Chapter 3:

Findings

Contents **Para**

Findings

1 In this Chapter we set out our findings volume by volume in respect of each module, preceded by a brief introduction explaining the institution(s) or topic examined by the Inquiry in that module. The full report in respect of each module will be found in the volume and chapter identified below at the start of each section. Because of limitations of size we have grouped the chapters relating to institutions and topics in each volume in sequences that are not necessarily in the order in which each module was dealt with by the Inquiry, but reflects a thematic link between the chapters.

2 We have arranged the chapters relating to each institution or topic in volumes in a sequence that enables the reader with a particular interest in several institutions or topics to find the chapters relating to those institutions or topics in the same volume or the preceding or succeeding volume. Thus we placed the chapter on child migration to Australia between the chapters relating to the Sisters of Nazareth homes in Derry and Belfast because the Sisters of Nazareth sent most of the children to Australia from Northern Ireland on the Child Migrants Scheme. The chapter on Fr Brendan Smyth was placed after the last chapter relating to the Sisters of Nazareth homes but before the chapter on Rubane House because he abused children in both homes. The chapters on Rubane and St Patrick's Training School were placed together in Volume 4 because both institutions were run by the De La Salle Order. The chapters relating to all the other juvenile justice institutions have been placed in Volume 5. The chapters in Volume 6 all relate to voluntary homes that were not run by central or local government, or by statutory authorities. Because of their size the five chapters relating to the Kincora Boys Hostel have been placed in Volumes 8 and 9, and Volume 10 consists of the report by the Acknowledgement Forum.

Volume 1 – Chapter 1 – Introduction

3 This explains the origin and Terms of Reference of the Inquiry, its structure, procedures and practices, as well as a brief overview of the social and economic background of Northern Ireland against which the residential institutions examined by the Inquiry have to be viewed.

Volume 1 – Chapter 2 – Governance and Finance

4 This chapter examines in detail the legal and government structures within which residential institutions operated during the period covered by the Inquiry's Terms of Reference, and the funding arrangements for those institutions. We made one finding in this chapter. While we do not underestimate the demands on the limited number of staff in SWAG (the Social Work Advisory Group) in the 1970s and early 1980s and recognise that they were contributing to policy developments and consultations at that time as well as maintaining some limited contact with children's homes. We accept that the visits SWAG made to children's homes meant that the children in those homes had the benefit of some external scrutiny of the conditions they were living in and the care they were receiving. However, as will be clear from our findings in relation to individual children's homes we found the lack of inspection by SWAG in this period amounted to a systemic failing by the Department of Health and Social Services (DHSS) to ensure these homes provided proper care.

Volume 1 – Chapter 3 – Summary of Findings

5 In this chapter we briefly explain the nature of each institution or issue examined by the Inquiry during its public hearings, followed by a summary of the findings of the Inquiry in respect of the issues examined in respect of that institution or issue. As these are summaries, it should be noted that some headings may encompass several distinct findings of systemic failings of the same type. The summary is not meant to replace those findings, and the individual findings in each chapter represent our definitive findings.

Volume 1 – Chapter 4 – Recommendations

6 This chapter contains the recommendations of the Inquiry relating to an apology and a memorial, together with the Inquiry's detailed recommendations as to the scope of financial redress to be made to those who were abused while in residential institutions and homes within our Terms of Reference.

Volume 2 – Chapter 5 – Module 1 – Sisters of Nazareth, Derry

7 The Inquiry devoted Module 1 to the examination of evidence relating to two homes run by the Congregation of the Poor Sisters of Nazareth in Londonderry, namely St. Joseph's Home, Termonbacca, and Nazareth House in Bishop Street. For simplicity's sake we referred in this chapter to St. Joseph's Home, Termonbacca as "Termonbacca" as this was the name by which it was commonly referred to by witnesses and officials alike. These institutions were dealt with in the same module because there are a number of overlapping features of the manner in which they were run and other links between them although we examined them separately.

8 The Inquiry devoted thirty-nine sitting days to this module commencing on 27 January 2014, spread over ten sitting weeks from 27 January to 29 May 2014. During the ten sitting weeks, one of which (week 6) was a closed session, the Inquiry received oral evidence from sixty-two witnesses and received written statements from a further ten witnesses. The evidence of one other witness was not admitted because they failed to turn up or give a reasonable explanation for not doing so.

9 In addition to the oral and written evidence we have taken into account the detailed written and oral closing submissions made on behalf of fourteen individuals against whom allegations of abuse were made, and we also received written and oral admissions on behalf of the Congregation of the Sisters of Nazareth, the Department of Health, Social Services and Public Safety, as the successor department to the Ministry of Home Affairs and the Department of Health and Social Services, each of which had statutory responsibility for these homes during the period with which we are concerned.

10 We also received oral and written submissions on behalf of the Health & Social Care Board, as the successor to the various local or statutory authorities which had responsibilities for the care of children in this area. We considered all of this evidence and paid careful attention to the various written and oral submissions which were made to us, however in accordance with our general approach and our Terms of Reference, we do not propose to refer to each and every detailed allegation that was made, whether against an individual or either institution, although we have taken all of the evidence and the submissions into account.

Findings in respect of the Sisters of Nazareth at Termonbacca

11 There was abuse in the form of improper sexual or physical behaviour by individual sisters towards children in their care.

12 There was abuse in the form of improper sexual or physical behaviour by other adults, employees, visitors and priests towards children in the care of the Sisters of Nazareth.

13 There was abuse in the form of improper sexual or physical behaviour by older children towards children in the care of the Sisters of Nazareth.

14 There was emotional abuse in the form of improper behaviour by individual sisters towards children in their care which undermined the self-esteem and emotional well-being of the children.

15 There was emotional abuse in the form of improper behaviour by other adults, namely employees, visitors and priests towards children in their care, behaviour which undermined the self-esteem and emotional well-being of the children.

16 Individual sisters and those in positions of authority within the Congregation at Termonbacca were aware of the matters above.

17 Although there was evidence of poor childcare in some respects, we consider this did not amount to systemic neglect.

18 No, or alternatively inadequate, steps were taken by the Sisters of Nazareth to prevent such abuse.

19 Individual sisters, and those sisters in positions of authority within the Congregation, did not take proper steps to report such abuse to the relevant civil authorities, namely social services and the police.

Findings in respect of the Sisters of Nazareth at Bishop Street

20 There was improper physical behaviour by individual sisters towards children in their care.

21 There was improper sexual behaviour by a visitor and by priests towards children in the care of the Sisters.

22 There was improper physical behaviour by older children towards children in the care of the Sisters.

23 There was improper behaviour by individual sisters towards children which undermined the self-esteem and emotional well-being of the children.

24 The Sisters of Nazareth were aware of the abuse and took no steps to prevent such abuse.

25 The Sisters of Nazareth did not take proper steps to report such abuse to the relevant civil authorities, namely social services and the police.

26 The Congregation of the Sisters of Nazareth did not take adequate steps to ensure that they had:

(a) suitable premises, and

(b) sufficient Sisters and lay staff, and

(c) suitably selected and trained sisters and lay staff to prevent abuse of the children in their care, and

(d) an adequate system of internal inspection, and

(e) an effective system of managerial support and supervision.

27 The Congregation of the Sisters of Nazareth did not take sufficient steps to try to obtain adequate funding for either Termonbacca or Nazareth House.

Findings in respect of the Ministry of Home Affairs and the Department of Health & Social Services

28 The Ministry of Home Affairs and the Department of Health & Social Services failed to:

(a) construct, and

(b) implement an appropriately rigorous inspection regime to ensure that children in St. Joseph's Home, Termonbacca and Nazareth House were safe from abuse.

29 The Ministry of Home Affairs and the Department of Health & Social Services did not take sufficient steps to ensure that St. Joseph's Home, Termonbacca and Nazareth House were required and/or helped to provide:

(a) suitable premises, and

(b) sufficient Sisters and lay staff, and

(c) suitably selected and properly-trained sisters and lay staff to ensure that the children in these homes would be provided with childcare that was:

(i) in accordance with the standards of the time, and

(ii) of the same standard as that received by children in homes in the statutory sector.

Failings by the welfare authorities

30 Neither the county borough welfare committees (or the Western Health & Social Services Board as their statutory successor) as the statutory bodies which placed, or assumed responsibility for, children in care in St. Joseph's Home, Termonbacca or Nazareth House, took adequate steps to monitor the care given to individual children in either home.

31 None of the statutory bodies which placed, or assumed responsibility for, children in either home took adequate steps to monitor the facilities for, and standards of care provided to, children in either home.

32 None of these statutory bodies took adequate steps to inform themselves of the provision made by the Sisters of Nazareth for the care of other children in either home whose circumstances might have brought those children within the responsibility of the statutory bodies concerned.

33 None of those statutory bodies provided adequate financial or administrative support for the children they placed in the care of the Sisters of Nazareth in either home.

Volume 2 – Chapter 6 – Module 2 – Child Migration to Australia

34 This portion of the Inquiry's Report is concerned with its investigations into why and how a number of children from institutions in Northern Ireland were sent to Australia, almost all of whom went in the years after the Second World War. When the Inquiry publicised its existence in Australia in 2013 we received a very large number of applications from people resident in Australia, mostly in Western Australia, and it became obvious that there were two main aspects of their experiences that required investigation: firstly, the allegations of abuse which they say they suffered in residential institutions in Northern Ireland before they went to Australia; and secondly, how and why these children were selected to go to Australia, because many allege that the process was itself abusive.

35 Many applicants were bitterly critical of the institutions for sending them to Australia, and of the Northern Ireland and United Kingdom Governments for permitting and facilitating their being sent to Australia. They also complain of the effect that being sent has had on their lives, not least because they allege they were subjected to serious forms of abuse in the institutions to which they were sent in Australia. In their evidence many described how they lost all contact with their parents and siblings. Although, after many years and much effort, some were able to re-establish some contact with their relatives, for others it was too late, because their parent had died, or, when they were able to trace their parent or family members, the reunions were not successful. Their complaints also extend to other matters, such as not being able to obtain birth certificates, or discovering that their names or dates of birth had been altered, things which created major difficulties for them in later life when they had to prove their identity for official purposes.

36 Many of those who spoke to us in person, or who described their experiences in their written statements, spoke movingly of the profound effect that being sent to Australia as children had upon them. Those who wish to study their accounts in greater detail will find them on the Inquiry website, together with the relevant documents and transcripts, at Days 42 to 50. The words of HIA 324[1] in his statement provide a striking example of the effect upon him of being sent to Australia as a child, views which are representative of the views of many applicants:

> "My life in institutions has had a profound impact on me. I have always wondered what it would be like to have had a family – a mother and father and brothers and sisters. I never got the chance to find out because I was sent to Australia. We were exported to Australia like little baby convicts. It is hard to understand why they did it. I know the theory – to populate Australia. I still cannot get over the fact that I was taken away from a family I never got the chance to know. I was treated like an object, taken from one place to another. I found it very hard to show affection to my children when they were young. I have improved as the years have gone on. I have a nightmare every night of my life. I relive my past and am happy when daylight comes."

37 HIA 324, who was born in 1938, was 75 when he spoke these words to the Inquiry legal team in Perth in 2013. Sadly he died before he was able

1 AUS 10743.

to sign his statement and see the Inquiry consider his account, and the accounts of the other child migrants who have contacted us.

38 It became clear that many questions were raised by what we were told.

- Why were child migrants sent to Australia?
- How many were sent?
- Who sent them?
- Who decided that they would go?
- How were they chosen?
- Were their parents consulted?
- What happened before they were sent?
- How did they get to Australia?
- What happened to them when they got there?
- Were they able to contact their parents or families afterwards?

39 In this part of our Report we examine each of these questions except for "What happened to them when they got there?" We took the view that the institutions remained responsible for any child they sent until the child disembarked in Australia, and so we examined the arrangements that were made for the children travelling to Australia, and the conditions during the voyages to Australia.

40 We made clear at the beginning of the public hearings of the module relating to Australia that our powers do not permit us to investigate the experiences of the applicants in the institutions to which they were sent once they arrived in Australia.[2] However, in order to examine whether the institutions in Northern Ireland took any steps to keep contact with the children, or to inform themselves of the progress of the children, it was necessary for the Inquiry to know what the applicants themselves had to say about these matters. Almost every applicant was very concerned about the difficulties they experienced in later life because of the inadequate information available to them about their origins and families in Northern Ireland. In addition, the applicants themselves had much to say about their experiences in Australia. In order to obtain a complete picture of all these matters, when the Inquiry recorded statements from these applicants we therefore included their accounts of the experiences to which they say they were subjected in various institutions in Australia.

