bungalow in the site as a reception unit to separate the groups given their different needs, but that this plan had not been progressed because of cost implications.
- 30 The first recommendation in the report of the inspection was that the aims of Fort James should be reviewed and a statement of aims and objectives established that should inform decisions relating to admission and the admission process.¹⁹ This recommendation was made in the knowledge that active consideration was being given to the closure of Fort James. Staff had informed the inspectors that the WHSSB, as part of its Purchasing Prospectus 1994/1995 – 1996/1997, intended to reduce its residential childcare places by fourteen beds over a three-year period and that the closure of Fort James, which would enable a reduction of sixteen beds, was being considered.

16 FJH 40261-2.

17 FJH 40283.

18 FJH 40262.

19 FJH 40299.

- 31 Given the obvious high level of demand for placements in Fort James, inspectors urged in the inspection report that any plan to close the home was based upon:
- “a comprehensive child care strategy;
 - a detailed preventative strategy;
 - a review of the number of beds required to support the Board’s overall child care strategy;
 - the development of a range of alternative placement options; and
 - an assessment of the likely impact of closure on the remaining children’s homes within the Board’s area.”²⁰
- 32 The Department, appropriately in our view, followed up these concerns in writing to the WHSSB cautioning against closure of the home in the absence of any rapid development of fostering services, and pointing out the impact that closure could have on Harberton House.²¹ Despite these concerns, the WHSSB continued with its plans and Fort James was closed on 31 March 1995.
- 33 We noted with concern that despite the high level of internal monitoring and external inspection of the home, recurring concerns about:
- the mix of children in Fort James in terms of age;
 - needs and length of stay;
 - over-occupancy;
 - low staffing levels;
 - the impact of emergency placements; and
 - lack of fostering provision
- were never fully addressed or resolved. During our consideration of Fort James the question arose about whether this was in part due to a historical underfunding of the north west of the province, which meant the WHSSB could not provide the full range of foster and residential childcare increasingly required of it in the 1980s and early 1990s. We address that question more generally in the section about Finance in Volume 1.
- 34 We will now consider the evidence we received from applicant witnesses about Fort James and the police investigations into alleged sexual abuse by FJ 5, an officer in charge of the home.

20 FJH 40299.

21 FJH 40055.

Evidence of HIA 108 about her time in Fort James

- 35 HIA 108 was initially admitted to Harberton House on 11 October 1980 when she was eleven years old, as an emergency application under a place of safety order. A case conference was held on 24 October 1980 and it was agreed that Fort James would be a more suitable placement for her. She was admitted to Fort James from Harberton House on 3 November 1980 and discharged to her parents’ care just under a month later on 1 December 1980.
- 36 In her written statement, HIA 108 described Fort James as badly run with an aggressive, noisy atmosphere.²² When she gave evidence in person she described the home as chaotic and referred to the mixture of young and older children and the aggressive behaviour of the older boys.²³
- 37 Her specific complaint about the home was that a priest, SND 67, who she alleged had previously sexually abused her in a parochial house in Strabane and in Termonbaca children’s home in Londonderry, was allowed access to her in Fort James and continued to abuse her there. She told us that shortly after she arrived in Fort James SND 67 met her when she was out walking with a member of staff and other children from the home. She said the member of staff told her that SND 67 had been asking about her and commented that he was a lovely man. HIA 108 said that four or five days later SND 67 came to visit her in the home and she was taken to a small meeting room and left alone with him. She said that on that occasion he did not abuse her, but that on subsequent visits to the home he sexually abused her, including digitally penetrating her back passage and causing her to bleed.²⁴
- 38 HIA 108 stated that when she tried to resist seeing SND 67 staff told her he was well-intentioned and that she was being disrespectful. She said that on one occasion when SND 67 visited she tried to physically resist being sent to meet with him and a member of staff, FJ 1, twisted her arm in order to make her do so. HIA 108 told us that SND 67 talked in a friendly manner to staff in Fort James, was given tea when he visited and prayed with some of the staff. She stated that the attitude of the staff towards SND 67 meant that he was able to continue to sexually abuse her two to three times a week while she was resident in Fort James.

22 FJH 030.

23 Day 12, p.63.

24 FJH 031.

- 39 HIA 108 said she told her key worker, SND 501, who was based in Harberton House that SND 67 had come to see her and that SND 501 had replied it was nice of a priest to call and see if she was okay. HIA 108 said she nodded as if she agreed with this view because “she did not feel the Welfare understood or cared about what was going on with her.”²⁵
- 40 The HSCB responded to HIA 108’s evidence and confirmed that there is no record of HIA 108 informing her key worker about the alleged abuse.²⁶
- 41 SND 67 gave evidence in person during Module 1 to respond to the allegations made about him by HIA 108. He stated that he had no connection to the area where Fort James was situated and would have had no reason to be walking in that area. He said he had no recollection of visiting Fort James in any capacity, and certainly not as described by HIA 108. He specifically stated that he did not visit the home eight to twelve times in a one-month period.²⁷
- 42 FJ 7 worked in Fort James from 1975 to 1990, but was absent from the home undertaking the Certificate in Social Services Certificate when HIA 108 was resident in the home. She explained that visits would have been recorded in the home’s diary.²⁸ However, as the diaries and log books maintained in Fort James prior to 1980 were not retained it was not possible for us to confirm, or otherwise, whether SND 67 visited the home. FJ 7 told us that during the time she worked in Fort James she could only remember one priest paying a one-off visit to the home to meet with a girl preparing for her confirmation and she confirmed that it was a local priest not SND 67 and that the girl was not HIA 108.²⁹
- 43 We carefully considered the evidence that HIA 108 provided about her time in Fort James and we found no evidence of systemic failings in the care she received in the home.

Evidence of HIA 60 about his time in Fort James

- 44 HIA 60 gave evidence in Module 5, as his evidence about his time at Fort James was not heard when he appeared in person in Module 1. He confirmed that he stayed at Fort James from September 1980 until July

25 FJH 031.

26 FJH 825.

27 SND 14215.

28 Day 128, p.4.

29 Day 128, p.5.

1981 and that he was over seventeen years of age when he was admitted. Initially he shared a bedroom but half way through his stay he was moved to an independent flat on the third floor of the building to help him prepare for leaving care. He confirmed he took care of himself in the flat and prepared his own meals.

- 45 HIA 60 told us that a member of staff, SND 541, came into his room on a Sunday morning and made reference to him being a Jew. He said he responded by referring to her being married to an “orange bastard RUC man”. He explained when he gave evidence that he was particularly upset by SND 541’s comment because he considered it a slur on his father who had recently died. HIA 60 stated that on the following Wednesday, SND 541’s husband, SND 542, arrived at the home, told him to come outside to have a chat, and then proceeded to punch him on the back of the head and face. He stated that three other members of the RUC were in a parked car in the grounds of the home. He described two of these men getting out of the car and running towards him while the third drove the car into the back of his legs so that he was thrown over the bonnet of the car. He told us that SND 542 and the two officers outside the car then proceeded to kick and punch him and that the beating only stopped because the husband of a member of staff SND 450 arrived to collect her from work and intervened on his behalf. HIA 60 said he was left with minor injuries consisting of cuts and bruises, and that he did not report the matter as he felt there was little point in reporting RUC officers to the RUC.³⁰
- 46 In response to this allegation the HSCB explained that it had no record of a SND 541 working in Fort James, but that some former employees of the home remembered SND 449 working in the home. When FJ 7 gave evidence she confirmed that SND 449 worked in Fort James at the relevant time and that SND 449’s husband, SND 448, was a police officer. She also confirmed that she saw no record in the log books of the events described by HIA 60 and that she would have expected such events to have been recorded.³¹
- 47 The HSCB also stated that it was unable to confirm that a member of staff called SND 450 was employed at the home at the time of the alleged incident, but there was a reference in a document³² that in 1983, subsequent to the time that HIA 60 was resident in Fort James, a lady called

30 Day 126, p.17.

31 Day 128, p.20.

32 FJH 5338.

SND 450 was working in the home as a temporary house parent. However, in documentation provided to the Inquiry about Fort James, unrelated to HIA 60, we found references to a lady called SND 450 working as a key worker in Fort James between early 1980 and 1982.³³

- 48 The HSCB pointed out that there are no entries in HIA 60’s social work case records about the incidents described by him or any reference to the injuries he said he suffered.³⁴ HIA 60 explained when giving evidence that he had not told his social worker, SND 466, about the incident because he did not have a good relationship with him.³⁵
- 49 HIA 60 also described an incident when he accepted money from a younger boy who was a resident in Fort James in the mistaken belief that the boy had received the money from his father, whereas he had actually stolen it from a car. HIA 60 said he was questioned by the police as a result of this incident and told he would be sent to St Patrick’s Training School. He said he found out later that his social worker, SND 466, had made an application to the court for an order to send him to a training school but the Judge had rejected it.³⁶
- 50 The HSCB told the Inquiry that it has no record of HIA 60 being interviewed by the police about missing money. It confirmed that consideration had been given to applying for a training school order for HIA 60 because of his disruptive behaviour in Fort James but it was decided it would be inappropriate to do so because HIA 60 was over seventeen years of age.³⁷
- 51 Twelve days after his eighteenth birthday, HIA 60 was housed in a bungalow that had been allocated to him by the Housing Executive in response to an application for emergency housing which had been made on his behalf. He told us that when he returned to Fort James to collect his belongings a member of staff, FJ 7 told him through a locked office window that he was discharged from Fort James with immediate effect. He said all his personal belongings were put in two bin liners outside the front door as if they were rubbish and that he was not afforded the dignity of packing his own belongings.³⁸ The HSCB told us that it has no record of events

33 FJH 30996.

34 FJH 375.

35 pp. 20-21, Day 126, 15 June 2015.

36 FJH 377.

37 FJH 377.

38 FJH 020.

surrounding HIA 60’s discharge from Fort James, but accepted that at that time it was not unusual for young people’s belongings to be put into large plastic bags when they were moving into their own accommodation. The HSCB explained that this practice ended once residential homes were allocated petty cash, which enabled them to purchase holdalls for young people to use to transfer their belongings.³⁹

- 52 We have carefully considered the evidence that HIA 60 provided about his time in Fort James, and it is clear from what he told us and our consideration of records provided by HSCB that it was an unsettled time for him and that his relationships with staff deteriorated while he was in the home. We consider it poor practice that HIA 60’s belongings were packed into two bin liners but accept the HSCB’s explanation for why that was the practice at that time. We did not find evidence of systemic failings in the care that HIA 60 received in Fort James.

Alleged Sexual Abuse by FJ 5

- 53 FJ 5 commenced employment as the officer in charge of Fort James on 2 September 1980, and remained in that post until 1 August 1983. On 7 October 1983 a former resident of Fort James, FJ 30 told his social worker FJ 41 that he had been sexually abused by FJ 5 while he was a resident in Fort James.⁴⁰ FJ 30 told FJ 41 that the sexual abuse started when he was on holiday with FJ 5 in Wales, continued following their return to Fort James and had only ended approximately a year before his disclosure to her. He explained that he had not told anyone about the abuse while he was resident in the home for fear of the outcome. He said he still felt confused and angry about what had happened but decided to tell her about it because he had recently viewed a documentary about venereal disease and was frightened he had contracted the disease from the sexual contact he had with FJ 5. FJ 41 explained to FJ 30 that she would have to inform her senior managers about what he had told her and also involve the police. FJ 30 accepted this.
- 54 FJ 41 reported the allegations to her senior managers and Mr Dunseath and Mr Victor Hutchinson, Assistant Principal Social Worker (Fieldwork) accompanied her on a further visit to FJ 30 at his flat on 12 October 1983⁴¹ to gain more details about the alleged abuse. Following that

39 FJH 378

40 FJH 30377-8.

41 FJH 627.

meeting a case discussion was held on 18 October 1983 where it was decided to refer the matter to the police.⁴²

- 55 FJ 5 was living in Wales at this time and on 2 November 1983 he provided a statement, under caution, to police in Wales about the allegations made by FJ 30.⁴³ He explained that when he commenced work in Fort James a very aggressive and threatening group of teenagers were in residence, and that most of them were older and bigger than FJ 30. He described FJ 30 as having a very troubled background and that his response to the behaviour of the other residents was to isolate himself for protection. He explained that FJ 30 achieved some of this isolation through creating a garden and tending chickens and when he became aware that FJ 5 had some knowledge and experience about both these activities he frequently and persistently sought his advice and help.
- 56 FJ 5 also told police that FJ 30 had difficulty sleeping at night because of experiences he had as a young child, and that a pattern had emerged where he stayed up talking to the night worker and went for walks in the garden during the early morning. FJ 5 explained that he considered this behaviour should not be encouraged or allowed and therefore established an alternative bedtime routine for FJ 30 which included staff reading to him.
- 57 FJ 5 told the police that FJ 30 developed a dependency on him, would constantly seek him out even when he was off duty, and would become extremely abusive and aggressive if he was denied access to him. He stated to the police:
- “Due to the fact that there was a heavy burden in terms of time and effort needed for FJ 30 and the fact that there was a severe shortage of senior staff available my contact with FJ 30 and the implementation of his programme increased to the extent that the vast majority of the work became mine. This resulted in me becoming exhausted and over-important in his life”.⁴⁴
- 58 FJ 5 admitted to the alleged offences and said they occurred during the peak of a period when he had been working an excessive amount of overtime, which he described as working 24 hours a day seven days a week. He said the offending behaviour occurred on three or four

