1
2
3 - - - - - - - - - - -
4
5 HISTORICAL INSTITUTIONAL ABUSE INQUIRY
6
7 - - - - - - - - - - -
8
9 being heard before:
10
11 SIR ANTHONY HART (Chairman)
12 MR DAVID LANE
13 MS GERALDINE DOHERTY
14
15 held at
16 Banbridge Court House
17 Banbridge
18
19 on Friday, 8th July 2016
20 commencing at 7.30 am
21 (Day 223)
22
23 MS CHRISTINE SMITH, QC and MR JOSEPH AIKEN appeared as
24 Counsel to the Inquiry.
25

1 Friday, 8th July 2016
2 (7.30 am)
3 SERGEANT Q (called)
4 CHAIRMAN: Good morning, ladies and gentlemen. Welcome at
5 7.40 in the morning on this, the last day of our
6 hearings, for what I imagine will be the last day.
7 I remind everyone if you have a mobile phone, please
8 remember to turn it off or place on "Silent"/"Vibrate",
9 and also remind you no photography is permitted in the
10 chamber or anywhere on the premises. Finally may
11 I remind you that no recording is permitted.
12 Good morning, Ms Smith.
13 Questions from COUNSEL TO THE INQUIRY
14 MS SMITH: Good morning, Chairman, Panel Members. Our first
15 witness is Sergeant Q. Can I just check, Sergeant, you
16 can hear and see me all right?
17 **A. Yes, I can both hear and see you.**
18 Q. Now I have one question I neglected to ask you when we
19 were speaking just a short time ago was whether or not
20 you wish to take a religious oath or whether you wish to
21 affirm. In neglecting to ask that I neglected to ask
22 you if you did wish to take a religious oath was there
23 a bible available to you there?
24 **A. I'm sure -- there's no bible available to me here.**
25 Q. Then I think we're going to have to ask you to affirm,

1 if you are content with that?
2 **A. I'm content with that, yes.**
3 CHAIRMAN: An affirmation has the same legal effect. It is
4 in the form of a solemn promise that you will tell the
5 truth. So it has the same effect as an oath.
6 SERGEANT Q (affirmed)
7 CHAIRMAN: Thank you very much.
8 MS SMITH: Thank you, sergeant. Now for the benefit of the
9 Panel members the statement to the Inquiry that has been
10 prepared by the Sergeant can be found in our bundle at
11 KIN2560 to 2576 and that includes exhibits.
12 Now, Sergeant, you were formerly serving in the
13 military and you retired in 1998. Isn't that correct?
14 **A. Yes.**
15 Q. You were in Northern Ireland from June 1974 to June 1976
16 and during that time you worked with Captain Brian
17 Gemmell here?
18 **A. Yes.**
19 Q. Not going through all of your statement, but at
20 paragraph 7 you say that you had a meeting with a man
21 called McCormick and you talk in paragraph 7 about what
22 you knew about Tara. You say it was a Protestant
23 extremist group operating in Northern Ireland, but at
24 the end of that first page in your statement you say:
25 "I was also aware of innuendo around Tara group

1 members' homosexuality."
2 I wondered how you were aware of that. Was that
3 because of something one person had said to you or was
4 this just something that was generally known?
5 **A. No, it was various reports from different personnel had**
6 **come in reflecting that.**
7 Q. At paragraph 11 of your statement you talk about your --
8 let me just get the sequencing right. You and Captain
9 Gemmell had a meeting with McCormick, who said a good
10 person for you to talk to to get information about Tara
11 would be Roy Garland. Then there was a meeting at
12 McCormick's house with Roy Garland, at which both
13 yourself and Captain Gemmell were present?
14 **A. That's correct, yes.**
15 Q. And then afterwards there was a second meeting which you
16 had with Roy Garland on your own and that was back at
17 the barracks at Thiepval. Is that right?
18 **A. At Thiepval barracks, yes.**
19 Q. That was the sequencing. At paragraph 11 you talk about
20 what McCormick had led you to believe:
21 "He said that Garland had had problems with McGrath
22 that were related to perversion and illegal activity by
23 McGrath. I believe I was referring to sexual abuse."
24 You are talking about what you put in your 1982
25 police statement:

1 "... referring to sexual abuse that Mr Garland said
2 he had suffered at the hands of Mr McGrath."
3 So you were clear before you even met Roy Garland
4 that he had suffered some sexual abuse at the hands of
5 McGrath because of comments that were made to you by
6 McCormick. Is that right?
7 **A. That's correct, yes.**
8 Q. And I just wanted to be clear: before you met Garland
9 for the first time you hadn't received any specific
10 instruction about the topics you were to cover with him
11 in the sense of obviously you were going to find out
12 what he knew about Tara, but you weren't constrained in
13 any way as to what discussions you were to have with
14 him?
15 **A. That's right.**
16 Q. So you had two meetings. The first is at McCormick's
17 house and you describe this here in paragraph 12 and 13.
18 You say in paragraph 13 that so far as you can recall
19 Mr Garland said in the course of our conversation that
20 he had been abused by McGrath. You go on to say:
21 "Although the language used at the time was
22 different to now, I don't think I fully understood the
23 meaning or significance of what was being explained to
24 me."
25 You say:

1 "I think Mr Garland also mentioned wider abuse at
2 a boys' home, but he didn't provide the name Kincora.
3 He mentioned that the boys home had some connection with
4 Ian Paisley and that as he thought public figures n the
5 Protestant community were aware of this abuse, and he
6 was afraid to go to the police."
7 Now when we were talking earlier and we talked a
8 little bit further on in our conversation about this,
9 but when you met Roy Garland he was in his 20s. He
10 wasn't a child, and I think you were saying to me that
11 while you were talking to him you weren't seeing him as
12 a child who had been abused, although you certainly
13 think that what had happened to him with regards to
14 McGrath had happened at an earlier stage to when you
15 were meeting with him. It wasn't something that was
16 ongoing; is that correct?
17 **A. That's correct, yes.**
18 Q. And I'll come back to when you think he told you about
19 the Boy's Home, but certainly you told the police and
20 you were clear that from the outset of your meeting with
21 him you knew that McGrath was a housemaster in a boys'
22 home; is that right?
23 **A. Yes. I'm not sure if it was specifically said that he**
24 **was a housemaster, but certainly that he was a sort of**
25 **a figure of some authority.**

1 Q. He worked in the boys' home; is that --
2 **A. Yes.**
3 Q. -the impression that you were given?
4 **A. Yes.**
5 Q. Or what you were aware of?
6 **A. Yes.**
7 Q. The second meeting that you had with him was you alone
8 at Thiepval, although, as you point out, it was being
9 recorded and there was someone in an adjacent room to
10 you as the meeting took place. Captain Gemmell before
11 you had that meeting, he made it clear that the
12 discussion was to be confined to potential extremist
13 activity and you felt that given the first encounter
14 that you had had with Roy Garland, that that might be
15 difficult, and I think you said it was impossible. You
16 felt that it would be impossible to constrain him in the
17 way that was being suggested; is that fair?
18 **A. That is correct, but also there had been two**
19 **instructions. The first one was that I shouldn't**
20 **contact Garland again.**
21 Q. Yes, that's right?
22 **A. So that was the first instruction, not to talk to him**
23 **again, and then I think within quite a short period --**
24 **I don't think it was a long period -- I was told I could**
25 **go ahead and interview him a second time.**

1 Q. And in preparation for that second interview you were
2 told you were just to confine the conversation to what
3 essentially the military were interested in. They
4 weren't interested in --
5 **A. To keep it to Protestant extremism and stay away from**
6 **any references to sexual -- anything that was sexual.**
7 Q. And also anything that was to do with religious
8 evangelicalism; is that right?
9 **A. As I say, I don't really recall that bit, so no.**
10 Q. Well, in any event you had this meeting with him --
11 sorry, in your statement you said that Captain Gemmell
12 also appeared to find the instruction extraordinary.
13 I wondered was that because he too, having met Roy
14 Garland, realised that it would be very difficult to
15 keep this man on track?
16 **A. I think so. He obviously knew, you know, about**
17 **personalities that we were interested in and if they**
18 **were involved in one side it would seem very difficult**
19 **to be able to talk to him about one thing and not the**
20 **sexual side of it, which actually proved to be the case.**
21 Q. You go on to say that you met with him. Captain Gemmell
22 was definitely not present at that second meeting. You
23 say in paragraph 17 that in the course of your interview
24 Mr Garland again referred to the abuse of boys at
25 a boys' home connected to the Protestant community.