2 Chairman's opening remarks. Day 42, 1 September 2014.

41 Many applicants who gave evidence to us in this module were unable to remember anything, or if they did they often remembered very little of their time in institutions in Northern Ireland. Where they can recall such matters, their evidence is referred to, where necessary, in those parts of our Report which deal with the particular institutions in Northern Ireland. This portion of our Report is solely concerned with the experiences of those who spoke to the Inquiry in relation to how they came to be selected to be sent to Australia, their experiences on the way to Australia, their experiences after they arrived to maintain contact with their relatives in Ireland during their childhood, or in later years, the success or otherwise of these efforts, and the effects on them of being sent to a different country many thousands of miles away as young children.

42 As part of our investigations we sent members of the Inquiry to Australia for approximately a month at a time in September to October 2013, and June to July 2014. On each occasion the team was made up of two members of the Acknowledgement Forum panel, two members of our legal team and two witness support officers. They went to Australia for two reasons. Firstly, to enable those applicants now living in Australia to have the same opportunity to describe their experiences to the Acknowledgement Forum as applicants who live in Northern Ireland and elsewhere. Some of the Australian applicants chose only to describe their experiences to the Acknowledgement Forum and did not wish to engage with the Statutory Inquiry element of the Inquiry's proceedings. The second reason was to enable our legal team to record witness statements from applicants in Australia, as well as to gather a considerable amount of documentary material and other information in relation to the matters which the Inquiry will consider later in this part of the Report.

43 Although the majority of the applicants who had been sent to Australia as children landed in, and still live in, Western Australia, some now live in other parts of Australia. In order to enable as many applicants as possible to speak to the Inquiry team at convenient locations, the Inquiry team saw applicants in Perth in Western Australia, in Brisbane in Queensland, and in Melbourne in New South Wales. Many of the applicants travelled considerable distances to speak to the Inquiry team and we are very grateful to them for doing so.

44 The Inquiry then devoted nine days of public hearings[3] to examining the experiences of those who were sent to Australia. During that time the Inquiry received oral evidence from eleven applicants. Three who were in Northern Ireland at the time were able to give evidence in person at Banbridge Courthouse, and the other eight did so by live TV-link from Australia. A further 38 witnesses gave their evidence in the form of the written statements which they had provided to the Inquiry; these were read out by Counsel to the Inquiry in public. Altogether we received evidence from 52 of the 65 applicants from Australia, because three further witnesses were not called during the Australian module but gave evidence in a later module in respect of their experiences in institutions in Belfast. Their evidence in relation to those institutions is considered in that part of the report that deals with those institutions, but their accounts of experiences relating to their migration to Australia are included in this portion of the Inquiry Report.

45 The remainder of the 65 chose not to speak to the Statutory Inquiry, and those who wished to do so spoke only to the Acknowledgment Forum. Sixty-five applicants represent almost half of all those whom we believe were sent to Australia from Northern Ireland as child migrants, and their evidence enabled us to piece together a detailed picture of many of the procedures involved.

46 The Inquiry received many helpful documents from applicants in Australia that greatly assisted us in our work. The Inquiry also carried out exhaustive searches in the Public Record Office of Northern Ireland (PRONI), as well as receiving evidence from the Sisters of Nazareth and the Health and Social Care Board. We also received helpful information from the Child Migrants Trust (CMT) and from Tuart Place in Australia. Documents we obtained from the National Archives of Australia at the end of the module threw considerable light on the arrangements for child migration to Australia between 1938 and 1950, and this file was subsequently added to the evidence bundle.

47 We wish to place on record our thanks to the Royal Commission, which provided staff to accompany applicants at the locations in Australia from which they were speaking to the Inquiry by live link, thereby enabling us to provide the same level and type of support to witnesses giving evidence as we did for witnesses in Northern Ireland. We are also most grateful

3 Days 42 to 50, from Monday 1 September 2014 until Monday 15 September 2014.

to the Chief Justice of the Family Court of Western Australia, and to his staff, and to the staff of the Family Court of Australia at Melbourne, for their invaluable help in making available their premises and staff to allow applicants to give evidence by live link.

48 The Inquiry was fortunate in securing evidence from Dr Ann Mary McVeigh, of the Public Records Office of Northern Ireland (PRONI), and from Dr Margaret Humphreys OBE, OAM. Dr McVeigh made available to us her thesis on the topic '*History of the Child and Juvenile Migration Schemes to Australia*', for which she was awarded a doctorate by The Queen's University Belfast in 1995. The greater part of the information contained in the portion of the Report relating to the historical background to child migration to Australia is drawn from Dr McVeigh's work, supplemented by her oral evidence.

49 The topic of child migration to Australia is one that has generated a considerable amount of controversy in both the United Kingdom and in Australia for more than 20 years. It was brought to the attention of the wider public by the work of Dr Margaret Humphreys in particular, and by her book *Empty Cradles: One Woman's Fight to Uncover Britain's Most Shameful Secret*, published in 1994. Not only did this provide much important background material for the Inquiry, but Dr Humphreys also prepared a detailed witness statement to which we refer later in this Report. In that statement, and in her oral evidence, she described many of the problems faced by former child migrants in re-establishing contact with their families in Northern Ireland and elsewhere, and the impact of their experiences upon them. These were matters which were also dealt with by applicants in their witness statements.

50 In addition, the Inquiry received a document entitled 'Report on the Impacts and Outcomes of Child Migration Experienced by Former Child Migrants in Northern Ireland', prepared by Dr Philippa White, Director of Tuart Place.[4] The accounts given by many of the witnesses and Dr White's report, taken together with the evidence of Dr Humphreys, provided a great deal of information which we shall consider later. We also received helpful information from Prof. Gordon Lynch, Michael Ramsay Professor of Modern Theology at the University of Kent. Prof. Lynch has made a special study of child migration, and his 2016 book *Remembering Child Migration: Faith, Nation-Building and the Wounds of Charity*[5] deserves to be read by everyone interested in the history of child migration.

4 AUS 6056-6057.
5 Bloomsbury, 2016.

Findings relating to the Northern Ireland Government

51 It was indifferent to the practice of the voluntary sector in Northern Ireland of sending child migrants to Australia.

52 It failed to fully inform itself as to what was happening once it became aware that significant numbers of such young children were being sent to Australia by voluntary organisations such as the Sisters of Nazareth.

53 It failed to make any enquiries whatever as to the fate of these children.

54 It failed to make any representations to the United Kingdom Government about the operation of the child migrant schemes.

55 The Minister of Home Affairs was wrong to approve the proposal by Tyrone County Welfare Committee that HIA 354 should be sent to Australia.

Findings relating to Tyrone County Welfare Committee

56 It was wrong to send HIA 354 to Australia.

57 It failed to give proper weight to the effect of severing contact between HIA 354 and his brother and sister when seeking approval from the Minister.

58 It failed to inform the Minister that HIA 354 had a brother and sister who were also in the care of the Committee.

59 It failed to inform the Minister that the foster parents of HIA 354 wished to adopt him.

Findings relating to the Irish Church Missions and Manor House Home

60 The home was wrong to send children to Australia who were so young.

61 The home failed to take sufficient steps to maintain contact with the children after they went to Australia.

62 The home did not give truthful information to parents of the children who enquired where their child was.

Findings relating to the Sisters of Nazareth

63 They were wrong to send children to Australia who were so young.

64 They failed to make any enquiries to satisfy themselves that the homes run by other Roman Catholic religious orders in Australia were suitable to receive their children.

65 They failed to take sufficient steps to maintain contact with the children after they went to Australia.

66 They did not give truthful information to parents of the children who enquired where their child was.

67 In many cases they did not provide detailed, accurate and timely responses to enquiries by former child migrants for information that would have assisted them to trace their parents and relatives.

Findings in respect of all institutions that sent children to Australia

68 Failing to ensure that those who accompanied the children were competent to look after the children during the voyage.

69 Failing to ensure that a suitable case history was sent with each child to the institution to which the child was being sent.

Volume 3 – Chapters 7, 8 & 9 – Module 4 – Sisters of Nazareth, Belfast

Volume 3 – Chapter 7 – Module 4 - Introduction and common issues

70 In Module 4 we considered two Roman Catholic children's homes, Nazareth House and Nazareth Lodge, which were sited near each other, about one and a half miles south of Belfast city centre. The Module commenced with an introduction by Senior Counsel on 5 January 2015, and continued until 19 May 2015 when there were closing submissions. In all, there were 41 days of hearings allocated to this Module.

71 In total, evidence was received concerning the two homes, either in person or through the reading of their statements, from a total of 117 witnesses who had been in Nazareth House or Nazareth Lodge as children. Of these, (taking account of witnesses who were in both homes) 74 gave oral evidence in this module. Thirty-three other witnesses, such as sisters, houseparents, social workers or inspectors also gave oral evidence. More people spoke to the Inquiry about the Belfast Nazareth homes, therefore, than about any other homes.

72 There were 50 applicants who had been resident in Nazareth House who contributed statements. The evidence of ten of these witnesses was read

out as they were unable to attend for health reasons, and two because the witnesses sadly had died since preparing their statements. Three did not engage further with the Inquiry. One witness had given his evidence about Nazareth House during the module on Rubane. We therefore heard oral evidence from 34 witnesses.

73 We received evidence from 52 former residents of Nazareth Lodge. The statements of five were read out because of the ill health of the applicants, and two because of the deaths of the applicants, again sadly before they could give oral evidence. Five of the witnesses had given their evidence in the Rubane module, so that in this module we received oral evidence from 40 witnesses. In all, 31 of the people who gave evidence to the Inquiry concerning the Belfast Nazareth homes had also been in Rubane, as from 1953 to 1972 the boys in Nazareth Lodge were usually transferred there at the age of eleven. Two of the witnesses were not applicants but were former residents, one of them appearing at the request of the Sisters of Nazareth.

74 A number of children were sent to Australia as child migrants from both homes. Of these, two former residents from Nazareth House and one from Nazareth Lodge gave oral evidence during the module, and have been included in the figures above. There were also ten more applicants from Nazareth House and twelve from Nazareth Lodge who gave evidence during the module concerning Australia. Their evidence is dealt with in Chapter 6. One of these witnesses had been in both homes, and so in total, therefore, 24 child migrants who had been in Nazareth House or Nazareth Lodge gave evidence to the Inquiry. It should be noted that many applicants who gave evidence in other modules provided only limited accounts of their time at Nazareth House or Nazareth Lodge.

75 We received evidence from seven social workers, six middle and senior managers in the social services and five members of the Social Work Advisory Group (SWAG) or Social Services inspectorate (SSI). One teacher, one GP, one chaplain, one handyman, two volunteers, five houseparents and eight sisters provided evidence. Three of these people did not appear due to ill health; the remainder gave both written and oral evidence. The evidence of all but one related to Nazareth Lodge, mainly because Nazareth House closed in 1984 and they provided evidence concerning enquiries into complaints about Nazareth Lodge in the following years. In addition, one sister who gave evidence had moved from one home to the other, and her evidence related to both homes.

76 Submissions were also received from Sister Brenda McCall on behalf of the Sisters of Nazareth, from the HSCB on behalf of the predecessor bodies which had provided social work support for the children and their families, and from Dr Hilary Harrison for the then Department of Health, Social Services and Public Safety.

77 We are indebted to the witnesses, all of whom came to address disturbing and painful personal memories or difficult issues for which their organisations had been responsible. The memories recounted to us typically related to events between forty and eighty years ago, and we have been aware that while the details of some incidents have remained sharp because of their emotional impact at the time, other memories are hazier or may have been influenced by the sharing of accounts or the passage of time. We are aware that for a small number of applicants who came to tell us of their experiences there has been the added shock that other witnesses have accused them of bullying or some form of abuse, and coming to terms with the perceptions of others will have added to their distress.[6]

78 The Congregation emphasised the risk entailed in relying on memories that may be faulty or false. We have been alert to the need to cross-check witnesses' written and oral evidence for consistency with the evidence of others and surviving documentation. As might be expected, we have come across errors and inconsistencies. One witness, for example, thought that as a very young child she had been in Nazareth House, but written records indicated that she had confused the home with another institution; in view of her age at the time and the length of time since her period in care, such confusion is thoroughly understandable.