42 FJH 631.

43 FJH 30381.

44 FJH 30385.

occasions, that it involved mutual masturbation on one occasion and on the other occasion he masturbated FJ 30. He said that FJ 30 anally penetrated him on two occasions but that he never anally penetrated FJ 30. FJ 5 indicated that these offences occurred in FJ 30’s bedroom in Fort James.⁴⁵ FJ 5 told the police he regretted deeply what had occurred and had made every attempt to do what was in FJ 30’s best interest before and since. FJ 5’s account was different from the account FJ 30 gave to police in Londonderry, where he stated that FJ 5 had anally penetrated him and that some of the sexual abuse occurred when he was on holiday with FJ 5 in Wales.⁴⁶

- 59 The WHSSB established a review group, chaired by Mr Haverty, District Social Services Officer, to consider the circumstances surrounding FJ 5’s alleged abuse of FJ 30 and to look at the detail of FJ 30’s period in care.⁴⁷ As part of this review, an interview was carried out with FJ 7 who had been appointed acting officer in charge of the home on 7 December 1983.⁴⁸ FJ 7 explained that she had been completing her studies to attain the Certificate in Social Services for some of the period in which FJ 5 had been the officer in charge but had helped out in the home during her studies. She said that the home was understaffed, staff were under a great deal of pressure and that FJ 5 in particular was very tired and had fainted on a couple of occasions in the home.⁴⁹ She was anxious to point out that during the period FJ 5 was officer in charge of the home he initiated positive developments, such as the introduction of the key worker system and greater contact between the home’s staff and social workers and foster parents.
- 60 Another member of staff, Eileen Wiley, was interviewed and she described the staffing situation when she started working in Fort James in February 1982 as “chronic”. She said that FJ 5 was exhausted and at times he was also sick.⁵⁰
- 61 Anne McDermot, who had commenced work in Fort James in September 1982, was interviewed⁵¹ and commented on the lack of staff in the home, the negative effect this had on staff and on the children who she felt did not get sufficient personal attention.

45 FJH 30385.

46 FJH 30360-30366.

47 FJH 30990.

48 FJH 30990-3.

49 FJH 30991.

50 FJH 30994.

51 FJH 30995-6.

- 62 FJ 40, who had been FJ 30’s key worker from early 1980 to April 1982 was interviewed⁵² and also commented on the low staffing levels in the home between 1979 and 1982 and how at times it had meant there was only one member of care staff and one member of management staff on duty. She confirmed that staff were under considerable pressure and that FJ 5 did a great deal of overtime. She said that FJ 5 was always caring toward the children and that she received good support and supervision from him, including assistance with any problems she experienced in working with FJ 30.
- 63 In relation to FJ 30’s absences from the home she recalled that he went on holiday with FJ 5 in March 1981 to Wales and that she thought they stayed at the house of a friend of FJ 5. She explained that prior to this trip FJ 30 shared a room with another boy, but following the trip the other boy moved out of the room and FJ 30 was left alone in the room. She stated that she believed FJ 30 was allowed to have sole occupancy of the room for professional reasons as he continued to be very deprived, demanded a great deal of attention and staff were still reading to him in bed.
- 64 She explained that in July 1981 FJ 5 took a group of five children on holiday to Wales and that initially he was not going to allow FJ 30 to go on the trip because of his poor behaviour, but that his behaviour improved and he was eventually allowed to go. She recalled two further trips when FJ 5 took FJ 30 on trips outside of Northern Ireland, but indicated that both trips had been agreed in advance with FJ 30’s social worker, FJ 41. The first trip was in May 1981 when FJ 5 took FJ 30 to London for an interview at the community service volunteers’ office. FJ 40 said that FJ 41 was heavily involved in arranging this trip and had agreed that it was more appropriate for FJ 5 rather than her to accompany FJ 30 to the interview. FJ 40 explained that FJ 5 and FJ 30 were away for a few days and she understood that after the interview they went to Wales for a couple of days. The second trip was when FJ 30 visited FJ 5 in Wales in February 1982. FJ 40 explained that this trip was arranged because FJ 5 was going on an extended trip to Thailand and FJ 30 was very upset at the idea of FJ 5 being away from Fort James for so long. FJ 40 indicated that these trips would have been mentioned at reviews and recorded in the log book.

52 FJH 30996-8.

- 65 In a memo dated 27 April 1984 Mr Haverty recorded notes about the conclusions of his review⁵³ in which he acknowledged the adverse impact that understaffing in the home, and particularly lack of senior staff, had during the relevant period. He recommended the establishment of a system to enable the senior staff in the home to meet on a regular basis at least once a week to examine care practices in the home, and to identify and modify strategies for the care of children in the home. Mr Haverty also pointed out that it was evident that staff had not been receiving supervision regularly enough and, while he expected this to improve given increased staffing levels in the home, it would be necessary to monitor on a regular basis the level of, and effectiveness of supervision of, staff in the home.
- 66 He also concluded that there was a need for greater clarity about roles and responsibilities in the home, including the responsibility of district staff and those involved in quality assuring the home. In particular, he stated that district staff should be informed about changes in the systems for management of the home.
- 67 We noted with interest Mr Haverty’s suggestion that consideration should be given to permission for children leaving the home to be further delegated to the officer in charge.⁵⁴ We considered this a surprising recommendation given that FJ 5 was the officer in charge when he was taking FJ 30 on holidays outside Northern Ireland.
- 68 In a memo dated 17 April 1984, Mr Carroll, the then Director of Social Services wrote to Mr Haverty to comment on the notes Mr Haverty made during the review that had been shared with Mr Carroll. In particular, he referred to the note of the interview with FJ 40 in which she was recorded as saying that she was concerned about FJ 30, and phoned him in Wales to see if he was all right because other children in the home were calling FJ 5 “a big queer”. Mr Carroll queried why FJ 40 did not see fit to report her concerns to more senior management.⁵⁵
- 69 FJ 5 was charged with buggery and aiding and abetting buggery contrary to Section 61 of the Offences against the Person Act 1861, as amended by the Homosexual Offences (Northern Ireland) Order 1982. His case

53 FJH 30986-7.

54 FJH 30987.

55 FJH 30983.

was heard from 11 September to 20 September 1984 in Londonderry.⁵⁶ Following the presentation of the prosecution’s case the trial judge gave a direction to the jury on 20 September 1984 that the verdict should be “not guilty” on every count. The *Derry Journal* reported that the complainant had asked the jury to disregard his evidence given under oath in the witness box and instead refer to his statements made to the police about nine months previously and that the trial judge had stated that under these circumstances he had no alternative but to ask the jury to record a verdict of “not guilty”.⁵⁷

- 70 FJ 33 was the officer in charge of Fort James at the time of the court case. He told us that staff were positive about FJ 5 and felt he had improved the practice in the home and promoted a more child-focused approach. He said they were shocked about the allegations made against FJ 5 and when the case collapsed they were left confused and wondering whether the alleged abuse had happened.⁵⁸

Conclusions about Fort James

- 71 Throughout the majority of time that Fort James operated it could not meet its agreed remit because of the impact of emergency placements, over-occupancy and the mix of children in relation to age, need and capabilities. We recognise that some of these circumstances were created by unforeseen factors that could not have been anticipated in strategic planning such as the discovery of a network of sexual abusers in Derry which made a number of emergency placements necessary. We also accept the point made by the HSCB through the Warning Letter process that finding suitable foster parents particularly for older children and children with sexualised behaviour was a difficult task and that the Foster Care Unit made significant efforts, particularly post January 1990, to develop fostering resources. We also noted the efforts made, for example in 1983/84 to increase the staffing levels in the home and reduce the number of emergency placements. Nevertheless, staff, senior managers, members of the Board who visited the home and inspectors consistently raised concerns about the impact emergency placements, over-occupancy and the mix of children in relation to age, need and capabilities were having on the quality of care provided to the children in the home. **We consider the WHSSB’s failure to effectively**

56 The Chairman of the Inquiry withdrew from discussion of this case as he appeared as counsel in the court case.

57 *Derry Journal* 21 September 1984.

58 Day 124, p.10, 10 June 2015.

address these issues, which were clearly having an adverse effect on the appropriateness and level of care that could be given to children in the home, amounted to a systemic failure to ensure that Fort James provided proper care.

- 72 Despite the high level of monitoring of the home, staff and in particular the officer in charge were allowed to work excessive overtime for extended periods. We consider that the implications of such work patterns for the quality of care that can be provided to children should have been understood and addressed by senior managers. FJ 7 and FJ 33 told us that FJ 5 recorded the levels of staff overtime and made the case for additional staff. We noted that in a memo dated 20 August 1981 from FJ 5 to Tom Haverty, he stated he was stressing a point he had made before:

“...that Fort James is severely understaffed. The type of therapeutic approach we are attempting to take could be a futile exercise; lack of staff time may sabotage the very great effort made by the team”.⁵⁹

We consider the WHSSB’s failure to address the excessive overtime worked by staff, in particular by the officer in charge, and the implications such work patterns had for the quality and safety of the care provided to children in the home, amounted to a systemic failing to ensure Fort James provided proper care.

- 73 We consider that the WHSSB acted appropriately in referring the allegations about FJ 5 to the police, reviewing the circumstances surrounding the period that FJ 5 was officer in charge of the home and identifying action to improve practices within the home and the management and monitoring of the home by district staff.
- 74 We noted that when FJ 30 was interviewed by senior managers following his disclosure to FJ 41 he told them that his close relationship with FJ 5 was noticed by staff and other children and led to him being ostracised.⁶⁰ He also said that the other children implied FJ 5 was “queer” or gay and called him “fanny” and that they also referred to FJ 30 as gay because of his openly close relationship with FJ 5.⁶¹ When FJ 40 was interviewed by senior managers she told them she heard children talking in this way about FJ 5 and as referred to above she was sufficiently concerned about FJ 30’s wellbeing to telephone him when he was in Wales with FJ 5 to check that he was all right.

59 FJH 6558.

60 FJH 627.

61 FJH 627.

The HSCB pointed out through the Warning Letter process that in the context of a residential home setting it was inevitable that children would on occasion refer to a staff member in derogatory terms which would be difficult to control in any setting involving a number of children. We accept that may be the case but consider that the children’s references to FJ 5’s close relationship with FJ 30 and their related inferences about FJ 30’s sexual orientation should have caused concern and been addressed by staff.

- 75 We found no evidence that any staff member raised the appropriateness of FJ 5’s relationship with FJ 30 and the other children’s perception of it with FJ 5 or referred any concerns about these matters to senior managers. **We consider this lack of action by staff to be a systemic failure to take all proper steps to prevent, detect and disclose abuse.**
- 76 We also found no evidence of senior managers questioning why the officer in charge was playing such a central role in the care of one resident, including taking him on trips outside Northern Ireland on a number of occasions. Setting aside any suggestion of a sexual relationship, we consider that senior managers who were in regular contact with FJ 5 as the officer in charge should have questioned the implications of his very close relationship with one child, not only for that child but also for the management of the home and the other children and staff’s perceptions of him as the officer in charge. We found no evidence that this happened and we consider the effectiveness of the considerable monitoring of the home by district staff has to be questioned if relevant matters about the practice of the officer in charge were not identified, or if identified, were not addressed.

Summary of Findings about Fort James

- 77 **We found that the WHSSB’s failure to:**
- (1) effectively address strategic issues in relation to the provision of residential childcare and lack of foster care, which were clearly having an adverse effect on the appropriateness and level of care that could be given to children in Fort James; (Para. 71)**
 - (2) address the excessive overtime worked by staff, in particular FJ 5 the officer in charge, and the implications such work patterns would have for the quality and safety of the care provided to children in Fort James; (Para. 72) and**

- (3) question the appropriateness of FJ 5’s close relationship with FJ 30 and respond seriously to comments from children in the home about that relationship and about FJ 5 and FJ 30’s sexuality, (Para 75)**

all amount to systemic failings by it to ensure Fort James provided proper care.