1 "I don't believe he mentioned the name Kincora. He
2 appeared to think that McGrath may have intended to use
3 this to blackmail the boys when they moved into
4 political life."
5 **A. Yes.**
6 Q. Sorry?
7 **A. To have some sort of hold over them later on.**
8 Q. We were discussing the fact that he had told you
9 certainly at the first meeting about boys attending
10 religious meetings at a place called Faith House at
11 which McGrath was present, leading what could be
12 described perhaps as a bible meeting or a bible club.
13 Do you recall that?
14 **A. No. You know, the specifics of that part of it no,**
15 **I don't.**
16 Q. But do you -- sorry?
17 **A. As a general thing yes, that was within the thing of**
18 **what he was saying.**
19 Q. So I am just wondering, I mean, we were teasing this out
20 earlier when we were talking, about whether it is
21 possible that when he was telling you that other boys
22 were being abused by McGrath, that because you knew that
23 McGrath worked in a boys' home, is it possible that you
24 were conflating that with what you knew about the fact
25 that he was also involved on a religious level with

1 these boys?
2 **A. Yes, and I don't -- you know, because of the**
3 **instructions I don't think I really pursued that down to**
4 **tie it down.**
5 Q. Yes, because the Inquiry has certainly heard and seen
6 from other sources that McGrath was seducing boys, or
7 suggested that he was seducing boys when he was having
8 political and religious meetings with them. So you
9 would accept then that it's possible whenever you were
10 recording or listening to what Garland was telling you
11 that because you knew that McGrath worked in a boys'
12 home, when he was talking about abuse of boys, you were
13 linking the two together?
14 **A. Yes, that's very possible.**
15 Q. Thank you. You also when you made notes -- you made
16 notes at this second meeting, which you then used to
17 prepare a report for Captain Gemmell. You handed him
18 a report?
19 **A. Yes.**
20 Q. Now we were discussing the fact that in 1982 you told
21 police that you wrote out your report in long hand and
22 you handed it to him, and when you did your statement
23 for the Inquiry your recollection was that you typed it
24 out. Now in one sense it doesn't really matter whether
25 it was a typed report or whether it was a handwritten

1 report, because the document that is exhibited to your
2 statement of exhibit 3, which has two references to the
3 Inquiry's purposes, but the one that you can see is
4 30313, I think it is?
5 **A. Yes.**
6 Q. Yes. At paragraph 21 of your statement you say that you
7 don't recognise that document, but the content of that
8 document accords with what Roy Garland told you at that
9 second meeting. Isn't that correct?
10 **A. Yes. Some of it does and some of it is extra.**
11 Q. Some of it is extra?
12 **A. Yes.**
13 Q. So what I was wondering is is it possible that this
14 document was created by Captain Gemmell from the report
15 that you handed to him?
16 **A. It's very probable.**
17 Q. And it may well be then that you could have handed him
18 a handwritten document which he then typed up in this
19 version, or you either handed him a typed version, which
20 he again translated into this typed document?
21 **A. Yes.**
22 Q. So --
23 **A. And indeed with the way we worked things, that is**
24 **probable as opposed to possible.**
25 Q. I think you said that certainly it looks like the kind

1 of document that was provided by your section?
2 **A. The type of information.**
3 Q. Yes, but the format as well, is it in the kind of format
4 that might have been provided also?
5 **A. Not from the one page that I've seen. You know -- you**
6 **know ...**
7 Q. But it certainly was the type of information that your
8 section --
9 **A. It doesn't follow any --**
10 Q. Well it doesn't record -- that document certainly does
11 not record everything that was said to you by Roy
12 Garland because, for example, when you spoke to police
13 in 1982 you made reference to the fact that he started
14 off the conversation with you by saying McGrath had
15 wanted him to engage in some sexual activity with a dog?
16 **A. Yes.**
17 Q. And obviously you did not record that in -- sorry. It
18 is not recorded in this document, but you think you may
19 have put that into the report that you handed to Captain
20 Gemmell?
21 **A. It would have certainly gone within my comments to him.**
22 Q. When you say in your comments when you handed over the
23 report you would have had a conversation, or do you
24 think it would have been in the written version?
25 **A. No. Within the written -- within my written version**

1 **I would have commented that the actual interview started**
2 **off like this.**
3 Q. Very well. So given that --
4 **A. That was his -- absolutely everything -- as soon as we**
5 **sat down and I had given him a drink, he said "Look, to**
6 **give you an idea of McGrath's perversions, he tried to**
7 **get us to go with animals." That was the actual quote.**
8 Q. That was something that has stuck with you over the
9 years, because it was something that you said to me that
10 while it might even seem outrageous today it certainly
11 seemed even more outrageous back then?
12 **A. Exactly.**
13 Q. What I wanted to tease out about that was, given the
14 instruction that whatever information you would get from
15 Garland was really to be about political extremism, it
16 is highly likely then that that kind of information
17 would have been filtered out before being passed on.
18 Would that be fair?
19 **A. Absolutely fair. It made my interview with him almost**
20 **impossible to keep steering him away from that and**
21 **trying to keep it to extremism topics --**
22 Q. So -- sorry?
23 **A. No. I'm really just agreeing with what you just said.**
24 Q. I just wanted to tease that out slightly further by
25 saying so if your document that you handed to Captain

1 Gemmell included all of this kind of comment, it is
2 highly likely then that he would have removed that
3 before passing it up the line, as it were?
4 **A. I would have thought almost definitely. Instead of it**
5 **only being an instruction, you then wouldn't have gone**
6 **out of your way to, you know, go out of your way to put**
7 **all that content in.**
8 Q. You talk in paragraph 24 of your statement -- sorry.
9 I just want to check one thing before you go on to
10 paragraph 24. Yes. You say in paragraph 23 that
11 Mr Garland never explained how he knew the boys were
12 being abused in a boys' home. Again is that because
13 maybe he actually wasn't talking about boys being abused
14 in a boys' home but just boys being abused generally by
15 McGrath?
16 **A. No. I am sorry but I have not quite understood your**
17 **question.**
18 Q. I mean, you say you knew that Garland was telling you
19 that boys were being abused by McGrath and I think you
20 have already accepted it is possible he may have
21 conflated that information with the fact that the abuse
22 was happening in a boys' home because you knew McGrath
23 worked in a boys' home, but as you say, it wasn't
24 something you asked him anything more about because of
25 your specific instructions not to go there?

1 **A. That's right. That is why these things -- I never, ever**
2 **clarified them.**
3 Q. And that's why I am asking you is because he never
4 explained how he knew boys were being abused in a boy's
5 home, it's possible that he might not actually have been
6 talking about abuse in a boy's home to you when he was
7 talking about boys being abused?
8 **A. Well, I still have the impression that he was, but**
9 **I couldn't discount the possibility that he wasn't.**
10 Q. Thank you. In paragraph 24 you're saying you are not
11 sure how much you believed him at the time. I wondered
12 was that because of comments such as the one that he
13 made about being asked to have sex with a dog or
14 an animal?
15 **A. Yes.**
16 Q. Is that part of the reason why you weren't sure how much
17 you believed him?
18 **A. It was that and he wasn't sort of a confident sort of**
19 **person, but bearing in mind presumably what his**
20 **background was, then it's really unsurprising.**
21 Q. Yes, and with hindsight you can make that call today?
22 **A. Exactly.**
23 Q. But at the time did you think that he was exaggerating
24 perhaps or what was your impression?
25 **A. I think the only -- as far as I could go on that was**

1 **that he wasn't a confident person.**
2 Q. At paragraph 26 you describe the fact that Captain
3 Gemmell in his account that he gave to police in 1982 is
4 clearly confused, because he definitely wasn't with you
5 at the second meeting with Garland, and he's confused
6 about that?
7 A. **Yes. I can't offer you any explanation for that. It**
8 **just didn't happen the way he's saying it did.**
9 Q. At paragraph 27 of your statement you say you have no
10 reason to doubt that Captain Gemmell passed on
11 Mr Garland's information about abuse at a boys' home
12 insofar as it was referenced in my report through the
13 chain of command, but given what we have just been
14 discussing about what is in the document at exhibit 3 of
15 your statement and the fact that he is likely to have
16 removed any reference to sexual activity or sexual
17 abuse, then would you still conclude that, or would you
18 accept that maybe he may have passed on the information
19 about those matters that you were told to speak to
20 Garland about and left out other matters?
21 A. **I suppose that is possible, but notwithstanding that, he**
22 **must have passed on the verbal report from our very**
23 **first meeting. The information which we had wasn't so**
24 **much different from following the interview.**
25 Q. Yes, and I think --