79 The fact that we have quoted witnesses extensively does not mean that we have accepted their versions of events unquestioningly. We appreciate that some evidence will have been affected by exaggeration or false memories, and the fact that we have not qualified every statement with a clause to state that this is the witness's allegation should not be taken to imply that we accept or reject the particular observation.

80 However, the more witnesses who repeated similar accounts of life in the two homes, and the more substantiating detail they provided, the more persuasive they proved to be. It is not our role to decide precisely what happened in relation to each allegation or to determine the guilt

6 SNB 100007.

of individuals, but to conclude whether on balance there were general systemic failures. The volume and detail of the evidence has been sufficient to provide us with a full picture of what life was like in the two homes and to reach conclusions about the allegations of systemic abuse. It should be noted that, while many witnesses have been quoted in this chapter, on most subjects there were many others who have not been quoted but who provided corroborative evidence.

81 Inevitably, the applicants to the Inquiry have largely been people who had unhappy experiences about which they wished to complain, and drawing together their evidence in this chapter has also been a selective process, primarily identifying the failings of the homes. The picture painted, therefore, is inevitably not a balanced account of life in the homes.

Findings relating to both homes

82 We consider the failure to meet the statutory requirement for both Nazareth House and Nazareth Lodge to be visited monthly to have been a systemic failure.

Volume 3 – Chapter 8 – Module 4 – Nazareth House, Belfast

83 Many of the tasks which the girls were required to perform were of little use to them as preparation for managing their own households, and in our view the excessive chores expected of the girls constituted systemic abuse.

84 The infrequency of changing bath water, the use of carbolic soap to clean teeth, the use of Jeyes fluid in the bath, the rough treatment when bathing and the queuing were outdated institutional practices which should have been superseded or never adopted in the first place, and they constituted systemic abuse.

85 The punitive approaches described in the evidence would not have given the children any sense of security but would have added to their anxiety; the measures would have been ineffective in dealing with enuresis and constituted very poor childcare practice, amounting to systemic abuse.

86 The home nursing described was very poor in terms of the failure to take some problems seriously, the rudimentary treatment given, the physical abuse on some occasions, and the lack of loving care for children who were unwell. This amounted to systemic abuse.

87 There was no valid childcare justification for confiscating the children's personal possessions, and this constituted systemic abuse.

88 During the earlier decades, the combination of aspects of poor childcare (such as excessive chores, an institutional approach to bathing, the use of Jeyes fluid, the handling of menstruation and sex education, the poor quality of food, the insistence on eating unwanted food, the failure to celebrate birthdays, the poor quality of education at the school on the premises and the failure to prepare children for discharge) which were all below the standard which might reasonably have been expected at that time and we consider amounted to systemic abuse.

89 The public corporal punishments inflicted in the 1950s constituted systemic abuse.

90 The range and variety of examples and the number of witnesses, particularly in relation to SR 189, SR 31, SR 134 and SR 116, indicate that the physical abuse practised by the staff was systemic.

91 We conclude that the emotional abuse suffered by some girls was systemic.

92 We consider the lack of inspection amounted to a systemic failing by SWAG to ensure that the home was meeting statutory regulations and providing proper care.

Volume 3 – Chapter 9 – Module 4 – Nazareth Lodge, Belfast

93 By the 1980s the bathing system used at Nazareth Lodge should have been abandoned long before and its continuation represented systemic abuse.

94 When Jeyes fluid was first developed in the late nineteenth century it was used for many purposes, but by the 1950s it should not have been used in baths or for hair washing. This practice was well out of date and in our view its use amounted to systemic abuse.

95 There was no justification for SR 118's cruel conduct in dealing with enuretic boys, which amounted to systemic abuse.

96 We accept that force-feeding took place and it constituted systemic abuse.

97 We consider the Sisters' failure to pass relevant information about a child's time in Nazareth Lodge, even if little was known about their lives before coming into the care of the Sisters of Nazareth, was unacceptable

and showed a lack of care and consideration for each child's individuality, development and well-being which we considered amounted to a systemic failing.

98 Taking account of all the aspects of daily life in the home, for the most part they constituted poor, out of date childcare practice, and we consider this was systemic abuse.

99 The physical abuse by staff, particularly on the part of SR 118, SR 34, NL 4 and NL 5, was so extensive that it created a punitive atmosphere. It was contrary to good childcare practice, the policy of the Order and the statutory Regulations under which the home worked. Furthermore the Sisters failed to apply a system of staff selection, supervision and management to prevent or limit the abuse. This was a case of systemic abuse and systemic failure.

100 The name-calling, denigration of parents, lack of care for sick boys, the emotional impact of physical punishment, and the lack of individual care in these examples all constitute emotional abuse as well as unacceptably poor child care practice, and we consider them to have been systemic abuse.

101 It was the use of charge boys to supervise younger boys in the absence of the sisters which predictably led to the most serious bullying. To rely on the older boys to control the younger ones unsupervised was a systemic failing.

102 In leaving the care and control of the younger boys to the older charge hands, the opportunities for sexual abuse were increased, and this amounted to systemic abuse.

Failings of the DHSS

103 We agree with the conclusion of the Hughes Inquiry that the frequency of inspection was unsatisfactory and consider the lack of inspection of Nazareth Lodge in that period amounted to a systemic failing by SWAG to ensure the home was meeting statutory regulations and providing proper care.

104 It is our view that in this instance the Department failed to accept its overarching responsibility for ensuring that the safety of children in residential care was maintained. We consider that this was a systemic failing.

105 We acknowledge that the Department was breaking new ground in drafting the complaints procedure at this time but we are critical that it included that agencies should undertake internal investigations of complaints and we are critical of the Sisters for conducting the investigation secretively.

Finance

106 We conclude that the shortage of finance and its consequent impact on staffing levels and physical standards of care amounted to a form of neglect and constituted systemic abuse. Although both central government and the welfare authorities bore some responsibility, this was primarily the responsibility of the Sisters of Nazareth.

Volume 3 – Chapter 10 – Module 6 – Father Brendan Smyth

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

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

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

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

111 For that reason it was necessary to refer in some detail to allegations of abuse of children by Fr Smyth elsewhere, and to consider the response of various organisations and individuals to those allegations. We were aware that Fr Smyth was alleged to have abused children in schools, in the homes of their parents, on visits to Dublin, and in places as far apart as Wales, Scotland and the United States of America. We had to refer to those allegations in order to see when those organisations and individuals were aware of the threat he posed to boys and girls with whom he came in contact as a priest, and to examine what those organisations or individuals did, or did not do, as a result of this knowledge.

112 It may seem to some of those who were abused by him on those occasions that we should have devoted more attention to those allegations, but were we to examine those other allegations in detail that would have exceeded our Terms of Reference. Nevertheless, by confining our investigation into his activities in this way it should not be thought that we did not appreciate the effect of his activities on those children who do not come within our Terms of Reference, or the implications for organisations or individuals in other countries outside our Terms of Reference.

The Norbertine Order

113 Permitting Fr Smyth's ordination despite a clear warning from the Abbot General that Fr Smyth should not be ordained.

114 Failing to:

(a) properly assess the grave risk Fr Smyth posed to children; and

(b) warn the bishops of the dioceses to which he was sent in later years, namely

- Menevia in Wales
- Annan in the Diocese of Galloway
- Providence, Rhode Island, USA
- Fargo, North Dakota, USA.

115 Taking deliberate decisions to withhold information about Fr Smyth's background when he was sent to other dioceses.

116 Giving advice from the Abbot General that it was not necessary to send that information to other dioceses.

117 Failing to act on credible reports of Fr Smyth's sexual abuse of children.

118 Allowing repeated efforts to be made to 'cure' Fr Smyth by sending him for various forms of medical treatment on several occasions, even though it was clear from continuing complaints that, despite earlier treatments, he was continuing to abuse children.

119 Failing to insist that he provided adequate information as to the nature and extent of his treatment, and the prognosis, from the various doctors who treated him.

120 Deciding not to withdraw his access to a car, thereby enabling Fr Smyth to travel freely and abuse children in many homes and locations in both Northern Ireland and the Republic, even after he had been charged by the police in 1991.

121 Failing to confine Fr Smyth to the Abbey in Kilnacrott and thereby keep him away from children.

122 Failing to report Fr Smyth to the police and social services in either Northern Ireland or the Republic of Ireland, thereby preventing him from being prosecuted and convicted, and so enabling him to continue his abuse.

123 Failing to have in place adequate procedures:

(a) to prevent Fr Smyth being ordained;

(b) to have Fr Smyth reported to higher authority in the Order, and to the Congregation of Religious and for Secular Institutes in Rome when the members of the Order received definite information that he was committing crimes against children.

124 Failing to notify the bishops of the Diocese of Down and Connor and the Diocese of Kilmore of the dangers Fr Smyth posed to children in their dioceses when he was known, or suspected, to be going to these dioceses.

125 Failing to vigorously pursue the existing procedures and to notify the Congregation of Religious and for Secular Institutes of Fr Smyth's crimes.

The Roman Catholic Diocese of Kilmore

126 Failing to notify the police and social services in the Republic of Ireland when the 1973 complaint was received, and failing to institute ecclesiastical proceedings against Fr Smyth at that time.

127 Failing to have Brendan Boland's father in the room with the child whilst the child was being questioned; and in the case of FBS 39 failing to notify his parents of the alleged abuse, or to have his parents present during questioning. In both cases there was also a failure to follow up with the parents of each child how the child was reacting to the abuse afterwards.

128 Failing to take all the steps open to the diocese to thoroughly investigate each allegation relating to Fr Smyth that came to its notice and to report the matter to the proper civil and ecclesiastical authorities on each occasion.

129 Failing to inform the civil and ecclesiastical authorities in Belfast about what had, or may have happened, to the two named children from Belfast.

130 Failing to report the allegations relating to Fr Smyth to the Congregation of Religious and for Secular Institutes.

131 Failing to exercise sufficient pressure on Abbot Smith to take vigorous action against Fr Smyth, such as laicisation or restricting his freedom of movement.

132 Failing to use the existing process properly by short-circuiting matters and proceeding directly to investigate Fr Smyth instead of referring the matter to the Archdiocese of Armagh.

133 Failing to ensure that all Fr Smyth's ecclesiastical faculties were permanently withdrawn.

134 When the faculties were renewed from year to year, failing to take proper steps to ensure that Fr Smyth was not still offending.

135 Failing to warn other dioceses, and in particular the Diocese of Down and Connor, about the allegations so that they could take steps to protect the children in homes in their diocese from being abused by Fr Smyth.

The Roman Catholic Diocese of Down and Connor

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

137 Failing to report the allegations against Fr Smyth to the social services and the police in Northern Ireland when they were received by the Diocese.

138 Failing to institute a penal investigation or process against Fr Smyth in the Diocese of Down and Connor on the basis of the allegations of his abuse in that Diocese.

139 Failing to exert greater pressure upon Abbot Smith in 1971, by (1) asking for urgent and immediate information, and for that to be confirmed; (2) threatening to institute the church inquiry process in Down and Connor against Fr Smyth as had been done in Kilmore by Bishop McKiernan.

The Sisters of Nazareth

140 The failures of SR 31 and SR 46 to report the complaints made to them about Fr Smyth to the mother superior.

The De La Salle Order

141 Failing to notify the police and social services in Northern Ireland of the allegations against Fr Smyth made to BR 1.

Volume 4 – Chapter 11 – Module 3 – Rubane House, Kircubbin

142 The Inquiry devoted Module 3 to the examination of evidence relating to Rubane House (Rubane), a home run by The Institute of the Brothers of Christian Schools, a Roman Catholic male religious order, on behalf of

the Roman Catholic Diocese of Down and Connor. The Institute of the Brothers of Christian Schools has always been best known throughout Ireland as the De La Salle Order and it will be referred to as 'the Order' in this chapter of the report.

143 The Inquiry devoted 30 sitting days spread over eight sitting weeks to this module, commencing on 29 September 2014 and finishing on 17 December 2014. Fifty-seven former residents of Rubane applied to give evidence to the Statutory Inquiry and we heard oral evidence from 47 of them. The witness statements of six applicants were read to the Panel during Module 3: four were read because they were unable to attend for medical reasons;[7] and, sadly, two because the applicants died before they could give oral evidence.[8]

144 The statements of two witnesses were also read because they had previously given evidence in person in Module 1, which dealt with the Sisters of Nazareth homes in Derry/Londonderry, and had only brief comments to make about their time in Rubane.[9]

145 We also heard evidence in Module 3 from two former residents of Rubane put forward as witnesses by the Order.[10] A statement from another witness[11] put forward by the Order was submitted towards the end of the module; we took this statement into account but did not consider it necessary to ask him for the evidence to be given in person.