Part Two:

Harberton House

- 78 As we explained at the start of this chapter, we decided to have a focused consideration of Harberton House because of incidents of peer sexual abuse that took place there and the evidence provided by HIA 233 about her time in the home. Before turning to these matters it is relevant to consider first the establishment and remit of Harberton House and the context in which it was operating when the peer sexual abuse occurred.
- 79 Harberton House was a purpose-built residential unit with a capacity for 25 children. It was opened on 8 September 1980 and the first children were admitted on 19 September 1980. The home was designed to provide a short-stay period of planned assessment for children in order to identify their care needs and develop plans to meet them. The home was also expected to provide emergency placements for children. Although the home was based in, and managed by, the Londonderry, Limavady and Strabane district, its facilities were available for use by Omagh and Fermanagh districts.
- 80 HH 22, the first deputy officer in charge of Harberton House, referred in her written statement and oral evidence to the planning of Harberton House and preparations for its opening, and commented that it was seen as an exciting initiative and one she wanted to be part of from the start.⁶²
- 81 As Harberton House was planned as a short-stay assessment unit the procedures developed for its operation focused on making sure a period of assessment was necessary and appropriate for a child and that the fullest use was made of the time-limited period children were expected to spend in the home.
- 82 A Core Evaluation Team was established to meet weekly to:
- (1) consider applications for assessments of children;
 - (2) discuss any relevant matters pertaining to the children in the home; and,
 - (3) discuss the assessment of each child’s needs and agree plans for their future care.

62 FJH 40182.

- 83 The Core Evaluation Team was chaired by HH 40, the Senior Social Worker, Residential Child Care. Initially, the other members were Dominic Burke, then Principal Social Worker (Fieldwork) or Mr Hutchinson, Assistant Principal Social Worker, (Fieldwork); HH 5, officer in charge of the home, and his deputy HH 22, Dr Munroe, Medical Officer and one of a team of educational psychologists. Mr Newman, Assistant Director of Social Services, was also recorded as attending meetings of the team.⁶³
- 84 Social workers who wanted to refer children for assessment were expected to attend a meeting of the Core Evaluation Team to present and discuss their referral. Once a child was accepted for assessment a member of residential staff in Harberton House was appointed as key worker. The key worker liaised with the field worker and met with the child and his/her family to help them understand and prepare for the assessment process. The involvement of the child’s family was seen as key to the assessment approach, and they were expected to attend weekly meetings at the home, which the child’s field social worker was also expected to attend.

Review of the First Six Months of Operation of Harberton House

- 85 Although the plans and procedures for the home were designed on the basis that it would operate primarily as an assessment centre it became clear only six months after it opened that it was mainly being used for emergency placements. HH 40, the first chair of the Core Evaluation Team, undertook a review covering the first six months of the operation of the home, from 19 September 1980 to 28 February 1981. In the report of his review⁶⁴ he recorded that in the first six-month period 62 children were admitted to the home, but only ten of these children were admitted for assessment on a planned basis following approval of an application for assessment by the Core Evaluation Team. The other 52 children were admitted on an emergency basis, without referral to the Core Evaluation Team. HH 40 noted that although some of these admissions were a result of an unexpected crisis in a child’s life that necessitated immediate action, others were required because appropriate alternative placements could not be secured for children whose circumstances and needs were known.

63 FJH 20928.

64 FJH 20925-33.

- 86 Ten of the 52 children admitted as emergency placements remained in the home to be assessed, while the remaining 42 children were held without being assessed until alternative placements were obtained for them. Although the procedures agreed for Harberton House were based on children admitted on an emergency basis staying no longer than one week, the average length of stay of these 42 children was three and a half weeks, and the length of stay ranged from one day to twelve and a half weeks. The 42 children ranged in age from young babies to adolescents, and HH 40 recorded that the three cots for young babies were mostly in use over the six month period.
- 87 On the basis of these figures, HH 40 concluded in his report:
“Before concentrating on the functioning of Harberton House as an Assessment Centre, it is necessary to recognise that in practice it has a dual function. It is a reception unit as well as an assessment unit, and in fact it is clear from the figures that in practical terms its primary function of assessment has been dwarfed by its role as a reception unit over this six month period.”⁶⁵
- 88 HH 40 identified that the demand on Harberton House to accept emergency admissions had been increased by changes to other children’s homes in the area: by St Joseph’s Termonbacca closing its nursery; and by Fort James working to change from a children’s home to a medium to long-stay treatment unit for adolescents. He also identified that the large number of children being received into care could not be accommodated by already limited foster care provision, and that there was a gap in the present provision for young babies, children and adolescents who because of their religious denomination could not be placed in voluntary homes run by Catholic orders.⁶⁶
- 89 HH 40 recommended that fostering provision should be extended and that the staffing levels in Harberton House should be reviewed, given the increased workload on staff dealing with emergency admissions, many of which involved babies or pre-school children whose care was resource intensive. He also noted that the demands of providing care to children on emergency placements meant that staff time was directed toward the care of these children, rather than planned work with the children who had been referred specifically to Harberton House for assessment.⁶⁷

65 FJH 20926.

66 FJH 20926.

67 FJH 20932.

90 HH 40 also acknowledged that, as well as practical difficulties in the first six months of the home’s operation, questions of principle had been raised by fieldwork staff and members of the Core Evaluation Team about whether the planned focus on assessment was appropriate. He noted that it had been suggested that procedures should be revised to allow the home to act as a treatment resource as well as an assessment centre.⁶⁸

Formal Review of Harberton House in 1984

91 Although the barriers to Harberton House fulfilling its planned remit as an assessment centre were identified and analysed as early as six months into its operation, it took until 1984 for a more formal review of its function and operation to be carried out. We noted the remit of the working party established to review the home at that time and its conclusion from the references to them in the report of the SWAG’s inspection of the home in 1986.⁶⁹ We asked the HSCB for a copy of the working party’s report but it informed us that it was unable to locate a copy.

92 The remit of the working party as detailed in the SWAG report was:

- “(i) to review the functioning of Harberton House;
- (ii) to examine the most appropriate structure to carry out this revised function according to changing need; and
- (iii) to devise an appropriate operational plan for this structure.”⁷⁰

93 The SWAG inspectors recorded that the working party published its report in December 1984, and proposed that:

“formal recognition should be given to the evolutionary changes which have occurred in order to meet the needs of children being admitted to Harberton House ie that the unit should be formally divided into:-

- (a) a reception/assessment unit with 13 beds; and
- (b) a medium stay unit with 12 beds.”⁷¹

94 Although these changes were agreed and implemented on 1 October 1986, following necessary renovations to the property to create two separate units, the throughput of children in the home continued to be a problem. The quality assurance arrangements for the home meant that it was a problem that was recognised at all levels within the WHSSB.

68 FJH 20931.

69 FJH 15429-15465.

70 FJH 15432.

71 FJH 15433.

Governance and Quality Assurance Arrangements

- 95 The governance and quality assurance arrangements for Harberton House were similar to those that operated in Fort James. TL 4 Senior Social Worker (Residential Child Care) undertook the responsibilities of the visiting social worker in accordance with the Conduct of Children’s Homes Directive (Northern Ireland) 1975. TL 4 visited the home on a regular basis, usually seven or eight times in a month and completed a standard monitoring report, which covered occupancy levels, the gender and age range of residents, the quality of primary care and emotional care provided, the maintenance of records, untoward incidents, level of contact between residents and their field social workers and the physical condition of the building. Gabriel Carey undertook audit visits to the home approximately every six months and produced detailed reports of his visits which he sent to the Principal Social Worker (Residential and Day Care), the Director of Social Services and the Assistant Director of Social Services.⁷²
- 96 The reporting of the audit visits was an important means of ensuring that the strategic direction of the home and the challenges it faced continued to be kept on the agenda of senior managers. Although the Core Evaluation Team continued to meet, its focus was on the immediate situations of the children in the home rather than any oversight of how well Harberton House was able to meet its agreed revised remit or related resource issues.⁷³
- 97 In addition to monitoring by senior managers, a member of the WHSSB’s Personal Social Services Committee visited the home on a regular basis and completed a proforma report which was shared with members of the committee and senior staff.
- 98 The continuing problems that Harberton House faced in moving children on to more appropriate and more permanent placements were highlighted through these quality assurance processes. For example, in the report of his visit to the home on 12 September 1989, Mr Carey commented in relation to admissions and discharges to the home:

“HH 5 again emphasised the need to get some movement, not least to enable staff to concentrate on work they should be doing with children. Prolonged admissions quite often create difficulty when children become somewhat frustrated about the lack of placement opportunities for

72 FJH 782.

73 FJH 11863-12542.

them and perhaps a sense of hopelessness about their situation sets in. This inevitably results in behavioural and disciplinary problems.”⁷⁴

99 He also recorded that HH 5 had pointed out that retaining children while more permanent placements were sought meant the ability to accept new admissions was severely reduced, and that in comparison to 1981, when 121 new admissions were accepted, only 49 admissions had been possible in 1989.⁷⁵

100 The issue of lack of throughput of children was also raised with Ms Imelda McGowan, the member of the Personal Social Services Committee who visited the home on a regular basis, when she visited on 22 September 1989. She recorded in her report of that visit:

“Staff were anxious to develop their family work and move towards use of the Unit for other than residential care. However, shortage of foster parents and places in longer stay Units mean that children who are ready to move on cannot do so. Therefore staff are tied up with the day to day caring role.”⁷⁶

As a result of Ms McGowan’s comments Mr Haverty, whose title was then Assistant Director of Social Services, wrote to Mr Carey asking for an update in the provision of foster care.⁷⁷

101 Mr Carey responded that he and his colleagues were alert to the difficulties created by the lack of foster care provision, and were aware that at any one time 30 children were waiting for suitable placements. He confirmed that he had a number of discussions with HH 5 about the impact this had on Harberton House. He referred to a sub-group which had been established to consider how £59,000 of funding available for specialist fostering should best be used and that he had made a bid for childcare development funds to appoint an additional home finding post in the fostering team.⁷⁸

102 The demand for residential places continued to grow, and Mr Carey wrote to Mr Haverty on 15 February 1990 about the pressures on field and residential services because of the number of children requiring care. He informed him that from 19 January 1990 to 15 February 1990, 28

74 FJH 40020.

75 FJH 40020.

76 FJH 15344.

77 FJH 15346.

78 FJH 15345.

children had been received into care and ten further children were awaiting admission. He explained that the majority of children in care had been admitted due to neglect, physical abuse, or the inability of parents to provide proper care and not sexual abuse, but pointed out that this did not mean that in relation to these children “disclosure of sexual abuse will not become an issue at a later stage”.⁷⁹ He reported that the officers in charge of the children’s homes had pointed out that because the homes were having to accommodate increasing numbers of children over their approved occupancy rates, staff were not able to give children individual attention, and care had become a holding process. He also reported that the officers in charge had told him that the number of children being admitted to the homes, and the level of disturbance of some of the children, created increased risks to children and staff because it made supervision difficult.⁸⁰

- 103 The lack of foster placements also continued to be a problem to the extent that HH 42, Senior Social Worker Foster Care, wrote to Mr Carey on 7 March 1990 about the ‘Crisis Situation in Foster Care’ pointing out that 59 children were waiting for long-term foster placements, eleven of whom were resident in Harberton, and asking for two additional social worker posts to help resolve the crisis.⁸¹
- 104 In order to manage the demand for residential care and the placement of children, Mr Carey convened and chaired regular meetings of TL 4, HH 40 and the managers of Harberton House, Fort James and the fostering team to discuss the overall demand for residential care (which often exceeded available places) and to agree what action was necessary. Such a meeting was held on 8 March 1990, the day after the memo referred to above about lack of fostering placements was sent to Mr Carey. Mr Carey chaired the meeting which had to consider how to accommodate four children, all of whom were under six years of age, who required urgent residential care. As no fostering resources were available in the immediate area, the possibility of using fostering resources in Fermanagh was being explored but the meeting concluded that if that proved unsuccessful, the only option was to open the staff bungalow in Harberton House and use it to accommodate the children.⁸² This ultimately proved necessary and

79 FJH 15516.

80 FJH 15516.

81 FJH 15493.

82 FJH 15495.

the next day, 9 March 1990, the bungalow was opened to accommodate these children.

105 As well as the challenges created by the number of children requiring care and the barriers to moving children on from Harberton House to appropriate placements, senior managers were also aware of the increasingly complex nature of the difficulties some of the children had experienced and were responding to. For example, in the report of his audit visit to Harberton House in January 1989 Mr Carey observed:

“the fact that there are increasing numbers of disturbed children being admitted to the unit some of whom have been sexually abused with all the risks that poses such as sexual precociousness does not appear to have adversely effected the determination of the staff to do a good job.However, overall whilst I am satisfied with the standard of care at the present time, I believe that the quality of care provided will be severely tested because of the increasing number of children with very complex personal and family problems that are being admitted to care.”⁸³

106 The reality of the risks created by the number and range of children placed in Harberton House, the complexity of their needs and the lack of more appropriate alternative placements for some of the children came sharply to the fore when it was identified that co-ordinated peer sexual abuse was taking place in the home.