1 **A. If he hadn't passed on -- if he hadn't passed on the**
2 **information verbally I see no reason for him to come**
3 **back and say in the first instance: "Don't see him**
4 **again" and then in the second instance "See him again**
5 **but steer away from any of the sexual aspects and keep**
6 **it solely to the Protestant extremism".**
7 Q. Yes. So, I mean, it is clear that he certainly put in
8 a report of some form, whether written or verbal, to his
9 superiors after the first meeting about what Garland was
10 saying, and given the entirety of what he was saying,
11 but what I am suggesting is that it's possible then,
12 given that he was given the instruction to steer away
13 from those things and he passed that instruction on to
14 you --
15 **A. Yes.**
16 Q. -- that he may not then have passed on the extraneous
17 information, if I can describe it in that way, to the
18 superiors the second time.
19 **A. I actually -- I actually believe that it would be very**
20 **unlikely to write a report about something we had been**
21 **told not to do.**
22 Q. But certainly --
23 **A. I can't say that for sure.**
24 Q. I absolutely accept that, but you certainly, as you say
25 in your statement, were never yourself ordered to

1 suppress any information about the boys' home that you
2 now know to be Kincora, but at no stage during your
3 encounters with Roy Garland were you ever aware of the
4 name of the boys' home concerned; is that fair?
5 **A. Yes. I don't think I heard it until the '80s.**
6 Q. Well, Sergeant, thank you very much for that. There's
7 nothing further that I want to ask you. The Panel
8 Members may have some questions for you, so I am just
9 going to hand you over to them. Thank you.
10 **A. Thank you.**
11 CHAIRMAN: Well, Witness Q, we do not, in fact, have any
12 questions for you. Thank you very much for coming to
13 speak to us from distant parts, but there is one formal
14 matter I want to go through with you before you leave.
15 Ms Murnaghan, could you just come forward and confirm to
16 us that the person who we see and have been hearing from
17 as Witness Q on the screen is the person who we believe
18 it to be?
19 MS MURNAGHAN: Yes. I understand that is correct.
20 CHAIRMAN: And you will confirm that in writing to the
21 Inquiry in due course.
22 MS MURNAGHAN: I will.
23 CHAIRMAN: We know who it is but you are confirming it is
24 the person?
25 MS MURNAGHAN: Yes.

1 CHAIRMAN: That's all. Thank you very much indeed, Witness
2 Q. Thank you for speaking to us, particularly since we
3 understand that you had to go out of your way to fit us
4 in today, but thank you very much for doing so. We are
5 very grateful to you.
6 **A. Thank you, and goodbye.**
7 CHAIRMAN: Goodbye.
8 MS SMITH: Thank you.
9 (Videolink terminated)
10 MS SMITH: Chairman, our next witness is unlikely to be
11 ready much more 10 o'clock. Dr Harrison is due to
12 attend a consultation at 9.00.
13 CHAIRMAN: Well, normal service will be resumed as soon as
14 possible.
15 (8.05 am)
16 (Short break)
17 (10.00 am)
18 DR HILARY HARRISON (recalled)
19 Questions from COUNSEL TO THE INQUIRY
20 CHAIRMAN: Good morning, ladies and gentlemen. For those of
21 us who weren't here as early as the rest of us were this
22 morning can I for the last time remind anyone who has
23 a mobile phone to ensure it is turned off or at least on
24 "Silent"/"Vibrate" and that no photography is permitted
25 here in the chamber or anywhere on the premises.

1 MS SMITH: Chairman --
2 CHAIRMAN: It is always pleasant to see Dr Harrison back.
3 I am sure she too hopes it is the last time, but she has
4 been sworn before.
5 MS SMITH: She has indeed, Chairman. Before I go to turn to
6 Dr Harrison's evidence, I just wanted to remind the
7 Inquiry that we have received other statements of
8 evidence in respect of the governance and finance module
9 from both the Health & Social Care Board and the
10 Department in respect of finance. It has not been
11 considered necessary to call the witnesses to those
12 statements. That will be Peter McLoughlin, Dominic
13 Burke, Thomas Frawley and Tara McBride and John Hunter
14 I think are the five statements the Inquiry has
15 received. Just to confirm the Inquiry has considered
16 them and not felt it necessary to call any of those
17 witnesses.
18 Now Dr Harrison returns again. I am going to ask
19 you a number of things, but we are going to deal with
20 both evidence in relation to Module 15, which is the
21 Kincora/Bawnmore module that we have been dealing with
22 in the past few weeks, and then I will return to deal
23 with some of the wider module 14 governance and finance
24 issues.
25 Just to be clear, the statements from you in

1 relation to the governance and finance aspect of our
2 work can be found in the GOV bundle. There is
3 a statement that you originally provided in Module 1.
4 That's at GOV13805 to 13869. There is also
5 a supplementary statement to Module 1 and that's at
6 GOV692 to 705. You provided a statement of
7 15th April 2016, which was technically in response to
8 questions that the Inquiry asked about the findings of
9 the Hughes Report, but it's also of general relevance to
10 the governance and finance issues. That's at GOV001 to
11 034. There's a further statement of 22nd April 2016,
12 which can be found at 678 to 691. A statement from
13 10th June 2016 at GOV781 to 786 and I will come back to
14 that. That's a concession statement effectively on
15 behalf of the Department.
16 There's a further statement that you filed in
17 response to issues raised by the Health & Social Care
18 Board evidence and that was dated April 2016 and that's
19 at GOV787 to 1123, which includes exhibits. In response
20 to that statement the Inquiry received a response from
21 Ms McAndrew on behalf of the Health & Social Care Board,
22 which is at GOV1302 to 1314.
23 Now, to be clear, Dr Harrison, I don't intending to
24 over all the matters where the Department and Health &
25 Social Care Board are at odds. The statements are

1 self-explanatory and the Panel will have regard to them
2 in due course. I will raise a couple of points as I go
3 through your evidence.
4 If I might deal first of all with some issues in
5 relation to Kincora itself. The inspections of Kincora
6 by the Ministry of Home Affairs were dealt with in the
7 Hughes Report at paragraphs 3.38 to 3.42. I don't think
8 we need to look at those, but that's at KIN75223 to 224.
9 They essentially found that those Ministry of Home
10 Affairs inspections were insufficient in the years
11 between 1960 and 1972.
12 The 1973 onwards were visits rather than inspections
13 by the Social Work Advisory Group, and the Hughes Report
14 refers to its findings about that paragraph 416 to 419,
15 which is at KIN752 to 54 -- sorry -- 75254 to 75255. It
16 talks about the low frequency of inspections and the
17 lack of resources that were available to SWAG during
18 that time period.
19 Now when we were talking earlier, Hilary, you
20 mentioned the fact that when you were employed as
21 a social worker and as a field social worker you were
22 actually for a period of time based in the Holywood Road
23 offices?
24 **A. Yes, that's right.**
25 Q. You actually visited Kincora yourself. You had some

1 boys whom you had placed there, and one boy in
2 particular who was there on a long-term basis in
3 Kincora. You were talking to me about the fact that
4 what has become clear to the Inquiry is, quite apart
5 from the abuse that was going on in Kincora, there was
6 issues with regard to understaffing, the fact that this
7 particular institution was set up as a hostel for
8 working boys, but was actually used for school age
9 children. What I was saying to you was that
10 inspections, as I call them, or visits by SWAG would
11 have at least picked up on that as an issue for the
12 running of this particular institution. When we were
13 talking you mentioned that you were present when Bob
14 Bunting gave his evidence to the Inquiry last week,
15 I think it was. You actually had experience of placing
16 young boys, is that right, of school age?
17 **A. Certainly not as young as some of the residents were,**
18 **but my recall is that on occasions I did place 14 year**
19 **olds on a very, very short-term emergency basis.**
20 Q. You made the point to me that Mr Mains himself would
21 have been asking, you know "What are you doing about
22 this child?" If the child went in, for example, on an
23 emergency basis over a weekend, he would have been on
24 the phone on Monday morning saying "What is the plan for
25 this particular boy". So he was not anxious to keep the

1 young boys in Kincora was your experience?
2 **A. Absolutely not. He was very diligent actually about**
3 **following up in terms of plans for any child, not just**
4 **the younger boys, but any boy who had been placed on**
5 **a short-term basis.**
6 Q. I just wanted to ask you a little bit about your own
7 impression and memories of Kincora itself. If you could
8 first of all tell us what you remember about it?
9 **A. Well, I remember in terms of the material standards**
10 **within the home they were very, very good. There were**
11 **some unusual features in that despite the fact that**
12 **there were nine or ten adolescents there, there was very**
13 **little evidence of that in the material standards of the**
14 **home, and I mean that in a good way. The home was very**
15 **pleasant. It was furnished to a good standard. As**
16 **I was explaining before, I actually had occasion to have**
17 **dinner with the boys there on occasions. I was invited.**
18 **Meals were laid out and, you know, there were**
19 **tablecloths on the tables, which wouldn't have been true**
20 **of every children's home. Everything was very nicely**
21 **served. The bedrooms, which I certainly had occasion to**
22 **visit one of the bedrooms belonging to the one that --**
23 Q. The boy you had responsibility for?
24 **A. The boy I had responsibility for slept in. There were**
25 **personal effects in those bedrooms. They were very**