146 The statement of one witness[12] was discounted because he failed to attend to give evidence and provided no reason for his lack of attendance.

147 The evidence of four witnesses was heard in Module 4,[13] which dealt with the Sisters of Nazareth homes in Belfast, as these applicants had only brief comments to make about their time in Rubane. Three gave their evidence in person and the statement of the fourth was read because he was unable to attend for medical reasons.

148 Therefore, in total, the Inquiry had the benefit of receiving evidence from 60 former residents of Rubane. Twelve of these former residents were admitted to Rubane in the 1950s, 26 in the 1960s, seventeen in the 1970s and five in the 1980s.

7 HIA16, HIA 160, HIA 262 and HIA 388.
8 HIA 159 and HIA 427.
9 HIA 381 and HIA 382.
10 DL 40 and DL 455.
11 DL 244.
12 HIA 260.
13 HIA 89, HIA 368, HIA 210 and NL 122/DL 208.

149 The Order provided written responses to each witness statement and we took these responses into account. We also received written statements from nine current and former brothers of the Order[14] who lived and worked in Rubane and received oral evidence from five of these brothers.[15] BR 2 gave evidence on two occasions; on the first he responded to allegations made against him and on the second, as a former brother director of Rubane, he provided more general information about how the home operated and was managed.

150 Brother Pius McCarthy, the Provincial Secretary to the Order in Ireland from 1974 to 1976 and from 1995 until his death in May 2014 provided witness statements and helpful background material to the Inquiry. The current Irish Provincial, Brother Francis Manning, also provided written statements and gave evidence in person on behalf of the Order.

151 Four former members of lay staff who worked at Rubane[16] gave evidence in person to the Inquiry. The Inquiry was only able to locate one former member of lay staff, DL 11, towards the end of the module. We accepted there were good reasons why he could not attend in person at short notice and took his written statement into account.

152 The Inquiry also considered statements from the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MoHA) and the Department of Health and Social Services (DHSS), each of which had statutory responsibility for the registration and regulation of Rubane as a children's home. We heard oral evidence from Dr Hilary Harrison on behalf of the DHSSPS and from a former employee of the Social Work Advisory Group[17] who was involved in the regulation of Rubane.

153 The Health & Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children placed in Rubane, provided written evidence including statements from fifteen current and former social workers who had experience of Rubane, as well as from Valerie Watt, the current Chief Executive of the HSCB. We considered these statements and asked for, and received, oral evidence from five of these individuals.[18]

14 BR 2, BR 3, BR 7, BR 10, BR 25, BR 29, BR 33, BR 62 and BR 77.
15 BR 2, BR 7, BR 10, BR 29 and BR 77.
16 DL 1, DL 81, DL 509 and DL 149.
17 DL 521.
18 DL 503, DL 515, Mr Bunting, DL 516 and DL 517.

154 Father Timothy Bartlett, Episcopal Vicar for Education and Director of Public Affairs for the Diocese of Down and Connor, provided statements and gave evidence in person on behalf of the Diocese.

155 We also considered documentation relating to police investigations and civil claims against the Order that identified 158 former residents of Rubane who did not apply to the Inquiry but who alleged similar types of physical and sexual abuse as that alleged by witnesses to the Inquiry. Counsel to the Inquiry brought relevant information from these investigations and civil proceedings to the attention of the Panel during the public hearings. Rubane was considered by the Committee of Inquiry into Children's Homes and Hostels chaired by His Honour Judge William Hughes (The Hughes Inquiry) and we considered the findings of that Inquiry in relation to Rubane.

156 We also considered written and oral closing submissions from the De la Salle Order, the DHSSPS, the HSCB and eight individuals[19] against whom allegations of abuse were made. In total, we considered almost 40,000 pages of documentation in this module, 20,000 pages of which were provided by the police.

Findings relating to the Ministry of Home Affairs

157 It failed to insist from the outset that Rubane be developed on the smaller children's home model in line with government policy.

158 It contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while over-crowding increased and the facilities and staffing levels became more inadequate and unsatisfactory.

159 It failed as the registering body to clarify with the Diocese and the Order the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.

160 It failed to ensure Rubane provided proper care by allowing the number of boys accommodated to more than double from 30 to 71 within six years without requiring the necessary improvements to the facilities or increases in staffing levels.

19 BR 2, BR 3, BR 10, BR 25, BR 62, BR 77, HIA 21 and HIA 147.

161 It failed to seek confirmation of who was the administering authority for Rubane and failed to check that monthly visiting was happening and thereby allowed crucial aspects of the statutory framework designed to promote and protect the welfare of children in voluntary homes to be ignored by the Diocese and the Order.

The Department of Health & Social Services

162 It failed to inspect the standard of care being provided in Rubane between 1976 and 1981.

163 It failed to ensure that the inspections of Rubane that were carried out in the 1970s gained a genuine insight into the quality of care being provided.

164 It failed to properly respond to the concerns raised by the EHSSB in 1981 about the general care provided to all boys in Rubane and thereby failed to acknowledge and exercise its statutory authority and powers as the registration and inspection body for Rubane

165 It failed to maintain information about an investigation into sexual abuse in a children's home in a manner that allowed its existence to be known to relevant staff and thereby shared with the Hughes Inquiry.

The Roman Catholic Diocese of Down and Connor

166 It contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while overcrowding increased and the facilities and staffing levels became more inadequate and unsatisfactory.

167 It failed to clarify with the Order and the MoHA as the registering body the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.

168 It failed to meet statutory regulations for voluntary children's home, in particular it failed to confirm the administering authority for Rubane and to appoint a monthly visitor.

169 It failed to take responsibility for negotiations with the MoHA about the development of the home and by only holding annual meetings of the governing board during the Order's negotiations with the MoHA caused delay and late interventions in planning.

170 It failed to hold meetings of the governing board between 1968 and 1972 and between 1982 and 1985 and thereby to assure itself of the quality of care being provided in Rubane.

171 It failed, through the chaplains appointed to Rubane, to find a means that respected the seal of confession but enabled information provided by boys about the physical and sexual abuse they were suffering to be shared with the relevant bishop and acted upon.

172 It failed through Father McCann's response to the first assault by BR 77 to take all proper steps to prevent, detect and disclose abuse.

Findings relating to the De La Salle Order

173 It contributed to a systemic failure to ensure Rubane provided proper care by allowing discussions about the type of redevelopment needed and how it should be funded to continue for a decade while overcrowding increased and the facilities and staffing levels became more inadequate and unsatisfactory.

174 It failed to clarify with the Diocese and the MoHA as the registering body the nature and aims of Rubane, the governance and management arrangements and the conditions needed to provide appropriate care.

175 It failed to meet statutory regulations for voluntary children's home, in particular it failed to confirm the administering authority for Rubane and to appoint a monthly visitor.

176 It failed to prevent excessive physical punishment by some brothers and lay staff.

177 It failed to prevent random violence by some brothers and lay staff which in some cases amounted to serious physical assault.

178 It failed to ensure that corporal punishment was administered in line with statutory regulations and the Order's own rules.

179 It failed to accurately record and report the use of corporal punishment as required by statutory regulations.

180 It failed to deal adequately with incidents of physical violence by brothers and lay staff towards boys which were brought to the attention of Brother Directors.

181 It failed to take necessary action to enable the investigation and prosecution of criminal offences involving physical abuse.

182 It failed to inform the Department or the Health and Social Services Boards about the search of Rubane and the reasons for it and therefore did not work with them to identify and manage any continuing risk to the welfare and safety of the boys in Rubane at that time.

183 It failed to report serious assaults by BR 77 to the police in order to protect the brother and the reputation of the Order rather than protect vulnerable children.

184 It failed to curtail BR 77's contact with children while he was subject to police investigations about physical assaults of boys in Rubane and instead moved him to work in a school.

185 It failed to provide guidance and effective supervision to brothers and to ensure, particularly in the earlier years, that they had a reasonable workload that avoided excessive contact time with the boys.

186 It failed to provide guidance and effective supervision to lay staff in Rubane, particularly to those who were clearly having difficulties in meeting the challenges of working with adolescent boys.

187 It failed to address understaffing, thereby allowing a lack of oversight of the brothers' interactions with boys, particularly in the evenings and at night time, that enabled sexual abuse to occur and continue unchecked.

188 It failed to properly investigate allegations of sexual abuse.

189 It failed to take necessary action to enable the investigation and prosecution of criminal offences involving sexual abuse.

190 It failed to report its investigation of the allegations of sexual abuse against BR 17 to the governing board, the MoHA or the police.

191 It failed to be truthful about the extent of BR 14's sexual abuse of boys and deliberately misled the MoHA about it.

192 It failed to report its investigation of the allegations of sexual abuse by HIA 36 against BR 15 to the governing board, the MoHA or the police.

193 It failed to implement and monitor adherence to its rules about how brothers should manage their interactions with boys and thereby betrayed the implicit trust that other bodies such as the MoHA, the welfare authorities

and the Diocese placed in the Order as a faith-based organisation suitable to be entrusted to run a residential home for children.

194 It failed to curtail the activities of BR 17 or increase monitoring of him despite suspicions that he sexually abused boys in Rubane and then moved him to a school where he would have continued trusted access to children which he ultimately abused.

195 It failed to report brothers who admitted sexual abuse of children to the police and thereby protected the position of such brothers and the reputation of the Order rather than seeking to prevent further harm to children.

196 It failed to keep boys free from the pain, fear and distress caused by the physical and/or sexual abuse they suffered or witnessed others suffering in Rubane.

197 It failed to limit the boys' help with potato-picking to the farm in Rubane and instead required them to pick potatoes and undertake other types of labour in neighbouring farms in adverse weather and with inappropriate clothing.

198 It failed to ensure initially that all boys in Rubane were adequately clothed and in later years up to 1981 failed to ensure that all boys were appropriately clothed.

199 It failed to require the Sisters of Nazareth to provide relevant information about at least a child's time in Nazareth Lodge when they were being transferred to Rubane and thereby demonstrated a lack of care and consideration for each child's individuality, development and well being.

Findings in respect of Welfare Authorities

200 In the period prior to the opening of chalets in 1968 they failed to address the fact that the home they were placing boys in had inadequate facilities and was poorly staffed.

201 The EHSSB failed to alert social workers to the police investigations in 1980 into physical and sexual abuse in Rubane.

Volume 4 — Chapter 12 — Module 7 — St Patrick's Training School

202 The seventh Module concerned four training schools, the first being St Patrick's, a Roman Catholic school run by the De la Salle Order. The Module commenced on 1 September 2015, Day 134 of the Inquiry, with a general introduction to the training school system by Senior Counsel, followed by an address by Junior Counsel concerning St Patrick's, and it ended on 14 October 2015, Day 150.

203 A total of 27 applicants provided statements which related to St Patrick's. Of these, eleven were read out for various reasons. Two had sadly died, some had given evidence in a previous module about another home, so their observations on St Patrick's had been provided earlier, and some were unwell. One witness who had provided a statement decided not to give oral evidence after consultation with counsel on the day. Four former residents at St Patrick's also gave evidence, while not being applicants. In all, we therefore received oral evidence during the Module from 19 witnesses who had been resident in the training school. A further 39 former residents had given information to the police about allegations or had made civil claims, so that evidence was considered from a total of 70 people who had attended St Patrick's.

204 Seven brothers and seven other members of staff gave oral evidence. One witness who had inspected St Patrick's gave evidence. Mary Madden, who had worked for the Northern Ireland Office in the final years of our remit when the NIO bore responsibility for the training schools, and Karen Pearson, who represented the Department of Justice and the then Department of Health and Social Services and Public Safety, gave evidence. The Diocese of Down and Connor, the De la Salle Order and the Health and Social Care Board were also represented as core participants.

205 We are indebted to all these witnesses for providing their accounts of events at St Patrick's. We are aware that recalling difficult times and presenting evidence in a public hearing will have been stressful for many witnesses, but both the written and oral evidence was invaluable in providing a full picture.

Findings

206 The failure of St Patrick's to conform to the Training School Rules in respect of secure accommodation, and of the Inspectorate to note the breaches and take action, constituted systemic abuse.

207 The use of informal corporal punishment was systemic abuse.

208 Permitting older boys to punish others when supervising them in the dormitory was a breach of the Training School Rules and was systemic abuse.