Peer Sexual Abuse

107 We noted from contemporaneous records that staff in Harberton House were dealing with incidents of peer sexual abuse from as early as 1981. At that time a boy who had been admitted to the home from Termonbacca was being closely supervised because of his sexual interest in and behaviour towards younger boys. In June 1981, the boy, then aged fifteen, admitted to HH 5 who was discussing his general behaviour with him that he had engaged in mutual masturbation on a number of occasions with two younger boys aged nine and eleven years.⁸⁴ Staff dealt with this matter through what HH 5 described as “an intensive level of supervision”.⁸⁵ The boy was also referred to a consultant psychiatrist

83 FJH 20106.

84 FJH 50724.

85 FJH 50725.

in Gransha psychiatric hospital and the psycho-sexual clinic in Belfast City hospital and a clinical psychologist worked with him a number of times in the home.

- 108 We are aware that further incidents of peer sexual abuse came to the attention of staff in July 1988, when one of the teenage children involved, a thirteen-year-old boy, HH 48, reported the activity to a member of staff. HH 48 explained that he was telling the staff member about the sexual activity because he wanted it to stop. HH 48 and the other boy and girl involved in the sexual activity, who were also aged thirteen years old, were spoken to by staff about their behaviour. The “Untoward Incident Report” completed in relation to the incident recorded that this was not the first incident of a sexual nature involving the three children in recent months.⁸⁶ TL 4, Assistant Principal Social Worker, informed Mr Haverty, Assistant Director of Social Services about the incident and recorded that the report “highlights a continuation of sexualised behaviour involving these children”.⁸⁷
- 109 At that time of this disclosure HH 48 had already come to the attention of the police and of the SSI. HH 48 had been admitted to Harberton House on 2 June 1988 on a Wardship Order as a result of non-school attendance. On 9 June 1988 he absconded and returned to his family home in Strabane. When he returned to Harberton House he told staff that while he was in Strabane he was sexually abused by a man who had previously sexually abused him when he lived at home. SND 502, Assistant Director of Social Services, informed Mr O’ Brien of the SSI by letter on 27 June 1988 about these allegations and that the accused man had admitted the offences and been arrested.⁸⁸
- 110 SND 502 wrote to Mr O’ Brien again on 25 August 1988 to inform him about the peer abuse that HH 48 was involved in. Mr O’Brien acknowledged receipt of this letter on 28 September 1988 and noted that staff in Harberton House were intensifying their work with the children involved and that the situation was being carefully monitored by the Core Evaluation Team.⁸⁹
- 111 In October 1988 the man who had been arrested and was subsequently charged with buggery and gross indecency was found hanged in a voluntary

86 FJH 50726.

87 FJH 50727.

88 FJH 50728.

89 FJH 50729.

home for ex-prisoners where he was living pending his court appearance. The WHSSB informed the SSI of this and that HH 48 had named two other men in Strabane who he said sexually abused him and that these allegations were being investigated urgently by the police. It was recorded in an internal SSI memorandum that WHSSB staff were concerned that a vice ring might be operating in Strabane. The internal memorandum considered what notification should be provided to the Minister given that the case might attract media attention. The author of the memorandum suggested that the Minister should be advised about the peer sexual abuse but commented:

“Such incidents are hardly a rarity but given the boy’s background this particular one might attract media attention.”⁹⁰

The Minister was informed about the case and told that the WHSSB was dealing with the incidents of peer sexual abuse.⁹¹

- 112 Therefore, staff and managers were alert to the risks of peer sexual abuse when other incidents of it came to their attention in March 1990. On the evening of 13 March 1990 a senior house parent, HH 31, pursued an aside made by a nine-year-old male resident over the dinner table about sexual activity between residents. The boy was subsequently talked to by staff. He gave them the names of other children he said were involved in the sexual activity. These children were also spoken to by staff that evening and the next day. Staff attempted to inform TL 4 about the disclosures, but he was unavailable so it was the morning of 15 March 1990 before senior managers were informed about them.
- 113 HH 32, senior house parent, provided an untoward incident report on 15 March 1990 about the disclosures.⁹² In the report HH 32 named eight children, four boys and four girls, aged from seven to thirteen years who had been interviewed about their involvement in the sexual activity. A case conference was held the next day, 16 March 1990, and immediate action was agreed including the children’s families being informed, the matter being reported to the RUC and the employment of a waking night member of staff in the home from that evening.
- 114 From the information provided by the children it became clear that the sexual activity they were involved in included fondling, oral sex, sexual

90 FJH 50732.

91 FJH 50731.

92 FJH 10063-70.

intercourse and bondage. It had commenced in December 1989 and was co-ordinated by some of the children to take place very early in the morning, and in the period around the end of the school day when they knew staff would be occupied with transporting children from school and handover meetings and would therefore be less available to supervise them. The incidents were described as happening in the playroom, bedrooms, the visitor’s room and the garden areas at the rear of the home. Children described acting as “lookouts” and behaving in a disruptive way to distract staff attention so that the activity could go unchecked. Although some children described consensual sexual exploration, others described being coerced and frightened into sexual activity.⁹³

- 115 Two of the boys who played a major part in the abuse implicated nine adolescent children resident in the home in it. The police interviewed one adolescent girl who admitted that she organised disruptive situations to distract staff attention so that the sexual activity could take place, but denied engaging in it herself. The police decided not to interview the other adolescent children. Staff did interview them and recorded that they denied any involvement.⁹⁴
- 116 Mr Carey wrote to Mr Haverty on 26 March 1990⁹⁵ to inform him about the disclosures to date and what immediate action had been taken. He reported that the most serious incidents had taken place in the early hours of the morning, and the decision to introduce a waking member of night staff had proved effective but that member of staff had left to take up another job. He explained that consequently an interim measure had to be introduced of one member of sleeping-in staff commencing work at 5am to supervise the children. He also explained that he was exploring the installation of electronic warning systems that would alert staff to children leaving their bedrooms at night.
- 117 Mrs McGowan, the member of the Community Care Committee who made regular visits to Harberton House visited the home in April 1990. She recorded her view that in light of the peer sexual abuse there was a need to review the adequacy of childcare resources generally within the WHSSB, and particularly within the Foyle Unit of Management because:

“...we are failing in our duty to protect children – providing a bed, shelter and food is not enough.”⁹⁶

93 FJH 11025.
94 FJH 20308.
95 FJH 15575-7.
96 FJH 10011.

- 118 Since the next meeting of the Community Care Committee was not until June 1990 Mrs McGowan wrote directly to Tom Haverty enclosing a copy of her report.⁹⁷ Mr Haverty responded on 18 May 1990.⁹⁸ He explained the increased demand for residential care for children since January 1990, acknowledged the untoward incidents in Harberton House and confirmed that the occupancy rate in the home had been reduced to 25 children.
- 119 Mr Carey wrote to Mr Haverty on 25 June 1990 to update him about the police investigations into the peer sexual abuse.⁹⁹ In due course, on 30 October 1990, Inspector McCracken of the RUC wrote to Mr Carey to inform him that the Director of Public Prosecutions had directed no prosecution and that rehabilitation of the children was best left to the Social Services.¹⁰⁰ Mr Carey also took the opportunity to point out that Harberton House had seven children over its occupancy level during the time the peer sexual activity took place, which necessitated the employment of six untrained members of staff. He explained that the number of children that had to be cared for, and the support that experienced staff were required to give to inexperienced staff, meant that the focus was on meeting the primary needs of children rather than engaging in therapeutic work. He suggested that this combination of factors may have explained why the sexual activity was not picked up sooner. He also made the point that the complexity of the needs of the children being received into care increased the need for additional and appropriately trained foster parents.

Involvement of the Department

- 120 On 23 March 1990, Mr Carey contacted Mr Wesley Donnell of the Child Care Branch of the Department to inform him of the events in Harberton House¹⁰¹ and SND 502, Acting Director of Social Services, wrote to Mr O’ Brien, Social Service Inspector, on 8 May 1990 to formally advise him about them.¹⁰² SND 502 set the incidents of peer abuse in Harberton House within the wider context of the pressures being experienced by the WHSSB because of the increased numbers of children being received into care and the complexity of their needs. She explained that the General Manager and the Area Executive team had agreed the establishment of

97 FJH 10047.

98 FJH 10095.

99 FJH 15568-155740.

100 FJH 11016.

101 FJH 15596.

102 FJH 10270.

two new social works posts in the fostering team and four new social worker posts in Foyle Community which she anticipated would do much to free up the situation in the children’s homes. Mr O Brien responded to SND 502 on 18 June 1990. He acknowledged that the increase in admissions to Harberton House may have contributed indirectly to the incidents.¹⁰³

- 121 Dr McCoy visited Harberton House and Fort James on 26 June 1990;¹⁰⁴ these visits had been arranged prior to the peer sexual abuse being detected in Harberton House. Following these visits there was considerable discussion between Dr McCoy and his senior colleagues about how to ensure a proper investigation of what had occurred between the children in Harberton House. It was clear from the internal SSI communications in October 1988 about the peer abuse involving HH 48 that officials understood the potential for peer sexual activity and abuse in children’s homes. However, the number of younger children involved in this case concerned them as did the fact that the sexual activity had gone on for a sustained period without being detected. Consideration was given to whether a formal investigation should be carried out to consider generally the care of sexually abused children in children’s homes and to focus specifically on the lessons to be learnt from Harberton House.¹⁰⁵
- 122 Subsequently, Dr McCoy telephoned SND 502 and asked her to provide a report on the overall circumstances of the incidents in Harberton House that could be shared for information with the Directors of Social Services of the other Boards. SND 502 told colleagues that Dr McCoy had indicated that the requested report could be used to appraise the Department of the problems the WHSSB was facing in providing childcare with a view to making the Department more amenable to requests for resources to deal with the problems.¹⁰⁶
- 123 On 23 July 1990, SND 502 wrote to Dr McCoy and outlined the overall situation the WHSSB faced in relation to childcare and the investigation and action taken in relation to Harberton House.¹⁰⁷ She explained that, given the resource difficulties and pressures the workers in Harberton House were facing at the time of the incidents and their perceptions

103 FJH 10026.

104 FJH 10286.

105 FJH 11016.

106 FJH 10037.

107 FJH 10113.

that senior managers, and she in particular, did not understand their “impossible situation”, it would not have helped staff morale or enhanced the safety of children for her to have undertaken an investigation of the incidents.¹⁰⁸ She also asked that “the ever increasing childcare difficulties should be looked at immediately with a view to the DHSS offering additional revenue”. She suggested that such additional revenue could be used to appoint additional social work practitioners and to create a childcare team, a child protection team and a team of social workers working with children in residential care.¹⁰⁹

124 This letter and its appendices were discussed by officials at a meeting in the Department on 26 July 1990, where it was agreed that the WHSSB should be asked to carry out an independent investigation which would:

- “review the background to the incidents and, in particular, why the incidents were not detected earlier;
- explore the lessons to be learned for the Province as a whole;
- examine the roles of individual staff including key workers and supervisors;
- review the training implications;
- explore the multi-disciplinary nature of the care and treatment requirements of the children involved.”¹¹⁰

125 Mr Hunter, Chief Executive of the Department’s Management Executive, contacted Mr Frawley, General Manager of the WHSSB, to request this investigation. Mr Frawley agreed to the investigation so that lessons could be learned and related training needs of social care and other professional staff could be identified. Mr Frawley agreed to ask SND 502 to liaise with Dr McCoy over who might undertake the investigation and agreed it should be done “in such a way as to avoid the appearance of a witch hunt and recriminations”.¹¹¹

126 On 31 July 1990 Dr McCoy met with SND 502 at Dundonald House and followed up that meeting with a letter offering draft terms of reference for the investigation, which included a specific focus on why the sexual activity between the children in Harberton House was not detected earlier and an examination of the roles and responsibilities and professional activities of staff responsible for supervision of the children in the relevant period.¹¹²

108 FJH 10118.

109 FJH 10119.

110 FJH 10995.

111 FJH 10994.

112 FJH 10992.

- 127 When Dr McCoy received a copy of the brief that had been given to the Review Team¹¹³ he wrote to Mr Hunter to express his concern that the terms of reference for the review failed to make specific reference to the events in Harberton House and why the sexual activities were not detected sooner. He suggested that “the Board will use the review to emphasise their inadequate revenue basis” and that “the issues of supervision and management in Harberton House will not get the scrutiny they deserve.”¹¹⁴
- 128 In response to Dr McCoy’s concerns, Mr Hunter wrote to Mr Frawley on 30 August 1990 and indicated that while it was reasonable for the review to consider resource implications he would be concerned, “if the Team concentrated on this issue to the detriment of other factors surrounding the care of severely abused children”.¹¹⁵
- 129 In a written statement to the Inquiry, Dr McCoy confirmed that his view remained that the emphasis in the terms of reference on the resources available to the Board generally was an attempt to extract more resources from the Department, he commented: “...it was opportunistic”.¹¹⁶