1 **neat, but they weren't impersonal. That's the material**
2 **standards.**
3 **In terms of staffing and the general atmosphere in**
4 **the home, there was always an impression of a home that**
5 **was very well controlled, that Mr Mains, who was the**
6 **Superintendent, was confident, had a very -- you know,**
7 **he had a good administrative mind, that he was caring.**
8 **He, for example, was excellent at finding boys**
9 **employment situations, sometimes boys who were very hard**
10 **to place. And I can recall, for example, that the boy**
11 **that I was responsible for supervising, it was Mr Mains**
12 **rather than me as a social worker who helped him**
13 **complete his Army application form. So there were**
14 **many -- there were many good things about the home that**
15 **really, you know, in terms of what was discovered**
16 **afterwards there were no -- to me there were no obvious**
17 **signs that there should be any concerns about the care**
18 **of children.**
19 Q. Just to be clear, you were telling me that you were
20 visiting from about 1974 until '77/'78?
21 **A. Yes.**
22 Q. To that time period. During that time period it would
23 have had three members of staff?
24 **A. Yes, that's right, yes.**
25 Q. You have talked about Mr Mains. Did you have any

1 contact with the other two gentlemen?
2 **A. I knew Mr Semple. Interestingly I didn't have any**
3 **contact with Mr McGrath. In fact, I didn't even**
4 **particularly recognise his name. When I saw**
5 **a photograph of him I realised that he had been the**
6 **person on duty, say, when I might have been leaving the**
7 **boy I was supervising back to the home, but I didn't**
8 **have much contact with him. My main contacts were with**
9 **Mr Mains and occasionally with Mr Semple.**
10 Q. In respect of Mr Mains you said that he was certainly
11 a man who was not -- the home reflected him in the sense
12 that it was run fastidiously and his own personal
13 appearance, he was image conscious?
14 **A. Yes.**
15 Q. And he was fastidious about his own look, if I can put
16 it that way?
17 **A. Yes, that's right.**
18 Q. And you did say that there two things that you remember
19 particularly. The front door was always locked and
20 always opened by a member of staff; is that right?
21 **A. Yes. My recall is that any time I went to the home the**
22 **front door was always locked. Now that was unusual in**
23 **that in other children's homes normally, you know, that**
24 **wasn't the case, and often a child in other situations**
25 **would open the door. In the case of Kincora it was**

1 **always a member of staff, but I didn't see anything**
2 **sinister about that, because the boys were adolescents.**
3 **Many of them had perhaps paramilitary contacts. The**
4 **home was in a very vulnerable position in that it was**
5 **right on the front of the road and in the midst of very**
6 **severe troubles at the time. That seemed to me to be**
7 **a security precaution.**
8 Q. And you were interested to see that there was
9 a three-tier cake stand in the photographs that were
10 shown to the Inquiry when Mr Aiken was producing to you
11 --
12 **A. Yes, my memory --**
13 Q. That was something else that was unusual?
14 **A. Yes. I had remembered that. This was before I saw the**
15 **photographs. It was nice, because at the end of dinner**
16 **these cake stands were brought out. They were placed on**
17 **the tables and there was, you know, obviously very nice**
18 **things on them. That is an abiding memory with me as**
19 **well. So I was interested when the evidence came**
20 **through to see that, in fact, one of the tables still**
21 **had its three-tier cake stand.**
22 Q. Just in respect of the fact that you were invited to
23 dine, was that something that was a formal invitation or
24 was it something more spontaneous or what was the
25 position?

1 **A. My memory is it was quite spontaneous, that if I had**
2 **arranged to see the young person in the evening, as we**
3 **had to -- the boys were all working. Of course, it**
4 **wasn't unusual for social workers to be visiting in the**
5 **evening. Often Mr Mains would say, "Well, look, if you**
6 **are coming straight from work, why not join us for**
7 **dinner," and it wasn't -- you know, there was nothing**
8 **that had to be pre-arranged many weeks or days in**
9 **advance.**
10 Q. You have described having access to the bedrooms. So
11 you had full access to Kincora once you got past the
12 locked door; is that right?
13 **A. Yes, yes.**
14 Q. In the time that you were there was there anything ever
15 that caused you to think that there was anything
16 untoward going on in Kincora?
17 **A. Absolutely not, no.**
18 Q. I think you said to me that it didn't take you by
19 surprise to learn later that Mr Mains was a homosexual,
20 but again that was just something, a sense that you had
21 about rather than anything --
22 **A. Yes, I had a sense rather than anything concrete at all.**
23 Q. And, in fact, you said that he, like many men at that
24 time in the mid '70s, would have made heterosexual --
25 **A. Heterosexual comments.**

1 Q. -- comments and innuendoes?
2 **A. Yes, that's right.**
3 Q. You overheard him on the telephone doing that?
4 **A. I do recall that. It certainly wasn't a kind of routine**
5 **feature of his interactions, but I did pick have up on**
6 **occasion.**
7 Q. Nonetheless, despite that you had -- as I say, you were
8 not taken by surprise to learn --
9 **A. No.**
10 Q. -- his sexual orientation was something other than what
11 he was maybe portraying?
12 **A. Yes.**
13 Q. Just about the fact that the hostel was being used for
14 school age children and it was at some point in time
15 understaffed, not perhaps when you were there, although
16 I will come back to the staffing levels in a moment, but
17 if there had been more frequent visits do you think
18 those issues would have been picked up on? I know we
19 were having a discussion about how many visits there
20 actually were taking place in terms of what the
21 documents were showing and what Hughes found and what
22 may actually have been happening?
23 **A. Uh-huh.**
24 Q. Because you were saying the visitors' book certainly
25 wasn't recording all the visits that were taking place;

1 isn't that so?
2 **A. Yes. Well, I think we were pointing out, for example,**
3 **Mr O'Kane's visit in 1972 -- sorry -- '79 when he did**
4 **an inspection, his name doesn't appear in the visitors'**
5 **book. I know that the first time my name appears is in**
6 **conjunction with a colleague, but I was actually taking**
7 **her as a new member of staff to introduce her to the**
8 **home and staff. So I had been well acquainted with the**
9 **home before that, but I'm not there. However, apart**
10 **from that we do know that Miss Hill visited at least 12**
11 **times during the 1960s and she completed formal**
12 **inspection reports I think in '65 and '72 and would have**
13 **been --**
14 Q. We were looking earlier -- I don't think we need to call
15 it up, and I am not even sure I have the page reference
16 number, but certainly her inspection report from 1972
17 made reference to the staffing levels being the same as
18 in her earlier report?
19 **A. In her last report.**
20 Q. In her last report?
21 **A. Yes.**
22 Q. We know that at that stage in 1972 whenever she was
23 reporting or giving that inspection report, Mr McGrath
24 had started working there. So there would have been
25 a full complement of staff as it continued?

1 **A. Yes.**
2 Q. From that time?
3 **A. Yes.**
4 Q. So she was certainly not identifying any understaffing
5 at that time?
6 **A. Uh-huh.**
7 Q. Yet in 1965 neither Mr Semple nor Mr McGrath were
8 working at Kincora. So, therefore, it wasn't the last
9 report from 1965 that she was referring to, so there
10 must have been something in between times. Is that what
11 you are saying?
12 **A. Yes. I think from that we are assuming that reports**
13 **were made of visits and she does not say "Since my last**
14 **inspection". She says she stated it was since her last**
15 **report.**
16 Q. Just for completeness, the monitoring recommendations of
17 Hughes are set out in KIN75356 at paragraph 13.42. If
18 we could just maybe look at that, please, briefly.
19 75356, paragraph 13.42 there says:
20 "We have made the point that some of the monitoring
21 activities to which we inquired where by their nature of
22 limited value for the prevention of detection of
23 homosexual offences. This did not, however, lead us to
24 the conclusion that the activities were not worthwhile."
25 I am not going to read out the whole paragraph, but

1 if we scroll down to 13.53, which I think is three
2 pages ahead. It is at 75353. It talks about the SWAG
3 inspections. It says:
4 "In June 1980 the Department introduced a more
5 formal and detailed system of inspection of children's
6 homes and hostels. Under the new system two social work
7 advisers spent at least three days in each home and the
8 inspections covered."
9 And it sets out there. It goes on to talk about
10 annual inspections and then full scale inspections to be
11 carried out at five yearly intervals and what they were
12 going to cover.
13 So the plans had already been put in place by the
14 Department prior to Hughes Reporting. Once the Kincora
15 scandal arose the Department took steps to essentially
16 improve the regime, the inspection regime; isn't that
17 correct?
18 **A. That's correct.**
19 Q. Now if I might turn to the statement which is at GOV003,
20 and this is your statement of 15th April 1916 (sic),
21 because I am going to look at what, if we can term in
22 short terms the Seebohm issue. Can we go, please --
23 that's GOV003.
24 EPE OPERATOR: Give me a minute.
25 MS SMITH: Just checking we have the bundle there. Sorry.