209 The humiliation of stripping a boy naked to stand in full view on a number of occasions constituted systemic abuse.

210 The failure to report the abductions of Bernard and Gerard Teggart to the Police was clearly a systemic shortcoming on the part of the Brother Director. The failure of the Board of Management to meet immediately after the boy's death, to investigate and to provide support to the staff and boys was negligent and constituted systemic abuse.

211 There is nothing to suggest that the NIO took any steps following the death of Bernard Teggart to investigate whether any policies or procedures needed to be changed to protect boys from suffering a similar fate, and their failure to do so represents a systemic failing on their part.

212 Statistical returns concerning absconding were provided by St Patrick's to the NIO and these records would have been open to Inspectors when they visited. Prior to the concern raised by the death of SPT 81 neither the NIO nor the SSI had raised absconding as a major issue with St Patrick's and this was a systemic failure on their part.

213 The failure to circulate the findings of the report on absconding from Rathgael more widely and assist St Patrick's in finding ways of dealing with persistent absconding was a systemic failure on the part of the NIO.

214 Furthermore, the APRU, which had been set up as a combined unit to support all the training schools and which had undertaken the research on absconding, also failed to share their findings with St Patrick's, when they must have known that it had a similar problem.

215 The failure of St Patrick's to take adequate measures to counter absconding constituted systemic abuse, in that it left boys vulnerable in terms of the risks they faced when absconding, in the patterns of criminality which were fostered while absconding, and in the effect of their absconding pattern on their later lives.

216 We consider that the frequency with which the secure rooms were used and their use for young children, contrary to the Training School Rules, amounted to systemic abuse on the part of St Patrick's and by the SSI in failing to address this breach of the Rules.

217 The failure to appoint sufficient staff amounts to systemic failure.

218 We consider it to be a systemic failure that St Patrick's was not inspected between 1971 and 1988, and we consider the lack of formal inspections a systemic failing.

219 The sexual abuse perpetrated by the Brothers, particularly as reported in the television room, was systemic.

220 BR 1 sexually abused boys while he was at St Patrick's and this constituted systemic abuse; if he had been apprehended and had not been promoted to be Brother Director of Rubane House, the boys there would not have been abused by him.

221 Bishop Farquhar was at fault in failing to suspend BR 26 during the police enquiries, and St Patrick's was at fault in undertaking their own limited investigation. These failures were systemic, potentially putting the boys then and subsequently at St Patrick's at risk.

222 The failure of the Brother Director:

(i) to inform both the police and his Committee of the allegations of abuse by DL 137 in 1978 and again in 1980,

(ii) to dismiss DL 137, permitting him to resign,

(iii) to protect potential victims of sexual abuse in providing DL 137 with a positive job reference which omitted the reason for his departure from St Patrick's were systemic failures.

223 The prevalence of unauthorised physical punishment in the 1960s and early 1970s was contrary to the Training School Rules, and constituted systemic abuse.

224 It was a systemic failure that potential whistle-blowers felt unable to speak up.

Volume 5 – Chapter 13 – Module 7 – Introduction

225 In Module 4 we considered Nazareth Lodge, which was an industrial school until 1950. In Module 7 we heard witnesses from St Patrick's, which was an industrial school and reformatory until 1950, when it became a training

school. In the same Module we also considered Rathgael, a training school which admitted both boys and girls, a few of the witnesses having also been in Malone or Whiteabbey, Rathgael's predecessors. We also heard from applicants who had been in Lisnevin, a secure training school, and Hydebank, a young offenders' centre. In Module 10, witnesses who had been in Millisle, a borstal, gave evidence. In Module 11 we heard from applicants who had been in St Joseph's, which was the only training school specifically for girls which we considered.

Volume 5 – Chapter 14 – Module 7 – Rathgael Training School

226 Rathgael was registered as a training school for boys in 1968, but its role was rooted in the earlier history of the reformatory and industrial school system in Northern Ireland, and in particular Balmoral Industrial School, Malone Reformatory and Whiteabbey, a school for girls.[20]

Findings

227 RG 17's practice of using frequent unrecorded informal corporal punishment was unacceptable and amounted to systemic abuse.

228 NIO's failure to ensure that Rathgael was inspected from 1973 to 1987 was a systemic failing.

229 The extent of the unregulated physical punishment applied by some staff amounted to systemic abuse.

230 The failure to prevent bullying by peers amounted to systemic abuse.

231 The lack of training in control and restraint was a systemic failing.

232 RG 47's sexual exploitation of HIA 236, his failure to raise concerns about HIA 236's crush with colleagues and their failure to question the relationship properly all constituted systemic abuse.

233 A small number of staff sexually abused girls during this phase and this amounted to systemic abuse.

20 For a fuller history of Rathgael and its predecessor institutions, see RGL 22202-22246. We are indebted to Campbell Whyte and Lindsay Conway for much of the information describing the running of Rathgael.

Volume 5 – Chapter 15 – Module 7 – Lisnevin Training School

234 We considered evidence about Lisnevin Training School (Lisnevin) during Module 7, which dealt with juvenile justice institutions. Module 7 commenced on 1 September 2015 and concluded on 24 November 2015. Twelve applicants referred in their written statements to time they spent in Lisnevin. Two of these applicants, HIA 320 and HIA 50, referred to spending periods in Lisnevin but made no further comment about their time in the school.

235 The evidence of HIA 418 and the responses to it were summarized as HIA 418 could not attend in person for medical reasons. We set aside the evidence of HIA 275 and did not take it into account as he did not appear to give evidence in person and gave no reason for not doing so. We heard evidence in person from the remaining eight applicants.

236 Dr Bill Lockhart OBE, a chartered forensic psychologist, provided psychological services in Lisnevin from 1973 until 1983 as part of the Adolescent Psychology Research Unit (APRU). Dr Lockhart provided a detailed statement with exhibits about Lisnevin[21] and gave evidence in person. We also received a statement[22] and evidence in person from LN 25 who worked as a care worker and then manager in Lisnevin. LN 8, a former teacher in Lisnevin, provided a written statement.[23]

237 We considered response statements to the evidence of applicants and contemporaneous documentation to support these statements provided by the Department of Justice (DoJ) and the Health and Social Care Board (HSCB).

238 We were assisted by a joint statement submitted by the DoJ and the Department of Health, Social Services and Public Safety (DHSSPS), which provided background information about the establishment and operation of Lisnevin.[24] The DoJ also provided a helpful and detailed closing submission responding to the evidence given about Lisnevin during Module 7.[25]

21 LSN 1227-1250.
22 LSN 1224-1226.
23 LSN 872- 874.
24 LSN 925 -957.
25 RGL 90160–90187.

239 We were also assisted by a written statement and exhibits from Alan Shannon CB,[26] a retired civil servant who held senior policy and operation responsibility for training schools from 1990 to 1992 and a statement from his successor Mary Madden CBE, who held that responsibility from 1992 to 1995[27] and who gave evidence in person during our consideration of St Patrick's Training School.

240 Dennis O'Brien was appointed deputy headmaster at Lisnevin when it first opened. Later in his career he was appointed as an inspector with the Social Services Inspectorate (SSI) and in that role he was a member of the team who undertook the first SSI inspection of Lisnevin in 1988. Mr O'Brien provided a statement which we also took into account.[28]

Findings

241 The lack of schooling from September 1981 to May 1982 amounted to a systemic failing by the Lisnevin Management Board, the NIO and the Department of Education to ensure the institution provided proper care.

242 The failure of the director to refer allegations of the assault of a boy by staff to the RUC amounted to a systemic failing to take all proper steps to prevent, detect and disclose abuse.

243 The delay in providing adequate training for staff in control and restraint methods amounted to a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.

244 Accommodating boys in bedrooms with limited furnishing and making them store their clothes in the corridor outside their bedroom amounted to a systemic failing by the Management Board and the NIO to ensure the institution provided proper care.

245 The use of a tariff system of standard sanctions, and the associated reduction in managerial involvement and oversight of use of separation, amounted to a systemic failing by the Management Board and the NIO to ensure the school provided proper care.

246 The failure to address inadequate staffing levels which were clearly having an impact on the daily experience and care of the boys amounted to a systemic failing by the Management Board and the NIO to ensure the school provided proper care.

26 LSN 254-675.
27 LSN 676-760.
28 LSN 875-877.

247 The lack of inspection of Lisnevin from when it opened in October 1973 until the first inspection by the SSI in April 1988 was a systemic failing by the NIO to ensure that the school was providing proper care.

248 The leave arrangements during the summer months, which led to a dependence on casual staff, was a systemic failing by senior managers to ensure the school provided proper care.

Volume 5 – Chapter 16 – Module 7 – Hydebank Wood Young Offenders Centre

249 During Module 7 we heard evidence from four witnesses who were admitted to Hydebank Wood Young Offenders Centre (Hydebank) during the period 1983 to 1990. HIA 275 referred to his time in Hydebank in his statement but we left his evidence out of account as he failed to appear to give evidence in person or to provide a reason for not doing so.

250 We also heard from Maxwell Murray who commenced work as the deputy governor of Hydebank on October 1984 and remained there until April 1987. He acted as governor of the facility for most of the last two years he worked there. Mr Murray provided a very full and helpful statement to the Inquiry and appended exhibits of relevant documentation, for example guidance provided to officers about what type of clothing inmates should be allowed to wear,[29] and how they should report incidents and occurrences.[30] His statement and exhibits amounted to 1,202 pages. We are grateful for the detailed background information Mr Murray provided about how Hydebank operated in the period he worked there and for his responses to the evidence witnesses gave about their time in Hydebank. We also received a helpful statement and exhibits about the use of control and restraint techniques in Hydebank from Mr David Dowds of the Northern Ireland Prison Service.

251 We were assisted by a joint statement for this module provided by the Department of Justice (DoJ) and the Department of Health and Social Services and Public Safety (DHSSPS) and a closing submission provided by the DoJ. We considered response statements to the evidence of witnesses from the DoJ, the Health and Social Care Board (HSCB) and from a former prison officer, HB 4, who responded to specific allegations made against him.

29 HYD 1469.
30 HYD 1311.

Findings

252 On admission to Hydebank boys experienced a strict regime, and the repetitive cleaning tasks and requirement to maintain their cells to a strict high standard were aimed at ensuring inmates conformed to the discipline of Hydebank and the authority of officers. It is probable that some officers took the approach of intimidating boys at the committal stage in order to enforce obedience and discourage any resistance to the regime.

253 Hydebank was a prison and was dealing with some boys who had been found unmanageable in open training schools, and a firm approach was necessary in order to maintain discipline. Despite that imperative, the evidence of Mr Murray and that provided through inspection reports and reports of the visiting committee indicated that a progressive regime was operated that allowed boys to gain privileges and to move purposefully towards release. That evidence also indicated that there was a range of educational, vocational and training activities available to the inmates.

254 The witnesses we heard from had negative experiences in Hydebank and did not consider their time there in a positive light. However, having carefully considered the evidence provided to us, we decided that the complaints we received did not amount to evidence of systemic abuse in Hydebank.

Volume 5 – Chapter 17 – Module 10 – Millisle Borstal

255 Woburn House, as it was officially known, was a borstal for males aged sixteen to twenty-one from 1956 to 1980, but it was usually known as Millisle Borstal. It was designed to provide training for work, education and leisure activities for young offenders who were unsuited to training schools and who would otherwise have been sent to prison.

256 The Inquiry addressed the allegations of ten applicants in Module 10, which commenced with an introduction by Junior Counsel on 18 January 2016. Seven applicants were heard in person and two statements were read out on the grounds of the ill health of the applicants, HIA 262 and HIA 320. The statement of one further witness, HIA 294, was based on the account he gave to the Acknowledgement Forum, as he had hoped to give evidence in person but was sadly deceased before he was able to prepare a witness statement. Evidence was heard from three former officers and one former governor (Duncan McLaughlan), as well as Stephen Davis on behalf of the Department of Justice. Evidence for the Module was completed on 26 January 2016.

257 We wish to express our appreciation for the help provided by the witnesses concerning their experiences as trainees at Millisle, nearly all of whom had already given evidence in relation to other residential institutions. We are aware that recalling such memories can be a painful process. We are grateful to all those in the Department of Justice who identified relevant records and contributed to the statements for the Inquiry presented by Stephen Davis, the Director of Operations for the Northern Ireland Prison Service (NIPS). We are indebted to the officers who were employed at Millisle for providing first-hand recollections, and in particular to Duncan McLaughlan who was Governor during the period covered by most of the allegations.