The Review Process

- 130 The Review was chaired by Bob Bunting, Assistant Director of Social Services (Family and Child Care) Eastern Health and Social Services Board and he was assisted by Mr T Armstrong, Senior Social Services Manager WHSSB and Miss J Ross, Principal Social Worker (Training and Staff Development) WHSSB. The review team took the view that residential services for children could not be seen in isolation but had to be considered within the context of the total WHSSB’s family and childcare programme. We consider this an appropriate approach since, as set out above, the number of emergency placements Harberton House had to deal with and the lack of foster placements to send children on to hampered its ability to fulfil its remit.
- 131 In considering the wider context in which the home operated the review team compared the social work resources of the Foyle Community Unit, the unit of management within the WHSSB in which Harberton House was located, with those of North and West Belfast, the unit closest to it in population size. The comparison showed that the staffing establishment

113 FJH 10987.

114 FJH 10986.

115 FJH 10984.

116 FJH 40886.

of the North and West Belfast unit’s Family and Child Care Programme, which consisted of fifteen senior social workers and 53 social workers, meant it had nine more senior social workers and twenty more social workers than the Foyle Unit.¹¹⁷

- 132 The review team identified that the increased demand for childcare and the lack of resources to address it during 1989 and 1990 indicated “a high level of risk for children and staff in the Unit”.¹¹⁸ It referred to field social workers having to keep children in risk situations when they would have preferred them to be in care, and to residential staff being unable to undertake therapeutic work because of the number of children for whom they had to provide basic care. The team concluded that the extension of the range of services available, for example the provision of fee-earning foster parents, would provide advantages both in terms of efficiency and cost-effectiveness.
- 133 After making these general observations about the context within which Harberton House operated the review team considered how the home was run, including its admission and discharge records in the relevant period. It concluded that although the home was over-occupied in the relevant period, and this necessitated the employment of inexperienced staff who required training and support, the “main problem was the constant pressure of dealing with a highly disruptive and sexualised group of children”.¹¹⁹
- 134 The review team considered the profile and current position of each of the eight children who had been identified as being involved in the sexual activity. They also included within their considerations the adolescent girl referred to above who had been interviewed by the police and admitted distracting staff in order to let the sexual activity take place. The review team stated that they were of the opinion that the adolescent children “were involved in the sexual activities though to what extent remains unclear”.¹²⁰ They considered reviewing the other eight young people and looking at their records but decided not to as the police had decided not to interview them. Given the review team’s suspicions about the involvement of adolescent children in the sexual activity we consider that it was a lost opportunity that they did not widen their review to consider any other recorded incidents of peer sexual activity in the home. This could have

117 FJH 20301.

118 FJH 20302.

119 FJH 20307.

120 FJH 20308.

identified other occasions, such as that involving HH 48, where sexual activity between three children was recognised as a recurring problem and where (at least on one occasion) it only came to the attention of the staff through one of the children involved making a disclosure about it.

- 135 The review team identified that only one of the nine children was understood to have been sexually abused prior to admission to care and another, an adolescent girl, was known to have previously had sexual intercourse with adolescent boys. The other seven children had been admitted to care because of behavioural problems and/or relationship problems with their parents or foster carers. However, through disclosure work while they were in Harberton House, prior to the uncovering of the peer sexual activity, the staff reached the view that all but two of the children had been sexually abused, had witnessed sexual activity or had been involved in sexual activity with other children prior to their admission to care.¹²¹ Staff told the review team that they had received some relevant in-service training about caring for sexually abused children but were unable at times to apply this training due to the pressures they faced on a day-to-day basis.
- 136 The review team concluded that supervision of the children had been inadequate because of the low staff to resident ratio caused by the increased number of residents and the policy of staff having two days a week during the school term for report writing, liaison with families etc, which reduced their direct contact time with the children.
- 137 During the review process, the chair of the review team was copied into a memo that HH 22, the acting officer in charge wrote on behalf of Harberton House staff to Gabriel Carey on 1 November 1990.¹²² In this memo, HH 22 pointed out that staff were continuing to have to deal with over-occupancy of the home leading to a dependence on inexperienced and unqualified staff, which was creating a similar set of circumstances to that which pertained at the time the peer sexual abuse occurred earlier in the year.

She placed on record the feeling of the staff group that:

“... this present situation mitigates [sic] against fulfilling the Board’s statutory responsibility to provide care, protection and control for children who require it.”¹²³

121 FJH 20342.

122 FJH 10084.

123 FJH 10084.

138 Mr Carey responded to the memo on 16 November 1990¹²⁴ and detailed the action that had been taken to raise resource issues with the Department and establish new social worker posts. He acknowledged the frustration of staff and indicated it was shared by all childcare managers but pointed out that managers, including HH 22, must provide leadership to help staff work through difficulties and provide the best standard of service possible to the children in their care.

139 In her oral evidence to the Inquiry, HH 22 said that she could not emphasise enough the impact that overcrowding had in Harberton House. She explained that staff felt they had no real say on admissions, because if a child needed to be cared for and there was nowhere else they could go they had to be admitted.¹²⁵

The Review Team’s Conclusions and Recommendations

140 The review team concluded that there were a number of important aspects which in combination created exceptional conditions within Harberton House that made it possible for the sexual abuse to continue undetected. They identified these aspects as:

- the number of children with sexualised behaviour in the home at the same time;
- the power exercised by two boys in particular and their intimidation of other children; and,
- the level of planning of sexual activity, including the distraction of staff and acting when staff cover was at a minimum.

The inadequate staff to child ratio was seen as a contributory factor in the relevant period but the review team made a more general point that the size of the home with two groups of twelve and thirteen children made it difficult to provide a satisfactory standard of care for the type of children and young people requiring residential care.

141 The review team assessed the performance of all residential and fieldwork practitioners as adequate, given the pressures they were under, the limits of their knowledge and awareness, and the resources available. In the case of residential staff, this conclusion was qualified as being in the context of the number of staff on duty to care for the total group of children. The point was made that, given the substantial group of very disturbed children

124 FJH 10081.

125 Day 127, p.91.

in the home, consideration should have been given to increasing the number of staff on duty. The performance of the management staff of the home and senior social workers was also deemed adequate; the review team found they were clear about the pressures staff were working under and informed middle and senior managers about them. The performance of middle and senior managers was also deemed adequate given the increasing demands and the resources available.¹²⁶

142 The review team stated that the workloads of field social workers and the management span of control of senior social workers were not conducive to providing child protection of satisfactory quality and that it was unrealistic to expect the workload of the Assistant Principal Social Worker (Family and Child Care) to be carried by one person.

143 The concluding statement of the review report focused on the lack of resources:

“The Unit of Management is under-resourced in relation to the amount, range, complexity and stressful nature of the Family and Child Care work which has to be undertaken. This remains the case, though the 6 additional Social Worker posts have reduced some of the pressures.

There are clear indications that the present situation represents a high level of risk for both children and staff in the Unit of Management.”¹²⁷

144 Given this analysis, it is perhaps not surprising that the eighteen recommendations in the report of the review focused on the need for strategic development of childcare services and additional resources. The review team recommended an immediate review of the size and function of Harberton House with a view to reducing the residential care component and concentrating it into one unit. It also suggested that the physical space this would create could be used as an adolescent support centre and as a facility for a multi-disciplinary team to develop expertise in the assessment of sexually abused children. It recognised that the residential places that would be lost through such a development might still be required and recommended that if that was the case a further smaller residential facility should be developed.

145 In addition to recommendations about improving staff development and supervision, an immediate review of staffing levels and the duty rota in the two Board homes was recommended to ensure that there were sufficient

126 FJH 20337.

127 FJH 20354.

staff on duty to provide satisfactory care for the total group of children and allow time for individual work. A practical recommendation was made that the mound in the grounds of Harberton House should be levelled to facilitate the supervision of children.

WHSSB’s Response to the Review Report

- 146 The review report was presented to the WHSSB Area Executive Team on 22 November 1990 and presented to the Community Care Committee of the WHSSB on 7 December 1990. Mr Bunting, the Chair of the review team, discussed his findings with Committee members. Mr Frawley, General Manager, cautioned the Committee that the recommendations were wide-ranging and could have serious resource implications and asked for the management team of the Foyle Community Unit to be given time to consider them.¹²⁸
- 147 Mrs McGowan, the Committee member who made regular monitoring visits to the home, referred to the statement in the review report that “children and staff were still at risk”. She urged serious consideration to be given to minimising the level of risk as a matter of priority.¹²⁹ However, the Committee agreed that senior managers should be given the opportunity to consider the recommendations and to report back to its next meeting.
- 148 Mr Frawley and HH 34 (Unit General Manager) attended the next meeting of the Community Care Committee on 1 February 1991 and the minutes of that meeting recorded that they provided committee members with an update on the measures that management and staff were taking to address “difficult aspects of caring for children”.¹³⁰ The committee agreed that the Board should convey its concern about the need for additional funding to the Department. Mr Frawley undertook to write to the Department and while pointing out that it might consider the pressure on childcare as a national rather than local problem he said he would:
- “...put forward the case again for the Board’s uniquely underfunded situation and ask the Department to consider the matter in the knowledge of the analysis they have sight of and consider making some exceptional arrangement for the Board.”¹³¹

128 FJH 10432.

129 FJH 10432.

130 FJH 10436.

131 FJH 10437.

The chairman of the Community Care Committee is recorded as concluding the discussion by pointing out that while the Board had the responsibility to deal with the issues identified in the review report the Department, being a party to that report, also had a responsibility towards solving the problems.¹³²

149 Mr Frawley wrote to Mr Hunter of the Department on 13 February 1991.¹³³ He explained that in light of the sort of investment that would be required to address the recommendations in the review report and the level of funding available to the Board compared to other Boards, particularly the Eastern Board, the Community Care Committee had asked him to ask the Department to consider making a separate allocation “to address this very worrying problem”. He explained that the committee appreciated the difficult financial climate, but felt that “an issue of this complexity and public concern does need urgent attention”. Mr Frawley finished his letter requesting a meeting to discuss this and more general matters relating to finance.

150 An internal memorandum from a civil servant Mr Green entitled “*Review Of Child Care Services*”¹³⁴ recorded the outcome of a meeting Mr Green, Dr McCoy, Mr Kearney and Mr Hunter had with Mr Frawley and Mr Burke on 27 February 1991. Mr Frawley was recorded as telling the officials that the Chairman of the WHSSB remained extremely unhappy about the Board’s funding deficit and considered that the DHSS had not done enough to address it in the allocations for the next financial year. Mr Frawley advised that the matter was likely to come to a head at the forthcoming Policy and Resources Committee meeting when:

“...the need for additional resources for the development of Child Care Services will be on the agenda and the disparities in staffing levels and other resources between the Western and Eastern Boards will be highlighted”.¹³⁵

Mr Green recorded the explanations he provided about why the funding arrangements could not be improved immediately, including that the DHSS held no reserves, and pointed out that £300,000 had already been skewed to the WHSSB despite the DHSS’s limited ability to allocate additional funding. He also provided assurances about the DHSS’s commitment to introducing a full capitation based funding position. Despite these assurances Mr Frawley requested an urgent meeting with Mr Hunter.

132 FJH 10437.

133 FJH 10979.

134 FJH 50740-41.

135 FJH 50740.

151 This meeting took place on 6 March 1991 and Mr Hunter’s memorandum to Mr Green about it confirmed that Mr Frawley had raised the WHSSB’s need for additional resources for the development of childcare services as well as broader issues about the funding available to the Board. Mr Hunter recorded that he had provided the same explanations and assurances as Mr Green had previously offered to Mr Frawley and offered some hope that additional funds might be available in 1992/93 that the Board could use to develop its child care services. However he recorded that he made clear to Mr Frawley that in the meanwhile:

“...it was the Board’s responsibility to manage any problems which currently exist in respect of the delivery of these services.”¹³⁶

152 Mr Frawley subsequently wrote to Mr Hunter on 20 March 1991 to record the WHSSB’s Resource Allocation Committee displeasure at what it perceived as “positive discrimination by the Department against this Board in properly addressing the issue of equity in resource allocation”. He went on to state that “Board members felt that their position and that of the Board in relation to both staff and children was becoming untenable”.¹³⁷ Mr Hunter provided a written statement to the Inquiry in which he said he did not recall meetings he may have had with Mr Frawley and that as far as he could remember the WHSSB never argued through its area and operational planning process that it was under-funded for a particular service.¹³⁸ As indicated previously we consider the WHSSB’s funding situation more generally in the section dealing with Finance in Volume 1. However, in relation to responding to the particular funding issues raised by the Bunting Review we consider that the WHSSB, through its senior officials, persisted in trying to attract funding to improve its child care services and made clear that its position in relation to both staff and children was becoming untenable.