1 Just before I move on from that, Hilary, I am moving on
2 now to more general governance issues, but is there
3 anything else you wanted to say specifically about
4 Kincora itself or anything before I do move on?
5 **A. Well, I just think it might be worth mentioning**
6 **something we didn't discuss earlier. That was that**
7 **I actually did investigate a complaint against Mr Mains**
8 **made by the boy whom I was supervising. I think I gave**
9 **evidence to this effect in the Hughes Inquiry. It was**
10 **nothing to do with inappropriate -- certainly not**
11 **inappropriate sexual behaviour, but the boy concerned**
12 **had felt quite free to call me and say "This happened to**
13 **me and I am not happy he about it". I mean, I can**
14 **explain the circumstances if necessary, but it was just**
15 **to say that even that boy himself who was in the home**
16 **for a number of years was completely unaware of any of**
17 **the activities taking place within it, and certainly had**
18 **he been the subject of any kind of assault, sexual**
19 **assault, then I have no doubt that he would have**
20 **immediately notified us to that effect.**
21 Q. I think that is certainly helpful information?
22 **A. Uh-huh. Uh-huh.**
23 Q. So what you are essentially saying is that not only were
24 you as a visitor to the establishment not aware of
25 anything untoward going on, but a resident who had been

1 there for a long time was unaware of anything going on?
2 **A. Yes, and he --**
3 Q. -- certainly he never told you of anything.
4
5 **A. Yes, and he gave a statement to the police.**
6 Q. To that effect?
7 **A. To that effect, yes.**
8 Q. The statement on the screen here, if we can just maybe
9 scroll down, please, to paragraph 2.2. I am going to
10 paraphrase this and please forgive me if I misstate
11 anything that's in your statement, because it is
12 certainly not my intention to do that.
13 Essentially in paragraph 2.2 you are saying that --
14 and we have looked at this in previous modules -- the
15 lack of inspection of voluntary homes established by the
16 Ministry of Home Affairs diminished regularly during the
17 '70s, and you are saying that reflected a conscious
18 shift, a policy shift on the part of the DHSS when it
19 was reorganised. I should say when the Social Services'
20 landscape was reorganised in 1972/'73. You are saying
21 that that policy shift was influenced by the Seebohm
22 report, that was a UK report and that the ethos, if you
23 like, of that report was not so much regulatory as
24 promotional and educational, and that even the very
25 title -- we had this discuss in previous modules -- the

1 very title, Social Work Advisory Group"?
2 **A. Yes.**
3 Q. Rather than Social Services Inspectorate, which it
4 eventually morphed into, the clue was in the title, as
5 it were.
6 At 2.4, if we can scroll down, you are saying that
7 this was essentially a deliberate policy intent on
8 behalf of the DHSS to move away from inspections to this
9 Seebohm influenced regime. Regime is maybe too strict
10 a word for what was happening?
11 **A. Uh-huh.**
12 Q. You certainly can't point to any minutes of any meeting
13 to show that there was in deliberate shift; isn't that
14 correct?
15 **A. That's correct, and I would have to stress that we are**
16 **proposing this. We are not saying that this was**
17 **an actual case. We are suggesting that this may have**
18 **explained the shift, but whilst we can't point to any**
19 **policy documentation or minutes that actually set that**
20 **out as a fact, it is interesting that when Mr Wilde, who**
21 **was the then Chief Social Work Adviser, was writing to**
22 **the Permanent Secretary following the Kincora scandal**
23 **actually uses the words in his minute "Regulatory and**
24 **Expectorial" and "Promotional and Educational" with**
25 **reference to the role of SWAG, which is actually**

1 **virtually a direct lift from the Seebohm report. Now**
2 **I don't think those words would necessarily have been in**
3 **his head. I think he may well have been referring to**
4 **some documentation to hand.**
5 Q. I think perhaps if I might just sum up, as it were. You
6 sitting here in 2016 and, in fact, the years that you
7 have been involved in representing the Department for
8 the Inquiry, you were trying to work out: why did we
9 move from what had been happening under the Ministry of
10 Home Affairs where we had these formal inspections being
11 carried out to this situation where there's this gap?
12 **A. Yes.**
13 Q. And attempting to answer that question of why did this
14 happen, you set about doing your own research; isn't
15 that correct?
16 **A. Yes.**
17 Q. You examined the position with regard to England and
18 what social work service did in respect of inspections
19 of voluntary homes in England, and we have seen
20 correspondence -- I don't know that I need to call it
21 up -- there is correspondence between yourself and
22 Sir William Utting which is at GOV1224. You also wrote
23 to David Gilroy?
24 **A. Yes.**
25 Q. I think that letter is at 1227. Sorry. Yes. I think

1 it is maybe 1297. For completeness there is a history
2 that he wrote of the Social Services Inspectorate in
3 England. That history is at 1229 to 1296. So it's in
4 the bundle there.
5 Maybe if we just look -- after writing to Mr Gilroy
6 you then had a telephone discussion with him. You
7 followed that up with a letter to him, if we look at
8 that, please, it is 1299. That letter sets out the
9 summary of your conversation with David Gilroy and you
10 asked him to confirm the accuracy of that and he
11 subsequently does that. So it is GOV1299.
12 EPE OPERATOR: It is not just coming up at the moment. Are
13 you sure that's it?
14 MS SMITH: It should be. Maybe the bundle has not been
15 updated. 1299 to 1300. Two pages. Well, while we are
16 doing that I actually have it here. So I will maybe
17 read out just what you said in that, obviously I have
18 not lifted it. I have got 1298.
19 MS DOHERTY: 1297.
20 MS SMITH: 1297 is the first letter to Mr Gilroy, but after
21 the telephone conversation you wrote to him again?
22 MS DOHERTY: 1299 or it's at LIS13818.
23 MS SMITH: Perhaps if you have the LIS bundle.
24 EPE OPERATOR: Yes.
25 MS DOHERTY: 13818.

1 MS SMITH: Look at 13818, please. Thank you.
2 EPE OPERATOR: No. I just need a minute.
3 MS SMITH: I haven't got the LIS bundle.
4 EPE OPERATOR: I do, but that particular one is not coming
5 up. I will just check with the machine.
6 MS SMITH: We are having some difficulties.
7 CHAIRMAN: Perhaps you would just read out the relevant
8 passages.
9 MS SMITH: Unfortunately, I have got his response but I am
10 not sure whether I have actually got the ...
11 CHAIRMAN: Ms Doherty will pass it up to you.
12 MS SMITH: I am very grateful. Thank you. Thank you very
13 much. Yes. This is your letter to him which is dated
14 18th May 2016. I will just read it out in full. It
15 says:
16 "I really appreciate our helpful discussion on 12th
17 May 2016 and the details you were able to provide
18 through this and subsequent e-mail correspondence in
19 relation to your experience of the work of the Social
20 Work Service and the Social Services Inspectorate in
21 England.
22 You are a former Deputy Chief Inspector SSI England.
23 You explained that you joined a regional team of the
24 SWS/SSI's predecessor body in 1976, some five years
25 after the SWS had been established by the Department of

1 Health and Social Security.
2 With reference to the question of inspections of
3 children's homes by the SWS during the 1970s, you did
4 not have access to documentation to support the
5 following information, but it reflects your recollection
6 of the position at the time."
7 You then set out a number of points:
8 "1. Voluntary homes 'were visited' by SWS officers
9 rather than inspected by inspectors in accordance with
10 the corporate SWS style. Though the overall programme
11 of visits was conducted under powers of inspection
12 vested in the Secretary of State."
13 So if I might pause there, essentially there was
14 a power of inspection for children's homes and for
15 voluntary children's homes and that was interpreted as
16 being visits rather than inspections; is that correct?
17 **A. Yes. Yes, that's right.**
18 Q. "The DHSS/SWS policy was that such visits should be made
19 to each voluntary home annually."
20 You believe this policy was in place from the
21 inception of SWS in 1971. You yourself undertook some
22 visits to voluntary children's homes and confirm that
23 these were conducted in an advisory, supportive and
24 developmental style as described in the extract from
25 page 8 of your history of the Social Services

1 Inspectorate.
2 This you learned was in contrast to a more formal
3 style of inspection which you understood to have been
4 formally adopted by Home Office Children's Inspectors,
5 some of whom had joined the SWS when the Home Offices's
6 childrens homes inspection functions passed to the DHSS
7 in 1971.
8 Again, if I might pause there, that's consistent
9 with had happened in Northern Ireland?
10 **A. That's right.**
11 Q. There was a more formal regime under the Ministry of
12 Home Affairs and then the DHSS moved to SWAG.
13 When you joined SWS in 1976 there were no centrally
14 devised protocols or guidelines to support the conduct
15 of SWS visits to voluntary homes or the issues to be
16 considered during the visit. Nevertheless, the
17 procedure was that following each visit a report on the
18 home was to be forwarded to child care branch within the
19 DHSS. These reports were not shared with the
20 administrative authorities of the home or local
21 authorities again similar to the situation in Northern
22 Ireland. A follow-up letter which provided feedback in
23 relation to the visit was to be sent to the homes
24 administrating authority. If issues of concern or
25 matters requiring further attention were identified, an