258 Nearly all the evidence was provided by the Department of Justice, but some records, such as Prison Service personnel details, were not available, presumably as a result of destruction of files considered to be no longer required. In particular, there was a review of records at Millisle in May 1977 at which it was noted that there were 'dead' files for over a thousand trainees and these were presumably destroyed.[31] There are therefore some gaps in our knowledge. Unlike other institutions investigated by the Inquiry there were no social services files concerning the trainees during their time in Millisle as there were no social workers actively involved with them then. There was also very little police documentation, as (with one exception) the witnesses had not complained to the police and their allegations had not been investigated previously.[32]

259 We accept that there was on occasion low-level violence in the closed unit between 1977 and 1980. This was contrary to Governor McLaughlan's instructions and may have reflected working practices introduced by prison officers from other prisons in the early months of the closed section, but it was unacceptable and constituted systemic abuse. It is our further conclusion that on occasion low-level physical abuse was also reported in the open borstal, and that this was also systemic abuse.

260 We consider Officer Skillen's behaviour to have been systemically abusive.

261 We also consider it a systemic failure that at times information about Officer Skillen and his misconduct failed to reach senior officers who could have taken action, and that when it did reach them, as reported in the evidence, they failed to take action.

31 MIL 141, 143.
32 MIL 106-107.

262 The Prison Service complaints system whereby trainees could address complaints to the Governor, the Visiting Committee or the Department was undermined by the pressures exerted by prison officers and rendered largely ineffective, and we consider this to have been a systemic failure.

263 The emotional impact of the training methods in the closed unit and the emotional damage associated with physical abuse constituted systemic abuse.

264 The night staffing was insufficient to prevent peer abuse, and the failure to protect trainees was systemic.

Volume 5 – Chapter 18 – Module 11 – St Joseph's Training School

265 In Module 11 we considered evidence about St Joseph's Training School (St Joseph's) which was run by a Roman Catholic congregation, the Sisters of St Louis. Module 11 commenced on 8 February 2016 and concluded on 22 February 2016. We received evidence from sixteen former residents of the school, five of whom gave evidence in person during Module 11: HIA 203; HIA 178; HIA 161; HIA 198; and HIA 376.

266 The statements of two former residents, HIA 249 and HIA 176, were summarised and read out during Module 11 because they were unable for medical reasons to give evidence in person. We also took into account statements from three former residents of St Joseph's who wanted to tell us about their positive memories of the care they received in the school: SJM 73; SJM 74; and SJM 75.

267 Two former residents, HIA 49 (Day 9) and HIA 233 (Day 16) gave evidence in person about their time in St Joseph's during Module 1, which dealt with children's homes in Londonderry run by the Sisters of Nazareth. Four other former residents - HIA 124 (Day 96), HIA 195 (Day 101), HIA 175 (Day 100), and HIA 84 (Day 109) - gave evidence in person about their time in St Joseph's during Module 4, which dealt with children's homes in Belfast run by the Sisters of Nazareth.

268 During Module 11 we heard evidence in person from four nuns who worked in St Joseph's: SR 235, SR 234, SR 247 and Sister Canice Durkan. We considered helpful statements from SR 240 who was the Director of St Joseph's for almost thirty years from 1972 to 2000. Unfortunately SR 240 was unable for medical reasons to give evidence in person. We also

considered a statement from SR 254. In addition to these statements the Sisters of St Louis provided written responses to the statements of former residents and related contemporaneous documentation.

269 A former member of lay staff of St Joseph's, SJM 4, provided a statement in response to allegations made against her and a written closing submission. SJM 56, who was HIA 176's social worker when she was in St Joseph's, provided a statement about his work with HIA 176.

270 We were assisted in developing our understanding of the establishment and operation of St Joseph's by the access we were given to extensive records relating to the school, which were maintained and retained by the Sisters of St Louis. These included daily logs, visitors' books, punishment books, the minutes of meetings of the Board of Management and quarterly returns about the use of corporal punishment, which were submitted to the Ministry of Home Affairs (MoHA). We were also assisted by police material and civil claim papers in relation to St Joseph's.

271 The Department of Justice (DoJ) provided a general statement about St Joseph's and written responses to the statements provided by former residents. However, it was unable to provide detailed responses to the statements of applicant witnesses born before 1957 as its records for residents of St Joseph's only extend back to those born after that year. The Department of Health, Social Services and Public Safety (DHSSPS) provided witness statements about the inspection and regulation of St Joseph's.

272 The Health and Social Care Board (HSCB) provided a general statement about St Joseph's and written responses and background documentation about the involvement that any of its predecessor bodies had in the care of applicant witnesses.

273 The Sisters of St Louis, the DoJ, HSCB and the DHSSPS also provided written closing submissions. We are grateful for the evidence all witnesses provided for this module and the assistance it gave us in considering whether there were systemic failings in the care provided in St. Joseph's.

Failings by the Ministry of Home Affairs and the Northern Ireland Office

274 The lack of formal inspections in the period from 1968 to 1987 was a systemic failing by the MoHA, and then the NIO, to ensure that St Joseph's

was providing proper care and meeting statutory requirements about the operation of training schools. This meant that girls in the school at that time did not have the benefit of external monitoring of the facilities and practices in the school.

Failings by the Sisters of St Louis

275 During the period of SR 237's directorship, between 1957 and 1971, she was physically abusive to girls to the extent that it amounted to systemic physical abuse.

Volume 6 – Chapter 19 – Module 8 – Barnardo's

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

277 The Inquiry devoted two weeks covering eight sitting days between 7 December 2015 and 17 December 2015, during which we heard oral evidence from three applicants and received the written statement from a fourth. We also received oral and written evidence from Lynda Wilson, the Director of Barnardo's Northern Ireland, and from five former employees of Barnardo's. The Inquiry tried unsuccessfully to locate BAR 2, but on 17 December 2015 he made contact with the Inquiry. He was then provided with the relevant evidence, and ultimately provided the Inquiry with a statement dated 24 February 2016. He was offered the opportunity to give oral evidence but declined to do so.[33]

278 We had written submissions from a number of those who were the subject of allegations, as well as submissions on behalf of Barnardo's, the Department of Health, Social Services and Public Safety (DHSSPS) as the successor department to the Ministry of Home Affairs (MOHA), and the Department of Health and Social Services (DHSS), which had statutory responsibility for these homes during the period with which we

33 BAR 2546-2548.

are concerned. We also received written submissions on behalf of the Health and Social Care Board (HSCB), as the successor to the various local or statutory authorities which had responsibilities for the care of children they placed in Barnardo's.

Findings of systemic failings by Barnardo's in relation to Macedon

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

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

281 There were systemic failings in the way in which the allegations about BAR 3 were handled by Barnardo's staff at Macedon.

(1) They were not reported for some months by BAR 8 to BAR 24.

(2) A deliberate decision was made by BAR 24 not to report the full facts to his superiors or to anyone else.

(3) BAR 75 does not seem to have reported the remark made to him by BAR 47 that BAR 3 was a "real fruity boy" to his superiors at Barnardo's.[34]

282 The reluctance on the part of some Barnardo's staff in Northern Ireland in the 1980s to report allegations about staff to the proper authorities was a systemic failing.

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

284 The 'wooden spoon' episode, and the way it was ultimately dealt with, represented a number of systemic failings on the part of Barnardo's.

- The three staff who struck HIA 101 acted in breach of Barnardo's policy of no corporal punishment.

34 BAR 8619.

- That each resorted to the use of a spoon in such an impulsive fashion suggests this may well have not been the only occasion that staff resorted to a wooden spoon to administer minor corporal punishment.
- To admonish the three staff, and to place a note on each of their personal files, was an inadequate and inappropriate response. The proper course to have taken at that time would have been for each to have received a formal written warning.

285 The way in which BAR 1 was allowed to frighten children with ghost stories and the 'evil eye' practice, and that it went unreported and/or undiscovered for several years, represented a sysytemic failure by Barnardo's staff to exercise proper supervision.

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

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

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

289 The failure to prevent the relationship between BAR 2 and BAR 47 developing, and then to put a stop to it, represented a systemic failing on the part of the management at Macedon to ensure proper standards of professional behaviour on the part of BAR 2.

290 There was poor management at, and of, Macedon during BAR 1's employment.

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

Systemic failings by SWAG

292 The failure to carry out inspections of Macedon in the 1970s.

Volume 6 – Chapter 20 – Module 9 – Manor House

293 The Inquiry devoted Module 9 to the examination of Manor House Home (Manor House), a children's home in Lisburn, County Antrim. Manor House was run by The Society for the Irish Church Missions to the Roman Catholics, which was a mission agency associated with the Church of Ireland. The organisation is now known as the Irish Church Missions (ICM) which is a registered charity concerned with the encouragement of Gospel growth in Ireland.

294 The Inquiry devoted four sitting days to this module commencing on 5 January 2016 and finishing on 8 January 2016. We received complaints about Manor House from six former residents. We heard evidence from two of these witnesses, HIA 346 and HIA 341, on 4 September 2014, as part of Module 2 of the Inquiry which dealt with child migrant schemes. During Module 9 we heard three witnesses, HIA 365, HIA 290 and HIA 366, and a summary of the statement of HIA 289 who was unable to attend in person for health reasons.

295 HIA 354, who gave evidence on 3 September 2014, during Module 2 of the Inquiry, referred to a brief stay he had in Manor House in November 1950 prior to being sent to Australia. HIA 354's only memories of Manor House were of being taught hymns and being given a bath and new clothes prior to his departure to Australia. He had no complaints about how he was treated in the home.[35]

296 In addition to the evidence from witnesses, we considered information provided by the ICM about the establishment and operation of Manor House and its written responses to the statements provided by witnesses about the home. Reverend Edmund Coulter, the current Superintendent of ICM and Reverend Courtney, a retired Church of Ireland clergyman, gave evidence in person. Dr Hilary Harrison provided a written statement and gave evidence in person on behalf of the Department of Health, Social Services and Public Safety (DHSSPS). Fionnuala McAndrew, Director of Social Care and Children's Services, Health and Social Care Board, provided a statement and exhibits on behalf of the Health and Social Care Board (HSCB), and the HSCB also provided written responses to the statements from former resident witnesses.

35 MNH 033/4.

297 We also examined police material about investigations into allegations of peer sexual abuse in Manor House, sexual abuse of a resident by an adult visitor to the home and sexual abuse of another resident by a man unconnected to the home.

298 We spent some time considering the initial funding and inspection of the home by the Ministry of Home Affairs (MoHA). This was because the MoHA's engagement with Manor House provided the only example we are aware of where the MoHA contemplated removing registration granted to a voluntary children's home under the Children and Young Persons Act (Northern Ireland) 1968.

Findings of systemic failings by the ICM

299 The irresponsible approach by the General Committee of the ICM to re-open Manor House as a children's home amounted to a systemic failing to ensure the home provided proper care.

300 The general state of dilapidation of Manor House in 1953, the inadequate sleeping, toilet and washing facilities for the children, the poor heating and the low staffing levels amounted to a systemic failing by the Management Committee to ensure the home provided proper care.

301 The harsh response by staff in the 1940s and 1950s to children who suffered from enuresis, including segregating these children and making them sleep in unacceptable conditions amounted to a systemic failing to ensure the home provided proper care.

302 The Management Committee's delay in appointing an officer in charge during the period August 1963 to June 1965 and its failure to appoint a monthly visitor amounted to a systemic failing to meet statutory requirements and ensure the home provided proper care.

303 The Management Committee's failure in the early 1970s to engage directly with the MoHA to find out more about and address Miss Forrest's criticisms of the home amounted to a systemic failing on its part to ensure the home provided proper care.

304 In relation to the sexual abuse of HIA 365, HIA 290 and HIA 289 by a male visitor to the home there was a systemic failing on the part of the staff to take proper steps to prevent, detect and disclose abuse.

305 The extent of sexual activity between boys in the home in the period 1975 to 1977 indicates a lack of supervision of children particularly at night

time which amounted to a systemic failure by staff to take all proper steps to prevent, detect and disclose peer sexual abuse in the home.

306 The lack of investigation of the claim by MH 25 that MH 39 had sexually interfered with another girl in the home as well as her amounted to a systemic failing by staff to take all proper steps to prevent, detect and disclose abuse.

307 The lack of supervision that allowed MH 23 to be sexually active from an early age with girls and boys in Manor House amounted to a systemic failing by staff to prevent, detect and disclose abuse in the home.

308 MH 9's decision with Assistant Principal Social Worker MH 73's in 1980 that an informal approach should be used to deal with a member of staff hitting a child with a stick amounted to a systemic failing to ensure the home provided proper care.