153 While these discussions were taking place Dominic Burke wrote to Dr McCoy on 27 February 1991 to inform him of the action the WHSSB had taken to meet the recommendations of the Bunting Review including allocating £35,000 to fund increased staffing in Harberton House and £39,000 to increase foster care. He indicated that he would provide Dr McCoy with the minutes of the Community Care Committee’s discussion of the review and share with him the Foyle Unit of Management’s response to the

136 FJH 50742.

137 FJH 50742.

138 GOV 629.

recommendations of the review and the resources it considered necessary to implement them. Mr Burke also referred to the discussion Mr Frawley and he had with Dr Mc Coy and his colleagues on 26 February 1991 about efforts being made to redress the resourcing issues in the Board’s Operational Plans and stated he would share the outcome of current discussions on the Plans with Dr McCoy as soon as possible. He reminded Dr McCoy that it was recognised at the meeting that:

“...these efforts because of other competing demands fail to meet the requirements as we explained additional resources will be required to meet this shortfall”.¹³⁹

- 154 In that context, he asked for additional funding of £130,000 to develop an assessment and treatment unit at Harberton (the inference was that this would be for peer abusers) and suggested that the provision of this funding from the Department would be “a recognition of this Board’s difficulties and our joint efforts in redressing the resource problems”.¹⁴⁰ He finished his letter by informing Dr McCoy that the Board was still experiencing sustained pressure within its childcare services. He explained that despite the increase in fostering provision Harberton House continued to be full and the staff bungalow was having to be used to accommodate children.
- 155 On 12 March 1991 Dr McCoy wrote to two of his staff, Mr Mc Elfratrick and Mr O Brien, copied to Mr Greene and Mr Kearney of the Child Care and Social Policy Division and provided them with a copy of Mr Burke’s letter. He asked for a general discussion about what further action the Management Executive/DHSS needed to take and a specific discussion about Mr Burke’s proposal for an Assessment and Treatment Unit.¹⁴¹ Mr Kearney responded to this minute and informed Dr McCoy that he had no money to offer towards the suggested Assessment and Treatment Unit. He explained that he had put forward a Public Expenditure Survey (PES) bid for funds to address child sexual abuse covering prevention, protection and treatment (for victim and abuser). However, he pointed out that even if the bid succeeded resources would not be available until 1992.¹⁴²
- 156 On 28 March 1991 Dr McCoy met with his colleagues Mr Simpson, Mr Kearney, Mr McElfratrick and Mr O’Brien to discuss the WHSSB’s ongoing work to meet the recommendations of the review. They noted that the

139 FJH 587.

140 FJH 588.

141 FJH 16347.

142 FJH 16346.

WHSSB was meeting on that day to discuss resource allocation proposals for 1991/2 which included:

- £35,000 to improve childcare services generally in Foyle Community Unit
- £30,000 to provide greater support to existing foster placements
- £45,600 to Nazareth House children’s home
- Additional funds to employ two house parents in Coneywarren home to bring the staffing levels up to those set down in Castle Priory guidelines
- £90,000 to establish child and adolescent psychiatry services for the area.

There was no reference in the note of the meeting to Mr Frawley’s letter to Mr Hunter, which had been copied to Dr McCoy and which had requested additional discrete funds to address the recommendations of the review, to the meeting Dr Mc Coy attended with Mr Frawley and Mr Burke or to Mr Burke’s written request to Dr McCoy for additional funds to establish an assessment and treatment unit. The meeting concluded that no direct action was required by the Department at that time. It was noted that the WHSSB was continuing discussions with the Foyle Unit of Management about their responses to the conclusions and recommendations contained in the Bunting review and that a report of these discussions would be submitted in due course. It was agreed that the WHSSB’s implementation of its operational plan would be monitored, staffing levels in children’s homes in the four Boards would continue to be monitored and discussions would continue with Board staff about the extent of peer abuse among children.¹⁴³

- 157 As part of the Warning Letter process the DoH pointed out that the information provided in Mr Burke’s letter of 27 February 1991 that the WHSSB was allocating £35,000 to meet increased staffing needs in Harberton House and £39,000 for extra Boarded-out payments and appointing additional field social work posts made it appear to the DHSS that the immediate pressures on Harberton House had been responded to quickly and appropriately by the WHSSB. The DoH also commented on Mr Burke’s reference to the discussion in the meeting Mr Frawley and he had with Dr McCoy and representatives from the DHSS Management

143 FJH 16344.

Executive in February 1991 about attempts to redress the under resourcing issues in the Board’s Operational Plans. The DoH suggested that this reference indicated that the DHSS Management Executive had asked the WHSSB to address under-resourcing issues in its operational plan and was sympathetic to the WHSSB’s request for additional finances to make up the shortfall in other services (ie “competing demands”) which had been created by the alleviation of the Harberton House situation. We found no reference in the minute of that meeting¹⁴⁴ to the DHSS asking the WHSSB to address under-resourcing issues in its operational plan and we understood from Mr Burke’s letter that he was saying the efforts taken to address the requirements of the Bunting review were insufficient because of other competing demands and that additional resources were required.

158 It was also agreed in the meeting of 28 March 1991 that Mr Kearney would ask Dr Kilgore to monitor the establishment of the Child and Adolescent Psychiatry Service which was contained in the WHSSB’s Development proposals for 1991/1992. Mr Kearney subsequently wrote to Dr Kilgore on 8 April 1991 to point out that although it was not possible to provide funding for an assessment and treatment unit it should be possible for the WHSSB to start to develop therapeutic programmes with sexually abused children if this aspect was recognised as a priority by the new consultant child and adolescent psychiatrist which the WHSSB intended to recruit. He went on to ask Dr Kilgore to highlight the importance of this work in any contact with the consultant once he/she was appointed. Mr Kearney finished by asking that he and Dr Kilgore stay in touch with developments in establishing the service to ensure that maximum use is made of it for child protection purposes.¹⁴⁵ There is no indication that this helpful intervention was shared with Mr Burke.

159 We noted that Mr O’Brien who attended this meeting had recently completed an inspection of Harberton House on the week beginning 11 February 1991. He made a number of observations and recommendations in his report of that inspection in response to the circumstances he found in the home, which were strikingly similar to those that the review team had concluded had aligned to create an environment in which the peer sexual activity in Harberton House in late 1989 and early 1990 had gone on for so long without detection.¹⁴⁶ These included:

144 FJH 50740-50741.

145 FJH 16342.

146 FJH 16513-16564.

- (1) The number of children living in Harberton House had exceeded the places provided in the home for some months and this situation was pertaining at the time of the inspection.¹⁴⁷
- (2) Although the staff bungalow was being used to accommodate children, the demand for residential care was such that children had to be diverted to other statutory and voluntary homes.¹⁴⁸
- (3) In the circumstances, Harberton was incapable of providing a reception/assessment service for all children coming into the Board’s care. The home had been reasonably successful in discharging children within twelve months of placement, thereby retaining the short/medium term nature of the facility and its main aim could have been attained if there had not been such a surge of admissions to the facility in the months preceding the inspection.¹⁴⁹
- (4) Staff ratios should be revised to allow staff sufficient time for primary duties and group care of children.¹⁵⁰
- (5) Less than half of the staff had been to short training courses on appropriate topics and “this was disappointing though, in circumstances where the home was over full and going through a difficult period understandable.”¹⁵¹
- (6) At best, staff were receiving supervision every two months when the expectation was that they should receive it every two weeks and at least once a month.¹⁵²
- (7) Staff were striving to implement programmes of care for individual children but the time taken had become protracted in some cases because of the number of children.¹⁵³
- (8) The officer in charge had informed him that Harberton was still catering for a considerable number of children who had sexual experience inappropriate to their chronological ages.¹⁵⁴

160 Mr O’Brien quoted Mrs McGowan’s conclusion that the Board “was failing in its duty to protect children”.¹⁵⁵ He also quoted the review team’s

147 FJH 16522.

148 FJH 16522.

149 FJH 16522.

150 FJH 16532.

151 FJH 16530.

152 FJH 16534.

153 FJH 16546.

154 FJH 16538.

155 FJH 16550.

recommendation that there should be an immediate review of the size and future of the home and its suggestion of the establishment of a multi-disciplinary team to undertake assessments of sexually abused children. He concluded that it appeared an appropriate time to review the procedures for admitting children to the home, revise its overall capacity and to reconsider its management structure and staffing levels.¹⁵⁶

- 161 There is no record that Mr O’Brien’s conclusions from this inspection informed the discussions he had with Dr McCoy and other colleagues on 28 March 1991 about the provision of childcare services in Harberton House. On 24 January 1992, Dr McCoy sent a letter to Mr Frawley expressing concern that reports of SSI inspections of children’s homes in the Western Board’s area had been issued to the appropriate unit of management and to the Nazareth Order in relation to Nazareth House, but that formal responses to the reports and the recommendations contained within them, had not been received.¹⁵⁷ Dr McCoy enclosed an overview report on the SSI’s findings from these inspections and in his letter highlighted issues from them which required attention. Therefore, it appears that almost a year after the inspection of Harberton House the SSI was awaiting responses to the significant recommendations contained in the report of that inspection.¹⁵⁸
- 162 Mr Frawley responded to Dr McCoy’s letter on 27 April 1992. He confirmed that responses to the inspection reports had now been sent. We noted that he also referred Dr McCoy to a detailed report that was recently sent to him about a review of the WHSSB’s implementations of the recommendations arising from the Bunting Review. Mr Frawley also pointed out that Dr McCoy would be aware from the Board’s Annual Monitoring Reports for 1990/91 that the significant demand for care places meant the Board had to take a managed approach between the need to provide care and protection for children who were at risk in the community and meeting the objectives of individual units. Therefore, although responses to inspection reports had not been received we accept that there were other ways in which the WHSSB was accounting for its performance to the SSI.
- 163 We noted that the WHSSB’s Social Care Committee considered the recommendation of the report of the inspection of Harberton carried out

156 FJH 16562.

157 HIA 5822-3.

158 FJH 50734.

in February 1991 when it met on 8 April 1992.¹⁵⁹ The minutes of that meeting recorded Mr Haverty informing the Committee about action taken to address certain recommendations including the need to ensure regular supervision of staff and review the staff rota to enable more staff contact with children. However, there was no record of any discussion about the points raised by the inspectors about Harberton continuing to have to accommodate more children than it had places for, the staff bungalow being used to accommodate children and the home consequently not being able to meet its remit as an assessment centre. While we recognise that these matters may have been discussed but not put on the public record of the meeting, on the basis of the evidence before us it appears that the Committee did not address these significant resource and strategic issues.

- 164 With regard to Mr Burke’s letter of 27 February 1991 requesting additional funding, it appears from an annotation on the letter that it was received on 7 March 1991. Dr McCoy’s written response was over ten months later on 20 January 1992.¹⁶⁰ Dr Mc Coy and Mr Burke told us when they gave oral evidence that a good relationship existed between the SSI officials and WHSSB managers and that informal advice was sought and offered, so it may be that there was informal contact between these officials during the period that elapsed between letters. However, we considered that a ten month delay in providing a formal response to a letter that was seeking assistance to address serious problems was not good practice.
- 165 In his response, Dr McCoy referred to Mr Burke’s request for £130,000 to establish an assessment treatment centre at Harberton House and acknowledged that Mr Burke had sought his support for this funding application. He asked Mr Burke to let him know what stage the proposal was at and whether the Board had been able to allocate funding for it.
- 166 Mr Burke responded on 7 April 1992. He provided Dr McCoy with an update on the steps the Board had taken to implement the recommendations of the review team, including strengthening social worker and family aide resources and increasing fostering provision. In relation to Harberton House he informed Dr McCoy that a review of the structure of the three children’s homes in the Area had been undertaken and that the intention in relation to Harberton House was to revise the staffing structure and

159 FJH 50738.

160 FJH 590.

reduce the occupancy level to twenty. He explained that on the basis of this proposal, consideration was being given to the establishment of a separate small unit to cater for four or five children displaying particularly disturbed behaviour, including those who had been sexually abused and/or had been sexually abusive. He indicated that Dr McCoy would be aware of the WHSSB’s plans to reduce the number of residential places on a progressive basis. We took this to be a reference to Dr McCoy’s awareness of WHSSB’s Strategic Plan in which these intentions were set out.

167 Mr Burke did not specifically respond to Dr McCoy’s question about the funding for the assessment treatment centre. Although he indicated that there would be costs associated with reducing the number of residential places he did not give an indication of the level of costs or ask for any additional funding.¹⁶¹ When he gave evidence in person during Module 5, Mr Burke confirmed that it took about another ten years for an eight-bed assessment unit and emergency admission centre to be opened and that it did not open until after the closure of Fort James, Termonbacca and the Nazareth House children’s home in Bishop Street.¹⁶²

168 Dr McCoy responded to Mr Burke on 15 May 1992. He noted that the WHSSB had not been able to implement all of the recommendations of the review report because of competing demands but commented:

“The Board is to be commended for the comprehensive range of measures introduced following this most thorough scrutiny of its services.”