1 agreement was made with the Childcare Branch to
2 undertake a further visit to the home or take such other
3 action as deemed necessary.
4 With reference to the statutory homes, to the best
5 of Mr Gilroy's knowledge there was no SWS practice of
6 systematically visiting statutory homes either formally
7 or informally within your regional team between '76 and
8 '85.
9 Indeed, when we spoke he commented in 1985 when the
10 newly formed DHSS Social Services Inspectorate undertook
11 a programme of inspection of a large sample of statutory
12 homes, there was a sense that this was an important
13 first priority for the SSI.
14 I should be very grateful if you would confirm that
15 this is an accurate reflection of our discussion."
16 He did confirm that by letter of 18th May 2016,
17 which is in the bundle -- we now have things up on the
18 screen -- at 1301, GOV1301.
19 Essentially those were the points that he was
20 confirming that you had had a discussion with about him
21 in the letter which is now there on the screen.
22 What you were trying to do there was try to
23 ascertain what the position was in the UK versus
24 Northern Ireland. Certainly from 1980 in Northern
25 Ireland the position was different to that in England,

1 although in the '70s it seems to have been very similar?
2 **A. Yes. Well, if I could perhaps trace the history of why**
3 **the contact with David Gilroy was made. I had been in**
4 **touch with Sir William Utting, who had confirmed his**
5 **understanding also of the fact that Seebohm influenced**
6 **the establishment of the Social Work Service in England**
7 **and that it was a deliberate policy move away from the**
8 **old style inspection regime that existed within the**
9 **Department of Home Affairs -- sorry -- the Ministry of**
10 **Home Affairs.**
11 **I contacted Sir William Utting again, because**
12 **obviously questions were asked. We were wanting to ask**
13 **questions about then having moved away from a more**
14 **formal mode of inspection, what did happen with**
15 **voluntary homes, etc? He had mentioned in his letter**
16 **that he believed voluntary homes were visited regularly**
17 **because they were required to be registered by the**
18 **Secretary of State.**
19 **He, however, had no direct knowledge of how this**
20 **worked out. He was not able to tell me how frequently**
21 **this happened, and he referred me to David Gilroy, whom**
22 **he had said, "Well, if I can trace him, he is the person**
23 **who has direct knowledge".**
24 Q. And having done that, what Mr Gilroy was telling you was
25 "Well, actually yes, the regime was for annual

1 inspection of voluntary homes in England."?
2 **A. Yes, he was quite clear this was the policy. He didn't**
3 **have access to documentation, so we are really unable to**
4 **tell whether that policy was adhered to, but certainly**
5 **his recall was that was the policy.**
6 Q. Nonetheless, the policy would appear to have been
7 different from that in Northern Ireland?
8 **A. I think it's fair to accept that we have no evidence**
9 **that Northern Ireland prior to 1976 had adopted a policy**
10 **of annual visitation of voluntary homes and, you know,**
11 **I was pointing out earlier that it is interesting that**
12 **Mr Gilroy joined SWS in 1976 when it would appear that**
13 **our own SWAG revised their policy.**
14 Q. I will come back to 1976 but the fact that in 1976 SWAG
15 were saying "We need to move to an annual inspection
16 basis" actually confirms the fact that it wasn't taking
17 place annually prior to that?
18 **A. Yes. They stated that they wished to move to provide**
19 **an annual report, a report annually on each voluntary**
20 **home. So yes, that does imply those reports --**
21 Q. Were not happening?
22 **A. -- were not happening annually in every case.**
23 Q. At paragraph 2.5 of your statement at GOV005, you say
24 that that policy intent was not known to the Hughes
25 Inquiry. It is possible you think if the policy intent

1 had been known and made more explicit within the
2 evidence of the Hughes Inquiry, this might have tempered
3 some of the comments in the Hughes Report regarding the
4 DHSS record of frequency of inspections during the 1970s
5 period.
6 I think it is fair to say certainly from our
7 perspective, perhaps not from the Department's, but the
8 Hughes Report was critical of the Department for not
9 carrying out inspections between the period '72 to '83.
10 I know '80 moved on, but that was post Kincora and is
11 a reaction to that, if I might suggest, once the Kincora
12 scandal broke.
13 But surely if it was a deliberate policy and given
14 the fact that we cannot find, you in your searches
15 cannot find anything to suggest that it was such
16 a deliberate policy other than the fact there was this
17 clear movement in terms of what was happening on the
18 ground, surely the Department would have briefed those
19 senior people who were giving evidence to the Hughes
20 Inquiry and they would have stated that at the time,
21 that "We actually had this move. We moved away from the
22 more formal inspections to visits and to more
23 educational, advisory approach". I was putting it
24 bluntly to you when we were speaking earlier, I am going
25 to ask you: is this not just an attempt to try to roll

1 back, as it were, from what was accepted by senior
2 departmental representatives before the Hughes Committee
3 as a failing?
4 A. **Yes, and the Department fully endorsed the findings of**
5 **Hughes in relation to that period, that there was**
6 **an inadequate attention given to the need to regularly**
7 **review and inspect voluntary homes.**
8 **I think what we were trying to say was that we were**
9 **concerned -- the Department was concerned as much as**
10 **anyone about why this major policy shift had taken**
11 **place, and the interesting thing is when you review the**
12 **oral evidence given in Hughes and, indeed, the Hughes**
13 **report, it does not actually comment on what seems to me**
14 **to have been a very fundamental question as to whether**
15 **we move from a process of what would appear to have been**
16 **regular visitation, annual visitation by two inspectors**
17 **in, you know, up to the '70s to something that certainly**
18 **didn't replace that with something of the same ilk. It**
19 **just seems to me that there were questions there that**
20 **weren't asked.**
21 **In terms of why the senior civil servants did not**
22 **offer up that information by way of explanation, again**
23 **this is pure conjecture, but they were appointed**
24 **directly at that time. Dr Hayes only I think came to**
25 **the Department at the time of reorganisation. Mr Wilde,**

1 **who was the chief adviser, and Mr Armstrong, who was the**
2 **Deputy Chief, they also came just after the decision had**
3 **been taken to implement the new organisational**
4 **structures. So it would appear that the policy was**
5 **already a fait accompli by the time they were actually**
6 **placed in post at the time, you know, the SWAG group was**
7 **constituted, and again I was able to view the employment**
8 **contract of one of the inspectors, who was also**
9 **appointed around that time. There is no mention of**
10 **inspections.**
11 **So they did not seem to have access to that**
12 **information. Why I don't know, and why no-one asked the**
13 **question, which seems to us today to be an obvious**
14 **question to ask, I cannot explain that, but we would**
15 **stress we are not trying to diminish the findings of the**
16 **Hughes report in any way or its criticisms. We are just**
17 **saying that that might have provided an explanation as**
18 **to why there was a much more kind of what seemed to be**
19 **a laissez faire approach, but actually wasn't. It**
20 **wasn't about complacency. It wasn't about people saying**
21 **"We don't need to bother to do this any more". It did**
22 **appear to be a deliberate policy shift towards advisory**
23 **and supportive relationships.**
24 Q. If it were a deliberate policy shift it wasn't a good
25 policy; I think you would accept that?

1 **A. I think the Department would accept that, and actually**
2 **have accepted that by 1976.**
3 Q. Yes, because you go on to talk about in paragraph 2.6
4 here on the screen that SWAG recognised itself that the
5 less formal approach wasn't working by 1976 and resolved
6 to report annually, as we were saying, but that did not
7 happen because of lack of resources. So even though
8 SWAG are saying to the Department "Look, this is not
9 working. We really need to put this on to a more formal
10 footing and go back to the kind of reports we were
11 producing before reorganisation", the Department did not
12 resource them to allow them to do that; isn't that
13 correct?
14 **A. Yes. The resources weren't available to allow them to**
15 **do that, but we accept that they should have been made**
16 **available.**
17 Q. Essentially even though SWAG are asking in 1976, you
18 know "Let us do this. This is the route we want to go
19 down", it really was only rectified when the Kincora
20 scandal broke. So it would be speculation to say it
21 might never have happened or it might have happened some
22 time much later, but the fact that the Kincora scandal
23 broke, then that actually woke up the Department to the
24 fact that "Actually, we really need to do something
25 about this here"?