The Ministry of Home Affairs and the DHSS

309 The lack of inspection of Manor House for a period of over two and a half years following the initial registration of it as a children's home amounted to a systemic failing to ensure the home provided proper care.

310 The failure to ensure that an officer in charge was appointed during the period August 1963 to June 1965 and arrangements were in place for monthly visiting amounted to a systemic failing to implement statutory requirements and ensure the home provided proper care.

311 The low level of formal inspections of the home in the 1960s, and the MoHA's failure to raise Miss Forrest's criticisms of the home in the early 1970s with the Management Committee, amounted to a systemic failing by the MoHA to ensure the home was providing proper care.

312 The continuing lack of formal inspections in the 1970s when the SWAG took over responsibility for inspection of children's homes on behalf of the DHSS was unacceptable and amounted to a systemic failing by the DHSS to ensure the home was providing proper care.

The SHSSB

313 Assistant Principal Social Worker MH 73's agreement with MH 9 in 1980 that an informal approach should be used to deal with a member of staff who hit a child in the care of the SHSSB with a stick amounted to a systemic failing by the SHSSB to ensure the home provided proper care.

Volume 6 – Chapter 21 – Module 12 – Good Shepherd Sisters

314 As the Chairman explained on 4 November 2015, and again in his opening remarks at the start of this module on 7 February 2016, in this module the Inquiry investigated only those allegations made to it in relation to institutions in Northern Ireland run by the Roman Catholic female religious order The Congregation of Our Lady of Charity of the Good Shepherd (also known as the Good Shepherd Sisters) by those witnesses who were under the age of eighteen when they were placed in one of these institutions. This was because only children in residential care who were under the age of eighteen are within our Terms of Reference. For convenience in this chapter we refer to the Congregation as the 'Good Shepherd' or the 'Good Shepherd Sisters'.

315 The Inquiry investigated allegations relating to Good Shepherd institutions at three locations in Belfast, Derry and Newry. Because of the small number of applicants to the Inquiry who were in each institution, and because some of them were in more than one of the institutions, we decided to investigate all three in the same module. Module 12 started on Monday 7 March, 2016 and the public hearings extended over seven working days, finishing on Tuesday 15 March, 2016.

316 Although there were a number of references by witnesses to their experiences, or the experiences of others, when working in laundries in the three institutions we have investigated, the Inquiry has not engaged in a wider investigation into what are commonly called Magdalene homes or laundries, or mother and baby homes. Because such institutions contained adults over the age of eighteen, and as our Terms of Reference confine us to examining residential homes or institutions for children under eighteen, the experiences of people in such institutions who were over eighteen are outside our Terms of Reference. Whether their experiences should be investigated is a matter for the Northern Ireland Executive and the Northern Ireland Assembly.

317 During Module 12 we heard from nine applicants, seven in person and two whose written statements were read out because they were unable to attend due to poor health. We also received two statements from individuals who came forward to offer favourable accounts of their time as children when they were looked after by the Good Shepherd Sisters in these three institutions.

318 We heard evidence from five Good Shepherd sisters who served in one or more of the three homes at various times, and from Sr Ethna McDermott on behalf of the Congregation. We received witness statements and substantial quantities of material from the Good Shepherd Sisters, from the HSCB, and a small amount of material from the PSNI. We also received a witness statement from Dr Hilary Harrison on behalf of the Department of Heath, Social Services & Public Safety.

319 We concluded that there were the following systemic failings on the part of The Congregation of the Good Shepherd Sisters.

The Good Shepherd Sisters

320 It was unacceptable for young girls under the age of eighteen to be expected to do industrial work in the Good Shepherd laundries.

321 Permitting girls to be asked by a priest whether each was a virgin was a systemic failing.

322 The practices of reading out misdemeanours in front of others and making the offender kneel, or making an offender stand to eat her meal was a systemic failing.

323 By accepting children under school-leaving age, such as HIA 107 and her companions, on a long-term basis the Good Shepherd Sisters failed to ensure that proper care was provided for these children.

324 The failure of SWAG to carry out inspections of each of the three Good Shepherd Sisters Homes was a systemic failing.

325 The failure of each of the three Good Shepherd Sisters Homes to put in place a system of monthly visitors was a systemic failing.

The Ministry of Home Affairs

326 Failing to take steps to prevent children under school-leaving age, such as HIA 107 and her companions, being in the Good Shepherd on a long-term basis.

The Ministry of Home Affairs and/or the DHSS

327 Failing to detect the absence of a system of monthly visitors was a systemic failing on the part of the Ministry of Home Affairs and the Social Work Advisory Group.

Volume 6 – Chapter 22 – Module 15 – Bawnmore Boy's Home

328 Although Bawnmore Boys' Home was examined as part of Module 15 of the Inquiry because a number of those who were resident there were later moved to Kincora Boys' Hostel, we considered that Bawnmore should be dealt with in a separate chapter of our Report. Bawnmore is not to be confused with another children's home of the same name in South Belfast. The Bawnmore in this chapter was the home at Mill Road, Newtownabbey, County Antrim, which existed between 1952 and 1977.

329 The evidence relating to Bawnmore was considered on Days 208, 209 and 210, during which we heard evidence in person from four applicants: HIA 112, HIA 532, HIA 199 and HIA 409. We considered the evidence of HIA 83 who gave evidence at an earlier stage of the Inquiry, and we considered it unnecessary to ask him to give evidence again. We also received evidence from two former members of staff: BM 4 gave evidence in person, whilst BM 13 provided the Inquiry with a written statement.

330 We received a witness statement from Fionnula McAndrew on behalf of the Health and Social Care Board, as the successor to the Belfast Welfare Authority and the Northern Health and Social Services Board (NHSSB), which took over Bawnmore with the reorganisation of local government in 1973 and ran it until it closed in 1977. We also received a witness statement from Dr Hilary Harrison on behalf of what was at that time the Department of Health and Social Services and Public Safety (DHSSPS) and is now the Department of Health, and from Richard Pengelly, who is Permanent Secretary of the same department.

331 Bawnmore was one of the houses investigated by the Hughes Inquiry because of offences involving the abuse of children at the home. The offences came to light during the wider Caskey Phase One investigation by the RUC, which had been set up following the publication of the article in the Irish Independent of 24 January 1980 to which we refer in greater detail in the chapters relating to Kincora. The Caskey Phase One investigation was not simply confined to Kincora; it covered a number of children's homes or hostels, including Bawnmore. As a result of that investigation the police uncovered allegations against five men, two of whom (Peter Bone and Robert Elder) were prosecuted, pleaded guilty and were sentenced by Lord Lowry, Lord Chief Justice, on 16 December 1981 for offences relating to Bawnmore, at the same time that Mains, Semple

and McGrath were sentenced for offences related to Kincora, and Eric Witchell was sentenced for offences relating to Williamson House.

Belfast Welfare Authority

332 The failure to vet Peter Bone amounted to a systemic failing by the Belfast Welfare Authority.

333 The failure of BM 1 to report the abuse of HIA 532 by Bone to his seniors.

334 In relation to the allegations made against Elder by HIA 532 to BM 3.

- BM 3 did not make a written record of the allegations, or of Elder's response.
- BM 3 did not investigate the allegation about the photographs made by HIA 532 against Elder by asking to see them as he should have done.
- BM 3 did not report the matter to his superiors as he ought to have done.

335 The number of boys who were subjected to sexual abuse by staff members.

336 The failure of the Welfare Committee to fulfil its statutory duty to carry out inspections.

337 The failure by SWAG to carry out inspections.

Volume 7 – Chapter 23 – Module 5 – Fort James Children's Home and Harberton House Assessment Centre

338 The Inquiry devoted Module 5 to the examination of particular aspects of the operation of two children's homes in Londonderry: Fort James Children's Home and Harberton House Assessment Centre. 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.

339 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.

340 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.

341 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.

342 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, Dennis 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).[36]

343 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 1995,[37] and from the current Director of Women and Children's Services and Executive Director of Social Work of the WHSCT, Kieran Downey.[38]

344 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;

36 FJH 60077-60081.
37 FJH 599-770.
38 FJH 771-791 and 838 -859.

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

The Social Services Inspectorate

345 We found that the SSI on behalf of the Department failed to 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.

The WHSSB

346 We found that the WHSSB failed 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.

347 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.

348 These failings amount to systemic failings by the WHSSB to ensure Harberton House provided proper care.

Volume 7 – Chapter 24 – Module 13 – Lissue Hospital

349 Lissue Hospital was unique among the institutions considered by the Inquiry in that it was the only hospital to be investigated, and its functions therefore included medical and nursing care. It is not the Inquiry's role to evaluate the medical care provided, and if there remain medical issues which require investigation the task will need to be allocated to another inquiry to be undertaken by professionals with the appropriate qualifications and experience.

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

351 Module 13 commenced on 4 April 2016 with an introduction by Senior Counsel and we heard the evidence of ten witnesses who had been patients at Lissue Hospital as children. Sadly, one had died, and his evidence was therefore read out. Three former staff gave evidence concerning their respective roles in the multidisciplinary team - three nurses, Moira Mannion, LS 7 and LS 21, two consultant psychiatrists (Dr William Nelson and Dr Roger McAuley), and LS 80, a social worker. On behalf of the core participants Dr Hilary Harrison spoke for the Department of Health, Social Services and Public Safety, (since renamed the Department of Health) and a joint statement was presented by Dr Carolyn Harper and Mary Hinds for the Public Health Agency and Fionnula McAndrew for the Health and Social Care Board (HSCB). Since the closure of Lissue there have been twelve inquiries and reports based on investigations of issues related to the Hospital's functioning. Although undertaken following the end of the Inquiry's remit, their contents have a bearing on our findings, and the chapter therefore concludes with a summary of their contents. After nine days of hearings, the Module closed on 27 April.

352 The governance structure of the hospital from 1973 onwards was a systemic failure, and it is fortunate that it did not engender serious management problems.

353 The successes of the psychiatric unit at Lissue were thanks to cooperation between the individual professionals involved; the managerial structure within which they worked was faulty and systemically unsound.

354 We considered the absence of both formal and informal inspections of Lissue Hospital on a regular basis to have been a systemic failure on the part of the Ministry of Health and Local Government and the Northern Ireland Hospital Authority from 1948 to 1973, and on the part of the Ministry / Department of Health and Social Services and the Eastern Health and Social Services Board from 1973 to 1989.

355 While we cannot say what the outcome of a disciplinary inquiry might have been, we consider the failure of the Eastern Health and Social Services

Board to conduct its own investigations into the allegations of sexual abuse against LS 21 in 1993 to have been a systemic failure.

356 In view of the risk to the children who climbed on the roof at Lissue and the danger which they caused to other people, the lack of action to prevent access to the roof was a systemic failure.

357 The occasions on which physical restraints were used may have been few, but their use was unacceptable; they would not have been used in other types of residential childcare, and their use in a hospital cannot be justified.

358 While the policy was not at fault, the implementation of 'time out' at times was not always in accordance with the policy and constituted systemic abuse.

359 On the occasions when children were sedated to render the nursing task easier, the use of injections constituted systemic abuse.

360 At times some staff did overstep the mark and were unduly rough in their treatment of the children, and that this constituted systemic abuse.

361 We accept that some patients were sexually abused and consider this to have been systemic abuse.

362 There were many instances when staff were unfeeling and failed the children who required their support, and that these shortcomings were sufficiently frequent to be deemed systemic emotional abuse.

363 Any further inquiry into Lissue would be subject to diminishing returns; the additional information which might be gained could well be very limited and it would not justify the time and expense entailed.

Volume 8 – Chapter 25 – Module 15 – Kincora Boys' Hostel

364 Chapter 25 takes the form of an introduction setting the scene for Chapters 26, 27, 28 and 29. In Chapter 25 we briefly described the history of the Hostel, the nature of the allegations which resulted in the prosecution and convictions of Mains, Semple and McGrath; the various police investigations; the Hughes Inquiry; the continuing allegations; as well as explaining the arrangements made to enable this Inquiry to examine the allegations relating to the government departments and agencies which have not been devolved to the Northern Ireland Assembly and Executive

and so lay outside the original Terms of Reference of the Inquiry, and the approach of the Inquiry to all these matters.