He went on to identify three areas of continuing concern: unqualified staff continued to be recruited in Harberton House; only three out of the eight additional social worker posts recommended by the review had been established; and, the span of control of the Assistant Principal Social Worker had not been addressed. He made no further mention of whether funding was required for the proposed treatment and assessment centre.¹⁶³ Mr Burke acknowledged Dr McCoy’s letter on 21 May 1992 but did not make any further requests for funding.¹⁶⁴

169 We consider that the Department, and Dr McCoy in particular, demonstrated a proper concern that the circumstances of the co-ordinated peer sexual

161 FJH 592-598.

162 Page 51, Day 125.

163 FJH 10371-2.

164 FJH 10370.

abuse in Harberton House should be fully investigated and lessons learnt and shared with other Boards. However, we consider that the SSI should have engaged more fully and immediately with the WHSSB’s request for additional funding to strengthen its childcare services, even if funding constraints meant that assistance had to be limited to helping it to consider how its existing resources could be put to most effective use. We accept as pointed out by the DoH that the DHSS was not in the position to respond to the request for £130,000 for the assessment and treatment unit in the absence of properly costed proposals and operational plans. However, we saw no evidence that the DHSS or SSI on its behalf asked for this information. We found it particularly concerning that the SSI’s decision to maintain a watching brief on the WHSSB’s implementation of the Bunting recommendations was taken shortly after an inspector identified circumstances in Harberton House very similar to those that pertained at the time the co-ordinated peer sexual abuse occurred. The DoH pointed out that the suggestion in the Bunting report that an adolescent support centre could be established was linked to a recommended review of the residential component in Harberton House and that clearly that review needed to take place in the first instance. While we accept this point we could find no evidence that it was made at the time to Mr Burke when he requested the funding for the unit.

- 170 We are clear that the WHSSB was responsible for ensuring that it allocated the funding available to it in a manner that ensured its services for children were sufficient to enable it to discharge its statutory obligations and that it was also responsible for the management and quality assurance of its child care services. We accept that the DHSS was not in the position to immediately provide additional funding and that in any case the establishment of an adolescent treatment centre had to be considered within a wider review of the residential capacity of Harberton House. However, we saw no evidence of SSI engaging with the WHSSB to support it to consider how best to implement the recommendations in the Bunting review including, but not solely, the financial implications of doing so. This was despite the fact that the SSI was aware that adverse conditions were continuing to affect the care that children were receiving in Harberton House. **We consider this lack of engagement amounted to a systemic failing to ensure the home provided proper care.**
- 171 The WHSSB and the Department worked together to organise a seminar for providers of residential care in Northern Ireland about the risks of peer

abuse in residential care, which was held in February 1992. Mr Kearney of the Department made a presentation on the work he had undertaken to monitor the extent to which children in Northern Ireland were known to have been sexually abused prior to admission into care and the extent of known peer abuse within residential homes for children.

- 172 The Department included a requirement in the 1992-1997 Northern Ireland Regional Strategy for Health and Personal Social Services for Boards to start work to secure, in the longer term, access to evaluated treatment programmes for child and adolescent abusers aimed at containing and, if possible, reducing such behaviour. In addition, the Regional Strategy recognised the need for Boards to move away from multi-purpose children’s homes to a range of small specialist units designed to meet clearly identified needs.

Further Incidents of Peer Abuse in Harberton House

- 173 The review team’s identification of continued risk to children and staff in Harberton House was realised in May 1992 when further incidents of peer sexual abuse were identified in the home.¹⁶⁵ On this occasion an adolescent female resident told a member of staff that she had heard three younger male residents discussing sexual matters. When staff interviewed the boys it became clear that one of the boys aged eight years had threatened the other two boys aged seven years and intimidated them into simulating sexual intercourse, while fully clothed, while he observed them.
- 174 This activity had not gone undetected for a prolonged period of time; it was described as having happened “over the past few weeks”.¹⁶⁶ However, we noted that it was only brought to the attention of staff by another resident, and the activity took place at the same time as in the previous incidents, i.e. early in the morning and after school when staff were involved in hand-over meetings. The use of waking night staff, which had been introduced as a result of the previous incidents of peer sexual abuse in the home, had been discontinued at the end of October 1991. In response to this new incident, sleeping-in staff were increased to two in the medium stay unit, one of whom commenced work at 6am to supervise the children. Mr Carey asked senior managers to support a longer term measure of employing staff at care assistant level to act as waking night staff.

165 FJH 15536.

166 FJH 15481.

- 175 In 1992 the capacity of the home was reduced to twenty places, ten in each unit. However, the staff and children continued to have to deal with the impact of over-occupancy at times when the number of children requiring care was in excess of available places. For example, when Ruth Lavery visited the home, on 14 July 1993, she completed the pro-forma used by the visiting committee and recorded the concerns of staff that:
- “Numbers of children were regularly over the upper limit [because of] crisis interventions and limited fostering resources. Inability to develop specialist work with abused (& abusing children) because of general demands.”¹⁶⁷
- 176 Further incidents of peer sexual abuse came to light in April 1994 when staff investigated an incident that occurred on 25 April 1994 when a boy then aged eleven years, SPT 81, and another male resident exposed themselves to each other. During this investigation information emerged that SPT 81 and two other male residents aged seven and thirteen years had been sexually assaulting a female resident in the home for prolonged periods over a number of months. While this matter was being dealt with, a further incident of SPT 81 being involved in sexual activity with another boy was detected by domestic staff on 20 June 1994. SPT 81 was subsequently transferred to St Patrick’s training school on a Place of Safety Order on 22 July 1994 and sadly was killed in 1994.
- 177 In response to SPT 81’s death, the WHSSB established a team to review the care he received. Bob Bunting who had chaired the earlier review into the peer sexual abuse in Harberton House also chaired this review. In relation to the care SPT 81 received in Harberton House the review team concluded that the fact that the abuse of the girl in Harberton House by SPT 81 and two other boys went undetected, and that SPT 81 was able to intimidate the girl once the abuse came to the attention of staff, raised questions about the adequacy of supervision in the home.¹⁶⁸ The review team also questioned whether there was sufficient contact time between staff and children to allow necessary therapeutic work,¹⁶⁹ and concluded that the habitual use of ‘time out’ with SPT 81, 46 occasions in a four-month-period, made it an ineffective means of dealing with his behaviour.

167 FJH 17159

168 SPT 19032.

169 SPT 19047.

- 178 The review team also concluded that the homosexual activity between SPT 81 and another boy in June 1994 was serious and suggested knowledge of homosexual intercourse which should have been reported to the police so that they could have investigated how the boys had gained such knowledge and whether either of them had been sexually abused.¹⁷⁰
- 179 The review team recommended that the standards of supervision of the children should be improved in Harberton House and that staff rotas should be revised in order to increase contact time with children.¹⁷¹ There was no reference in the report to the previous review of incidents of co-ordinated peer sexual abuse in Harberton House or that similar recommendations had been made as part of that review.
- 180 It was clear from the evidence we considered that although Harberton House was designed to provide focused short-term assessment of children’s needs and some emergency beds, it was not able to meet its planned remit from soon after it opened. This was because the level of demand for residential care for children meant it had to accept a large number of emergency placements. Also, the lack of alternative residential care and fostering resources meant children could not be moved to appropriate services once their needs were assessed and care plans agreed. HH 5 reported to Mr Carey that this resulted in some children feeling frustrated and hopeless and led to behavioural and disciplinary problems.¹⁷² We consider that it was also likely to have meant that children whose care needs required to be assessed could not benefit from the services in Harberton House because places were not available as they were filled by emergency placements and children waiting for alternative appropriate placements.
- 181 At around the same time as Harberton House opened, it was decided that Fort James should focus on the care of older children. This decision had significant implications for the provision of medium to long-term care for younger children. We understand the view expressed by Mr Carroll at that time that residential care was not an appropriate choice for children under school years but, as he recognised, such an approach could only be sustained if there were sufficient and appropriate foster placements to accommodate such children.¹⁷³ This was not the case, and was known

170 SPT 19052.

171 SPT 19055.

172 FJH 40020.

173 FJH 6555.

not to be the case, and it meant that achievement of the stated remits of Fort James and Harberton House was undermined by the need to accommodate younger children, often in emergency circumstances. A clear example of the impact of this lack of provision was the placement in 1990 of four children all aged less than six years of age in the staff bungalow in Harberton under the care of a new team of inexperienced staff.

- 182 From the evidence we have considered, we have concluded that the WHSSB’s strategic planning of Harberton House did not take proper account of the need to ensure that complementary services were in place that would allow its remit as an assessment centre to be realised and protected. The HSCB accepted in its response to the Warning Letter process that that while there was a strong desire to use Harberton House as it was originally intended in reality the frustration of large numbers of admissions along with inadequate resources for alternatives made this very difficult. We consider that this failure in strategic planning contributed to inappropriate placements of children in the home and children remaining in the home after the assessment of their care needs had been completed. We also consider that the pressures this placed on staff contributed to the inadequate supervision of children and lack of therapeutic work with them that enabled the co-ordinated peer sexual activity in Harberton House in 1989-1990 to continue undetected for as long as it did. **We consider this failing in strategic planning amounted to a systemic failing by the WHSSB to ensure that Harberton House could meet its intended remit and provide proper care.**
- 183 When Dr Harrison gave evidence in person on behalf of the DHSSPS she told us that although the Department did not give capital funding to Boards, Boards were required to submit plans for children’s homes through the Department so that it could scrutinise the proposed purpose, function, location, structure and size of the home and its feasibility. She recalled that questions would usually go back and forward between the Department and Board about proposed plans and that the plans would only be put forward as part of a public expenditure bid when the Department was satisfied with them.¹⁷⁴ Dr Harrison explained that since the final bid had to have the Department’s approval it was expected that any elements the Department wished a Board to address in relation to a proposed home

174 Day 129, p.22.

would be incorporated in the final bid.¹⁷⁵ Dr Harrison could only speak from personal experience about the Department’s process for scrutinising plans in the 1990s. She confirmed that at that time the scrutiny would have included how a proposed home would fit within a Board’s wider childcare services, for example fostering provision.

- 184 Further to this evidence, we put additional questions in writing to the DHSSPS about the involvement of the Department in the consideration of the plans for Harberton House. Dr Harrison responded in writing on behalf of the DHSSPS and informed us that it had not been possible to locate any records about the Department’s consideration of the proposal to establish Harberton House. However, she outlined the standard procedures which the Department used at that time to consider such proposals and confirmed that the DHSSPS had no reason to believe that these procedures were not followed in relation to Harberton House.¹⁷⁶
- 185 Dr Harrison explained that a Board’s proposals for the development of a children’s home had to include the level of existing provision, the extent of the need identified, the type of service to be provided in the facility, the physical provision required and the proposed staffing level and structure.
- 186 The case put forward by the Board would then be considered by the Department’s officials and professional advisors. Dr Harrison confirmed that professional advisors would have commented on the specifics of submissions in terms of standards of accommodation, numbers of children and staffing arrangements etc and that since they had an overview of existing statutory and voluntary children’s home provision within the region:
- “...their views on the need for new provision would, of necessity, have had to take account of existing and projected numeric provision, as well as qualitative inadequacies or gaps in services and how the proposed home might address these or complement other necessary developments in child care services.”¹⁷⁷
- 187 In relation to the establishment of Harberton House, Dr Harrison told us it was unlikely that due regard would not have been given by the Department to the robustness of the WHSSB’s plans to avoid children remaining in the home longer than necessary.

“Part of this consideration would had to have been the extent to which

175 Day 129, p.24.

176 FJH 80002.

177 FJH 80003.

other services were in place to enable children to be assessed and moved in a timely manner to appropriate longer term placements. Also whether these services and (in the case of children who were to return home) family support services, were sufficiently adequate to support the proper functioning of a residential assessment unit within the Board’s continuum of services.”¹⁷⁸

- 188 We found it surprising that given this level of scrutiny the lack of fostering resources and the growth in the number of children requiring care (increasingly on an emergency basis) were not identified and addressed as part of the consideration of the proposals to establish Harberton House. The lack of records meant we did not have access to the detail of the Department’s scrutiny of the plans for Harberton House, including what time lag there was between funding for the home being agreed and the home opening. Clearly, if the time lag was significant then the demand for residential childcare and foster places may have increased in the intervening period. The lack of records also meant that we did not know if the Department gave any advice or guidance to the WHSSB about the establishment and operation of the assessment centre. Therefore, we are not in the position to reach any conclusions about the Department’s role in approving the plans for Harberton House. However, the fact that almost from the point of opening, Harberton House was unable to operate as an assessment centre made us question the rigour of the scrutiny process.
- 189 The level of internal monitoring and governance of Harberton House was high, and those involved in it accurately identified pressure points and how they were affecting the quality of the care provided to the children. However, this awareness did not translate into appropriate and effective remedial action. We concluded that the time and energy invested in monitoring Harberton House was only marginally effective in its ability to positively influence the nature and quality of the service being provided. The wider context of the increased need for children to be accommodated outside their families and the lack of specialist residential services and fostering resources meant that although problems in, for example, the throughput of children, could be clearly identified, solutions were less forthcoming. We did not consider this was because of lack of commitment or concern on the part of staff and their managers. It was clear from contemporaneous documentation and from the evidence we heard from former staff and managers that they were committed to providing high quality childcare and felt frustrated and

178 FJH 80003.

hampered by the lack of appropriate resources and reported the impact of this to senior managers and visiting committee members.