1 **A. Uh-huh.**
2 Q. As I have explained, the Inquiry has seen the formal
3 inspections of every children's home that was carried
4 out from 1980 onwards, including the training schools,
5 took place in advance of the Hughes Inquiry?
6 **A. Yes, that's right.**
7 Q. There is further discussion on this in the annexe to
8 your statement, which is at 010 to 14, which is
9 an extract from your statement that you gave us in the
10 Sisters of Nazareth Belfast module. I don't propose to
11 go over it but just to highlight that's where that is.
12 You then gave a statement of 22nd April 2016, which
13 is at GOV689. Yes. This was again about inspections in
14 England by the social work advisory homes -- voluntary
15 homes. Again there is a further discussion on the issue
16 of Seebohm particularly relating to, I think, Harberton
17 House.
18 Scroll on down through that, please, to the next
19 page. I am not quite sure -- yes. That's again
20 paragraph 6 there you are talking about the Seebohm and
21 discussing it with Sir William Utting as you have
22 described?
23 **A. Yes.**
24 Q. I am just highlighting that for complete necessary. If
25 we could go back to GOV007 at 4.2, Mr Armstrong, who was

1 then the Chief Social Work Adviser, conceded to Hughes
2 that there were 1974 guidelines on staffing of homes
3 issued and those guidelines in Northern Ireland were
4 lower than those recommended in the Castle Priory
5 report. The reference from the Hughes material is at
6 KIN70500 onwards where Mr Armstrong was giving evidence.
7 Why were the guidelines that the Department devised
8 for Northern Ireland lower some six years after Castle
9 Priory reported lower than what was recommended in
10 Castle Priory?
11 **A. Yes. I am afraid the Department is unable to offer any**
12 **explanation for this. We don't know. We have no**
13 **documentation that shows on what basis these ratios were**
14 **calculated. We know that by '74 obviously the Castle**
15 **Priory staffing ratios would have been very well-known**
16 **and certainly advisers should have been very well**
17 **acquainted with those, but I am sorry. We just don't**
18 **have an explanation as to where the lower ratios came**
19 **from. We do know, however, that from 1980 onwards when**
20 **the inspection really -- the rigorous inspection**
21 **programme was established that the standards under which**
22 **the staffing ratios in all homes were considered by**
23 **social work advisers and then inspectors were the Castle**
24 **Priory standards.**
25 Q. But the -- that was not the case prior to 1980, number

1 one, because the inspections weren't being carried out;
2 number two, the guidelines from 1974 were only requiring
3 homes to have much lesser standards than Castle Priory,
4 and might one of the reasons -- and I appreciate this is
5 speculation and you have no knowledge of this -- might
6 one of the reasons be -- could it have been costs,
7 because obviously if you need less staff for children in
8 a home, then that's going to reduce the cost of running
9 that home?
10 **A. It's possible. The other -- I didn't really think very**
11 **much about this before today -- well, before this**
12 **morning -- but the other -- the other thing I was**
13 **wondering was the -- the staffing in voluntary homes --**
14 **many of the faith-based homes, as you know, had staff**
15 **who were obviously members of orders and were there much**
16 **longer hours, etc, and it might have been something to**
17 **do with the fact of recognising their contribution and**
18 **that there were -- you know, in terms of calculating**
19 **those staffing ratios it might have required fewer**
20 **bodies to have the level -- the kind of ratio of staff**
21 **on at one any time within child ... -- I am sorry. This**
22 **is a very circuitous argument, but I find it as much of**
23 **a mystery as you do as to where these came from, but it**
24 **might have been something to do with that and therefore**
25 **they might accept that there were so many bodies to**

1 **certain numbers -- a ratio of certain bodies to children**
2 **as opposed to staff working regular hours.**
3 Q. That would certainly apply perhaps, that argument, to
4 a voluntary home --
5 **A. To the voluntary sector, yes.**
6 Q. -- but it wouldn't apply to the statutory homes.
7 **A. I accept that.**
8 Q. Just to be clear then, I take it -- and I think I know
9 the answer to this from having spoken to you -- but does
10 the Department accept the evidence given to Hughes by
11 its witnesses: Dr Hayes, Mr Buchanan and Mr Pat
12 Armstrong?
13 **A. We do, yes.**
14 Q. If so, then does the Department accept the finding of
15 the Hughes Inquiry? I know -- I am going to tease that
16 out a little bit, because we were having this
17 discussion, and I am just going to refer to
18 page references. I don't need to call it up, but what
19 actually happened -- and please if I have this wrong,
20 correct me -- but the Department received the Hughes
21 Inquiries. It considered them. It accepted some and
22 implemented them. Others it consulted with the boards
23 in respect of and ultimately either accepted or rejected
24 those recommendations.
25 For example, just to give one example of that would

1 be the question of vetting people as to their sexual
2 orientation and whether there should be an absolute bar
3 on homosexuals working in children's homes was one of
4 the things they looked at and consulted on and
5 ultimately determined that it should not be a total bar.
6 Isn't that correct?
7 **A. Yes, that's right.**
8 Q. There is a document -- a letter was sent out to all of
9 the boards -- and I don't think we need to look at it,
10 but it is at HIA4307 through to 4325 -- which was the
11 Department informing the boards of their response to the
12 Hughes' recommendations and what progress had been made
13 on those that it accepted and what consultations it was
14 engaging on in those that it was engaging in
15 consultations about. Isn't that correct?
16 **A. Yes.**
17 Q. So while it is true to say that -- I think it is fair to
18 say that by and large the Department accepted the
19 findings of the Hughes and set about implementing most
20 of the recommendations?
21 **A. Yes.**
22 Q. There was nonetheless a discussion about some of those
23 recommendations?
24 **A. Yes. I think we can say that certainly we accepted the**
25 **findings of the Hughes Inquiry. The recommendations**

1 **arising from those findings we accepted -- we**
2 **implemented most of those, but some we decided not to**
3 **implement or to give further consideration to.**
4 Q. Equally around the same time there was the Sheridan
5 Report that the Department had sought. Again the
6 recommendations of Sheridan, I think you were telling me
7 that, bar one or two, the Department accepted those.
8 For example, one thing that was rejected was the issue
9 of joint inspection, because that was not seen to be
10 independent.
11 **A. Yes, that's right.**
12 Q. It wouldn't have been an independent inspection if the
13 Department had allowed board members to help inspect
14 homes in which they were placing children.
15 **A. Yes, that's right.**
16 Q. I don't think the boards in fairness to them were either
17 pushing for that either.
18 **A. I don't think they were anxious to have that**
19 **responsibility.**
20 Q. At GOV682 at paragraph 1.16 you say that:
21 "The Black Report, the Sheridan Report and Hughes
22 resulted in a raising of the bar in respect of child
23 care services in Northern Ireland to a level beyond what
24 might have been achieved by the introduction of
25 legislation in the period 1968 to 1995."

1 But what about the argument that has been made and
2 forcibly made by the Health & Social Care Board that
3 legislation and accompanying regulations is essentially
4 at the heart of accountability and that's where
5 accountability really rests? I mean, I am being
6 tautologous, but do you see the point that's being made?
7 I think when we were having a discussion, you said that
8 it is not the only means by which people can be held
9 accountable.
10 **A. That's right, yes. I mean, we don't -- the Department**
11 **would not dispute the fact that the legislative**
12 **framework is extremely important and certainly contains**
13 **core elements, which, because they have a statutory**
14 **imperative, then, you know, they're -- by virtue of that**
15 **fact we can be certain that people are giving them**
16 **attention. They are not always -- even that in itself**
17 **does not always guarantee that the conditions of**
18 **regulations, etc, are met, as we know from, well, the**
19 **evidence before this Inquiry.**
20 **I think the particular point that the board was**
21 **making was really in respect of one issue, which was to**
22 **do with the monthly visiting of children in residential**
23 **care, the fact this was not placed on a statutory**
24 **footing, and we were trying to address the question**
25 **that, in fact, in relation to that particular issue the**

1 **practice by the time the Hughes Inquiry had reported had**
2 **been so firmly embedded in practice that it would not**
3 **have appeared to have been necessary at that stage to**
4 **introduce any changes by way of regulation.**
5 Q. But that practice only came about as a result of steps
6 taken in the Eastern Board, as I understand it. It
7 might not have been consistent across the whole of the
8 region?
9 **A. Prior --**
10 Q. Certainly by the time of the Hughes --
11 **A. -- yes. The Eastern Board was the first certainly to**
12 **implement that programme of visiting. I think the**
13 **Southern Board gave evidence to the Hughes Inquiry in**
14 **effect that it didn't have the resources to implement**
15 **that in full, but by the time the Hughes Inquiry**
16 **reported the Department had made it a requirement in its**
17 **monitoring and standards guidance that all children in**
18 **residential care had to receive a monthly visit from**
19 **social workers, and they looked at that particular issue**
20 **in each of the inspections that took place of both**
21 **voluntary and statutory children's homes.**
22 Q. But I suppose the point that the board was making,
23 Health & Social Care Board was making was the fact there
24 was an opportunity missed here to put it on a statutory
25 footing whenever the 1968 Act was passed, because it was