Volume 8 — Chapter 26 – Module 15 — The Nature and Extent of the Sexual Abuse of Adolescent Boys Resident in Kincora

The number of residents of Kincora known to have been sexually abused

365 Kincora opened in 1958 and closed in 1980. During that time 309 boys resided in the hostel. In their investigation in 1980 the RUC took 1963 as the starting point for their investigation. Of the 245 boys who resided in Kincora between 1963 and 1980, 104 (42% of the total) were traced and interviewed by the police. We now know that 38 boys were abused at some point during Kincora's existence. Although not all the surviving former residents could be traced, or have since come forward, it can be seen from these figures that the great majority of those who were traced were not sexually abused during their time in Kincora.

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

Awareness of abuse

367 It may seem strange that so many of those who were in and out of Kincora in various capacities, not just the residents but the domestic staff and visitors, were unaware of what was happening, but there was a consistent pattern of concealment of their behaviour by Mains, Semple and McGrath.

368 They approached boys who were vulnerable, or who they thought might be easily intimidated. If their initial approaches were firmly rebuffed they generally did not approach that person again. If they did, they went to considerable lengths to approach the boy when others were not around.

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

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

370 Whilst Mains and Semple knew each other before Semple was appointed as deputy warden, and Mains definitely knew of Semple's sexual abuse of residents before Semple was reappointed, there is no evidence either knew McGrath before he was appointed.

371 The evidence suggests that by the time McGrath was appointed Mains had stopped sexually abusing residents, and was engaged in a long-term homosexual relationship with an ex-resident. Semple did not engage in sexual abuse of residents after he was reappointed, and found outlets for his sexual urges elsewhere. This meant that McGrath was the only member of staff who abused residents between his appointment in the summer of 1971 until the home was closed in 1980.

Volume 8 – Chapter 26 – Module 15 – Belfast Welfare Authority, the Eastern Health and Social Services Board, the RUC, The Ministry of Home Affairs and the DHSS

Failings by Belfast Welfare Authority

372 Kincora was never adequately staffed, and this meant that for significant periods only one member of the care staff was on duty in the building.

373 Kincora was a hostel for boys who had reached school-leaving age, but too many children were admitted to Kincora when they were under school leaving age. These children were too young to be placed in such an environment, and too many of them spent too long in that environment when they were admitted.

374 In addition, there were insufficient staff with appropriate training or experience to deal with such young children.

375 Understaffing also meant that staff had to work very long hours, particularly in the case of Mains during the early years, when he was the only member of the care staff for a very long period of time. This meant that he was effectively expected to be on duty all the time. This was very poor practice, and the long hours and low pay put significant pressure on staff, and meant that recruitment of suitable staff was very difficult.

376 The insufficient levels of staff provided Mains, Semple and McGrath with opportunities which they exploited to target their victims when no one else was about to see what was happening, or to suspect what was happening.

377 The way the adolescent boys in Kincora were looked after meant that far too much was done for them by the domestic staff. We consider this created an attitude of dependence by the boys on the staff, and this dependency was exacerbated by inadequate preparation of the residents for independent living when they left Kincora.

The Ministry of Home Affairs and the DHSS

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

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

379 When complaints were made by residents, first of all to the Belfast Welfare Authority, and later to the EHSSB, these were not properly dealt with. In 1967, when the first complaints were received, Mr Mason decided that Mains's conduct did not amount to a prima facie indication of wrong doing. We consider that he was wrong to do so. The Town Clerk's Department was wrong not to implement Mr Mason's recommendations that clear procedures were not put in place to ensure that any further complaints about Kincora were properly reported to the City Welfare Officer. Written and clear instructions should have been given to relevant managers for the closer supervision of Kincora in the future.

380 Again in 1971 the Town Clerk and Town Solicitor did not report the allegations to the police as they should have done. Following the decision not to report the allegations to the police, the following steps ought to have been taken.

a. It should have been re-emphasised to Mains that he should avoid doing anything that could lead to allegations of impropriety.

b. Instructions should have been given that a very close eye was to be kept on both Mains and Kincora.

c. Procedures were not put in place to ensure further allegations about Kincora were properly collated and then referred to the City Welfare Officer, or to his deputy, for immediate attention.

381 After 1971 and throughout the remainder of the 1970s, anonymous phone calls and rumours that appear to have circulated about Kincora amongst staff and other social workers were not made known to senior staff in the EHSSB as they ought to have been.

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

The RUC Cullen/Meharg Investigation

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

384 It was not simply the case that over these years there were a small number of missed opportunities by the Belfast Welfare Authority, by the EHSSB and by the RUC. There were so many failings by all of these agencies that they amount to a catalogue of failures by each. Had the 1971 allegations been reported to the RUC, as they should have been, or if an effective investigation had been carried out by the RUC in later years, it is reasonable to infer that a thorough and competent investigation by trained detectives may have been successful in exposing the abuse in 1976, and possibly even in 1974. This would have meant that those who were sexually abused after 1976, and possibly after 1974, would have been spared their experiences.

Volume 9 – Chapter 28 – Module 15 – Kincora and the security agencies

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

386 The security agencies soon concluded that Tara was not a significant force, and they only paid intermittent attention to it and to McGrath in succeeding years.

387 By May 1973 both RUC Special Branch and other RUC officers knew that McGrath was reputed to be homosexual, but they had no proof of this. It was not until Roy Garland spoke to Detective Constable Cullen on 1 March 1974 that the RUC received an allegation that McGrath had engaged in homosexual conduct of a grooming nature in the past with Roy Garland when Roy Garland was a teenager. For understandable reasons Roy Garland was not prepared to come forward to give evidence at that time, and the result was that the RUC had a witness who would not appear in court and who was describing events involving homosexual acts that had occurred a considerable number of years before.

388 Although in 1973 the RUC Special Branch were aware of the allegation that McGrath was homosexual from what appears to have been another source, they did not pass the information relating to the other source to their RUC colleagues as they should have done. Had Special Branch passed on that information then their RUC colleagues, whether in CID or in uniform departments, could have added it to the information that they had already received from the anonymous Robophone message.

389 Despite Roy Garland's commendable efforts to alert Social Services and the RUC to the risk he accurately identified that McGrath might be taking advantage of his position in Kincora to sexually assault residents there, just

as he had sexually assaulted Roy Garland when a teenager, Roy Garland's efforts to do so were unsuccessful through no fault of his own.

390 Although the RUC, MI5, SIS and Army Intelligence were all aware of allegations that McGrath was homosexual, such allegations were common at the time against various political and other figures. In the absence of positive evidence of homosexual acts there was little that could be done by these agencies because no one other than Roy Garland had come forward with a definite allegation that would allow the matter to be pursued.

391 We are satisfied that it was not until 1980 that the RUC Special Branch, MI5, the SIS and Army Intelligence became aware that McGrath had been sexually abusing residents at Kincora, and they learnt of that when it became the subject of public allegations and a police investigation was launched. All four agencies, whilst aware that McGrath was alleged to be homosexual, had no proof of that. They were aware that he worked in a boys' hostel where he was in a position of authority. They were aware of allegations that he had abused Roy Garland a long time before McGrath went to work in Kincora.

392 However, by November 1973, MI5, unlike the other three agencies, were also aware that the person who had by then been identified as William McGrath had been accused of "assaulting small boys". By virtue of Section 5 (1) of the Criminal Law Act (Northern Ireland) 1967, MI5 officers were subject to the same legal obligation as everyone else in Northern Ireland to report the commission of an "arrestable offence" (that is an offence punishable by five years imprisonment) to the police where they knew or believed that such an offence, or some other arrestable offence, had been committed. An alleged assault on small boys could, depending on the nature of the alleged assault, have been an arrestable offence which ought to have been reported to the police.

393 With the benefit of hindsight, and in the light of what is now known about McGrath's abuse of residents in Kincora, it might be argued it was the duty of MI5 to bring to the attention of RUC Special Branch that MI5 had received a report that McGrath had been accused of assaulting small boys, and that by not doing so the MI5 officers who had this information were in breach of that duty. However, we consider that to take that view would be unjustified for several reasons. First of all, although the information was known to MI5 because it had been received eighteen months before, eighteen months separated the receipt of that information

and the information confirming the identity of William McGrath as the leader of Tara. Secondly, the information came to MI5 in a letter from James Miller who was simply reporting what an unidentified source said at a time when unsubstantiated allegations of discreditable behaviour by Tara members about each other were commonplace, and the report was therefore assessed as being of dubious reliability. Thirdly, the MI5 officers were concentrating on establishing what sort of organisation Tara was, and whether it could be a possible Loyalist terrorist group in the context of the extremely volatile political and security circumstances of that time. In all of those circumstances we do not criticise them for failing to appreciate the significance of this information.

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

William McGrath

395 Based on our extensive examination of a very large number of files held by RUC Special Branch, by MI5, by SIS and by the Ministry of Defence, we are satisfied that McGrath was never an agent of the State, although he may have enjoyed creating an air of mystery about his activities, part of which may well have involved him hinting at, or implying in an oblique fashion, that he was an agent of the State.

396 Not only have we found no evidence to indicate that McGrath was an agent of any of the four agencies, we have found many documents and references which very strongly indicate that he was not an agent.

397 William McGrath was a sexual pervert who had political and religious views of an extreme and bizarre type who managed to trick gullible young men who were interested in political matters into regarding him as an important

political figure. William McGrath was never more than a minor player on the wider political stage who managed to create a spurious air of self-importance through Tara at a time of great political instability, communal violence and terrorist activity. Tara was never more than an organisation of occasional interest to the security agencies.

Volume 9 – Chapter 29 – Module 15 – Conclusions about Kincora

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

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

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

Allegations of a cover up

400 Both the Belfast Town Clerk and the Town Solicitor died before the Hughes Inquiry investigated the sexual abuse at Kincora. The reasons why the Town Clerk and the Town Solicitor decided not to accept the recommendation made by Mr Mason in 1971 that the complaints against Mains should be reported to the RUC were never recorded. There are a number of possible

reasons why they took this step. One was that they did not agree that the information contained in Mr Mason's report was sufficient to justify the matter being reported to the police. If that was their reason then that was a wrong decision. Another reason may have been to protect the Belfast Welfare Authority from the embarrassment that would flow from a police investigation into a boys' hostel under its control. Another explanation may have been that either or both were determined to protect Mains from exposure as a homosexual. That would only be a possible consideration were there evidence to show that either the Town Clerk or the Town Solicitor knew that Mains was a practising homosexual. In the absence of any evidence, each of these possible reasons is no more than speculation.

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

Allegations by Colin Wallace and others

402 We are satisfied that Mr Wallace was moved from his post in the Army Information Service at HQNI, and subsequently dismissed, solely because there was very strong circumstantial evidence that he had been engaged in, and was still engaged in, the unauthorised disclosure of classified documents to journalists. We are satisfied that whatever he claims to have known about Kincora had nothing whatever to do with his posting to Preston or his subsequent dismissal.

403 We are satisfied that Mr Wallace was treated unjustly in two respects connected with the subsequent appeal he brought against his dismissal to the Civil Service Appeal Board. First of all the MoD did not reveal to the CSAB the full job description which had been prepared showing the true nature of his work. Secondly, the MoD briefed the Chairman, and then the Deputy Chairman, of the CSAB with information that was not made known to Mr Wallace, to his representative, or to the other members of the Board who sat on his appeal. That they did so, and that the gentleman concerned received the information, was thoroughly reprehensible and should never have happened.

404 These injustices were accepted by David Calcutt QC in his report to the MoD in which he recommended that Mr Wallace be paid £30,000 compensation. We understand that Mr Wallace eventually accepted this amount.

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

MI5

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

Sir George Terry's report

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

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

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

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

409 The recognition by the MoD in 1989 that incorrect answers may have been given by Ministers to the House of Commons and to others led the MoD to carry out a wide-ranging and detailed investigation to establish the correct position. When the correct position was known, the Ministry took the necessary action to place the correct facts before the House of Commons and to correct the errors that had occurred in the past. It appointed Mr Calcutt QC to consider the injustices suffered by Mr Wallace to which we have already referred. We are satisfied that once the MoD appreciated that incorrect information had been given, and that Mr Wallace had not been treated properly before the CSAB, it acted promptly and properly to establish the correct position, and to ensure that the injustices Mr Wallace suffered in the appeal process were remedied. The injustices were remedied by the payment of £30,000 to him as compensation.

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

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

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

412 Those investigations did not find, and our Inquiry has not found, any credible evidence to show that there is any basis for the allegations that have been made over the years about the involvement of others in sexual abuse of residents in Kincora, or anything to show that the security agencies were complicit in any form of exploitation of sexual abuse in Kincora for any purpose.

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