190 However, we noted that at the same time as Harberton House and Fort James were under pressure to accept and work as best they could with more children than they were equipped to deal with, the WHSSB’s Strategic Plan for childcare for 1992-97¹⁷⁹ set the objective to move to the position where no more than 15% of the children in its care should be in residential facilities by 1997.¹⁸⁰ This objective was in line with the 1992-1997 DHSS regional strategic plan, which required Boards to:

“...seek to reduce the need for residential care and, with the development of preventive and foster care services as alternatives to residential care to reduce the stock of residential provision”.¹⁸¹

In order to measure progress against this objective, Boards were asked to aim by 1997 to have at least 75% of the children in their care, excluding any children home on trial, in a family placement.¹⁸²

191 The WHSSB set a more ambitious objective of moving to a position where no more than 15% of the children in its care were accommodated in residential care facilities by 1997. The Strategic Plan stated that as of September 1991, 91 children, approximately 18% of the 506 children in the care of the Board were accommodated in residential care. The target set was to reduce this number to a maximum of 58 places over the planning period, which meant that the WHSSB was going further than the Department’s objectives.

192 The WHSSB recognised that it needed to improve its fostering provision significantly to achieve this change. It also considered at the time whether it should convert its children’s homes to provide smaller units, each of which would enable specialised individual work with children in care that could not easily be undertaken in multi-purpose units.¹⁸³

193 We recognised that the WHSSB was seeking to improve the appropriateness and effectiveness of its childcare services and to meet the Department’s objectives in this regard, and that in the absence of additional funding new services could only be developed through releasing funding from existing services. However, we considered there was a striking mismatch at this

179 FJH 1005-1015.

180 FJH 1011.

181 FJH 80143.

182 FJH 80145.

183 FJH 1012.

time between the targets being set for reducing residential childcare places and the increasing demand for such places that field and residential managers and staff were struggling hard to meet. We will return to the general issue of the funding of the WHSSB in the section about Finance in Volume 1.

- 194 Also, while the Department’s aspiration for Boards to develop preventative and foster services, and thereby reduce the need for residential care for children, was laudable, there seemed to be little recognition of the knowledge, gained through the SSI’s inspections of the WHSSB’s children’s homes, of what a major task the WHSSB faced in achieving such a major shift of resources. When the WHSSB decided to reduce its residential childcare places through the closure of Fort James in 1995, the SSI, appropriately in our view, was concerned about the impact this would have on Harberton House and advised caution and reconsideration of the planned closure. The WHSSB continued with the closure but explained in response to the SSI’s concerns that in the short-term eight additional residential places would be provided in Harberton House.¹⁸⁴ The SSI strongly, but unsuccessfully, advised against this interim compensatory measure because of the adverse effect it was likely to have on the management of Harberton House and the associated risks to children in the Board’s care.¹⁸⁵
- 195 We do not underestimate the challenges that the WHSSB faced in dealing with significant increases in the number and complexity of childcare cases while serving a community coping with high levels of deprivation, unemployment and social unrest. For example, contemporaneous documents record that the number of child protection cases in the Londonderry, Limavady and Strabane Unit of Management increased from 31 December 1982, where twelve children from six families were on the child protection register, to 31 December 1988, where 106 children from 44 families were on the register. It was also recorded that in the same Unit of Management there were 22 referrals about sexual abuse of children in the period 1 July 1985 to 1 July 1986, and this had increased to 100 such referrals by the period 1 July 1988 to May 1989.¹⁸⁶ Middle managers consistently reported on the pressures within residential childcare services and the associated impact on the quality and

184 FJH 40056.

185 FJH 40054.

186 FJH 10655-10662.

safety of the care that could be provided to children. Nonetheless, they recognised, as do we, that where children were in urgent need of care and protection some arrangement had to be made to accommodate them, however much that might compromise the limited resources available.

- 196 Immediately after the events in Harberton came to light the WHSSB allocated additional resources to increase staffing in Harberton House and increase fostering provision. It also considered the training needs of staff including the introduction of individual training needs profiles¹⁸⁷ and the need for the full range of child care staff to receive training in the development of skills in therapeutic work with victims of abuse.¹⁸⁸ Dominic Burke, in his letter of 7 April 1992, assured Dr McCoy that the WHSSB was continuing to develop its assessment of need strategies in relation to family and child care, was making good progress in related strategic planning and was undertaking a review of its three residential childcare homes. He also detailed planned further resource allocations to family and childcare programmes.¹⁸⁹ However, he reiterated the point he made to Dr McCoy in the letter he sent him in February 1991 that the WHSSB was experiencing difficulty in addressing all the recommendations of the Bunting Review because of the competing demands on resources.¹⁹⁰
- 197 It is clear that while the WHSSB was seeking to implement the recommendations of the Bunting Review and address the Department’s strategic objectives for childcare, managers and staff continued to struggle to provide appropriate residential care for children and the decision to close Fort James created further pressure. We consider a fundamental review of childcare services and residential care as part of those services was necessary at this time to protect the wellbeing and safety of children and that aspirational planning against a background of struggling and inadequate services was not appropriate.
- 198 Committee member, Ms McGowan’s recorded views were that the Board was failing in its duty to protect children¹⁹¹ and that urgent consideration needed to be given to minimising the continuing risk to children and staff identified by the Bunting Review.¹⁹² Although senior managers sought to reassure Ms Mc Gowan about what action was being taken to deal with the

187 FJH 10149.

188 FJH 10151.

189 FJH 592-598.

190 FJH 592.

191 FJH 10011.

192 FJH 10432.

circumstances she had highlighted we saw no evidence of the Board itself specifically responding to these concerns or increasing its scrutiny of the ongoing quality and safety of its children’s homes. As part of the Warning Letter process the HSCB pointed out that the Bunting review addressed issues about related services which impacted on residential care services. We accept this was the case and have indicated earlier in this chapter that we considered that was the right approach. However, our view remains that while the WHSSB made considerable efforts to address the pressures and issues highlighted in the Bunting review and engaged with the DHSS about them it did not undertake the fundamental review of its total childcare services that would have been necessary to address the fundamental problems it was experiencing in the delivery of its child care services and in particular in the provision of residential child care as part of those services. **We consider the WHSSB failed to instigate a fundamental review of its childcare services despite the findings of the Bunting Review and failed to increase its scrutiny of its children’s homes in response to Ms McGowan’s concerns and that these failings amounted to a systemic failing to ensure the homes provided proper care.**

Evidence from HIA 233 about her time in Harberton House

- 199 HIA 233 was placed in Harberton House on 28 October 1982 following the breakdown of a foster placement. She told the Inquiry that whilst she was in Harberton House a member of staff called HH 15 would grab her by the neck and “batter” her and that he abused her younger sister and other residents in a similar manner.¹⁹³ She alleged that the officer in charge of the home HH 5 knew HH 15 treated her in this way and did nothing about it. HH 5 strongly refuted this allegation in his second witness statement submitted to the Inquiry in Module 1, dated 10 March 2014¹⁹⁴ and continued to do so in his oral evidence to the Inquiry in Module 5.
- 200 In Module 1, the HSCB confirmed to the Inquiry that HH 15’s personnel file had been checked and there was nothing in his file concerning any complaints about his behaviour or disciplinary action. However, we noted that documentation provided by the HSCB in relation to Harberton House included references to a complaint by a resident in 1989 about physical abuse by HH 15 which was investigated by a principal social worker and

193 FJH 008.

194 FJH 056.

assistant principal social worker who determined the complaint was not founded. There was also a record of a complaint from SPT 81 in June 1993 that HH 15 lifted him by the collar and threw him into a room thereby hurting his neck. It was recorded that this complaint was investigated by TL 4, Assistant Principal Social Worker, who did not find it possible to find any supporting evidence to substantiate SPT 81’s complaint.¹⁹⁵ A further complaint was made by a resident in December 1994 that HH 15 had been rude to her on two occasions. It was recorded that HH 5 investigated the complaint and found no breach of professional practice.¹⁹⁶

- 201 When giving evidence in Module 5, HH 5 confirmed that he had no concerns about HH 15’s professional practice but pointed out that there was a problem, in that men (and particularly HH 15 because he was a man of considerable stature) were often used to defuse situations with children who were acting out in a physical manner. HH 5 was of the view that this approach made these male members of staff vulnerable. He stated that it was not until the mid-1990s that staff received appropriate training about managing and dealing with very challenging behaviour.¹⁹⁷
- 202 HIA 233 also told us she was raped by a boy in Harberton House when she was about thirteen, and that she told another resident about what happened and that girl reported it to a member of staff, HH 20. HIA 233 said that when HH 22, who was then head of the long-stay unit in Harberton was told about the matter, she said to her: “are we back with these lies again HIA 233”, and told her she was going to end up in a training school. HIA 233 told us that “Harberton” wanted her to report the matter to the police and she wanted to, but that nothing happened and she was not interviewed by the police.¹⁹⁸
- 203 HH 22 gave evidence in person during Module 5 and was questioned about how she responded to HIA 233’s disclosure about sexual activity with HH 18. HH 22 denied that she responded in the manner described by HIA 233. She told us that as a manager in the home her role would have been to see that policy and procedures were being followed rather than interviewing the children involved. She added that if she had made any reference to HIA 233 going to a training school that would have been a statement of fact, as that was the plan for HIA 233, and not a threat.

195 FJH 15777-15782.

196 Day 124, p.61.

197 pp.100-101, Day 124, 10 June 2015.

198 FJH 008.

- 204 The HSCB provided a response to HIA 233’s evidence in which it set out the following recorded events:
- An untoward incident report completed by Harberton staff on Saturday 24 October 1992 recorded that HIA 233 told another girl that she had sexual intercourse with another resident, HH 18 in her room on Friday 23 October 1992.
 - HIA 233, HH 18 and two other residents were spoken to about this by residential social work staff; HH 5 was informed and he in turn informed HH 40, Programme Manager.
 - The Care Unit of the RUC was contacted and HIA 233’s mother was approached for written consent to a medical examination, which she gave at 10pm on 24 October 1992.
 - HIA 233 was interviewed at Strand Road RUC station on Sunday 25 October 1992 in connection with the allegations about HH 18; another female resident of Harberton House and HH 18 were also interviewed by the police about the matter.
 - HIA 233 refused to be medically examined at the police station on 25 October 1992, and in the police statement she was recorded as being uncooperative and abusive during the interview.
 - The Care Unit of the RUC informed Harberton House by letter on 9 December 1992 that there would be no further police action taken regarding HIA 233’s allegations of a sexual nature against HH 18.¹⁹⁹

The HSCB also confirmed that prior to this incident HIA 233 was already on a waiting list for a place in a training school, and it was because a place became available that she was transferred to Middletown Training School on 28 October 1992.

- 205 We carefully considered the evidence of HIA 233 and the responses from the HSCB, HH 5 and HH 22. We consider that HIA 233’s allegations of rape by another resident were taken seriously and dealt with appropriately.
- 206 We noted HIA 233’s complaints about HH 15 and that two other residents complained about his overly physical behaviour towards them and one resident complained about him being rude to her on two occasions. These complaints were investigated by managers and it was recorded that they were not upheld. We note that Mr Carey regularly reviewed the complaints made about staff and the outcome of their investigation.

199 FJH 30615.

207 Although we did not find evidence of systemic failings in the care HIA 233 received in Harberton House we consider the complaints she and other children raised about HH 15 highlight the importance of senior staff monitoring the number and type of complaints being made against a member of staff since a pattern of low-level complaints may indicate unsuitability and merit more serious disciplinary action.

Summary of Findings about Harberton House

208 **We found that the SSI on behalf of the Department failed to:**

- (1) engage with the WHSSB to support it to consider how best to implement the recommendations of the Bunting Review, although it was aware adverse conditions were continuing to affect the care that children were receiving in Harberton House;**

and that this failing amounted to a systemic failing to ensure Harberton House provided proper care.

209 **We found that the WHSSB failed:**

- (1) in its strategic planning of Harberton House to ensure that complementary services were in place that would allow its remit as an assessment centre to be realised and protected so that it could assess the needs of children and make arrangements for them to receive planned care appropriate to their assessed needs;**
- (2) to instigate a fundamental review of its childcare services despite the findings of the Bunting Review and failed to increase its scrutiny of its children’s homes in response to Ms McGowan’s concerns;**

and that these failings amount to systemic failings by the WHSSB to ensure Harberton House provided proper care.