1 a requirement of foster care, children who were boarded
2 out that they had to be visited every month but not the
3 children in residential care, and that was
4 an opportunity missed?
5 **A. Within regulations it is likely to have been placed --**
6 **it would have been placed in regulations as opposed to**
7 **legislation.**
8 Q. Yes. Sorry. The regulations?
9 **A. I can't explain the fact that for many, many years, not**
10 **just here but in other parts of the UK there has not**
11 **been a statutory imperative in regulation for children**
12 **in residential care to be visited monthly. I can only**
13 **speculate that it has been deemed -- I don't believe**
14 **that that's because it has not been given any**
15 **consideration. I can only speculate that it was due to**
16 **the fact that children in residential care were deemed**
17 **to be in a much more secure position, less isolated**
18 **position than a child in foster care because they were**
19 **surrounded by several staff, by several other children.**
20 **In the case of the statutory homes, these people who had**
21 **the charge of children were actually employees of the**
22 **statutory body, and in the case of voluntary homes they**
23 **had been appointed by the administering authority who**
24 **was charged with ensuring the welfare of the children,**
25 **and it must have been something to do with the fact that**

1 they were deemed to be sufficiently secure without
2 additional statutory safeguards. Now whether that is
3 a plausible argument or not, you know, I don't feel it's
4 up to me to say, but I think that may have been the
5 thinking and, as I pointed out, that it is only very
6 recently that this has been implemented in other parts
7 of the UK. They actually have a lower standard than we
8 have in Northern Ireland in terms of frequency of
9 visiting.
10 I should also say that when we introduced the
11 Children Order, which would have been the most obvious
12 place for that kind of regulatory requirement to be
13 found, there were several consultation groups
14 established, including a focus group on residential
15 care, and that group considered all of the guidance to
16 the volumes of Children Order -- sorry -- volume 4 of
17 the Residential Children Order Guidance. They
18 considered it in draft form. The regulations were also
19 put out for consultation as, of course, was the primary
20 legislation. We have no evidence whatsoever that this
21 matter was raised in any of those consultations and, in
22 fact, I spoke to someone who would have been responsible
23 for, just recently responsible for being part of that,
24 and he could not recall that it was ever raised as
25 an issue.

1 **So whether it was given consideration and discounted**
2 **or whether the Hughes recommendations slipped off the**
3 **radar, I am not sure. I think what the Department is**
4 **confident about is that regular visitation of children**
5 **in residential care, monthly visitation has taken place**
6 **since 1970.**
7 Q. May I just ask another option? The Children's Officer
8 was lost in translation in the move to the DHSS and that
9 layer of safeguarding, if I can put it that way, was
10 lost by the fact that that role no longer existed under
11 the new legislation. Is there anything you wanted to
12 say about that?
13 **A. Well, I think I have tried -- we have tried to address**
14 **that point in the Department's statement that in fact**
15 **there was that gap had no practical effect, because the**
16 **Department had given approval to the children's officer**
17 **duties being discharged, in some cases by assistant**
18 **children's officers, and those visits continued, and**
19 **I think the Board have confirmed that, that those visits**
20 **continued during the whole of the reorganisation period.**
21 **Sorry. I need to correct something I said earlier.**
22 **I said that the monthly visiting was in place since**
23 **1980. I would have to say that we could only suggest it**
24 **was in place since about 1985 or '86 when the standards**
25 **were agreed by boards.**

1 Q. That was the monitoring standard?
2 **A. I can confirm that with certainty.**
3 Q. If I might move on to another issue shortly. This was
4 about the sharing of inspection reports with homes. Now
5 in the earlier years the Inquiry has seen that there
6 were extracts certainly of inspection reports that were
7 shared with a home and, indeed, in some cases with the
8 board, but they were not shared -- sorry -- they were
9 shared with the voluntary homes. They were then shared
10 with the voluntary homes themselves, but not with the
11 boards, although some may have been seen informally.
12 I know you talk about this in your response to
13 Ms McAndrew's statement, but Ms McAndrew has come back
14 and said what Mr Carroll actually said to Hughes was he
15 may have seen one or two reports, but did not have any
16 regular access to them.
17 Is it not the case that if the reports had been made
18 available to the boards they would have been alert to
19 concerns about particular institutions more readily?
20 **A. Certainly there would have been great advantage in the**
21 **sharing of reports, but it would appear that that was**
22 **kind of the accepted practice of the day and, in fact,**
23 **was reflected, as you will see from David Gilroy's --**
24 **Mr Gilroy's correspondence that that was also the**
25 **position in England, and there was no doubt a reason for**

1 **that about protecting confidentiality of information we**
2 **have seen instances where there were concerns about the**
3 **care of children placed by welfare authorities in boards**
4 **raised with and discussed with the Welfare Authority and**
5 **the board by the Department. I would find it very**
6 **difficult to accept that had there been a major issue**
7 **with a voluntary home in which there were children of**
8 **a Welfare Authority or a board placed that the Welfare**
9 **Authority and board would not have been alerted to that**
10 **fact.**
11 **Now this could be that there were other things in**
12 **the reports that welfare authorities and boards did not**
13 **see or weren't aware of but, you know, I would suggest**
14 **that any kind of material facts that, you know, that**
15 **suggested there were further concerns about the care of**
16 **children who were in the care of welfare authorities or**
17 **boards, I would be surprised if that was not made known**
18 **to the welfare authority or board. I don't have the**
19 **hard evidence to --**
20 Q. Support that?
21 **A. 0support that but, you know, looking at the way the**
22 **inspectors worked and the fact that they were in**
23 **continuous contact with both welfare authorities -- not**
24 **just childrens homes but the welfare authority**
25 **administering bodies and staff there. I would be**

1 **surprised if even information was not sought at times**
2 **from welfare authorities about how they viewed the care**
3 **in the home. In fact, I think some of the oral evidence**
4 **to Hughes shows there was a kind of policy of**
5 **consultation and that the boards relied on information,**
6 **if not the reports, but information in relation to the**
7 **experience of care of other children.**
8 Q. Well, I am now going to turn, if I may, to what the
9 Department accepts. Now this was in specific response
10 to questions asked by the Inquiry about what systemic
11 failings the Department accepts.
12 If we can go, please, to 782, GOV782. This is
13 a statement of 10th June 2016, which was not available
14 when we were dealing with the governance and finance
15 module back in April. Can we go to that, please,
16 GOV782?
17 EPE OPERATOR: I don't have that.
18 MS SMITH: It is important that that be able to be seen.
19 I am going to have to read out from a hard copy, Hilary.
20 It is page 72. You say that the statement has been
21 provided on behalf of the Department of Health, the
22 Department, in response to question 7 of the HIAI
23 request by e-mail dated 11th March 2016. It goes on to
24 say that:
25 "The contents of the statement have been agreed by

1 the First Minister and Deputy First Minister on behalf
2 of the Northern Ireland Executive."
3 CHAIRMAN: Sorry to interrupt. Can we not bring that up on
4 the screen?
5 EPE OPERATOR: I don't have it.
6 CHAIRMAN: I see.
7 MS SMITH: I am not sure why that is the position. We will
8 certainly try to rectify it. Can I just in respect of
9 that -- I will just ask that first point, and maybe we
10 can get the bundle updated for the rest of them.
11 CHAIRMAN: I think we will rise now until it is updated
12 because it is extremely important we have it on the
13 screen.
14 MS SMITH: Indeed.
15 (12.00 noon)
16 (Short break)
17 (12.10 pm)
18 MS SMITH: Hilary, just before I move on to what's on the
19 screen here, I am going to deal with it in a moment, but
20 can I just confirm a couple of other things we were
21 talking about? You boy whom you had care of who was
22 based in Kincora and made a complaint to you, I am not
23 going to ask you for his name, but if you would write
24 his name down so that the Inquiry can check through the
25 papers that it is relevant to him, and particularly I am

1 thinking of the police material in respect of him so we
2 can check that out. We may need a small statement to
3 that effect if you are willing to do that, just submit
4 it some time.
5 Can I just also confirm in respect of him when he
6 did complain to you was he still resident in Kincora, he
7 was?
8 **A. Yes, he was.**
9 Q. So it wasn't something he complained about later,
10 afterwards?
11 **A. No.**
12 Q. And there was one other thing that I was going to ask
13 you. It will come back to me I am sure. Oh, yes. Just
14 to highlight that in your statement you make reference
15 to the fact that although there wasn't a statutory
16 requirement to visit children who were resident in
17 children's homes, I think you make the point that
18 nonetheless there was another level of scrutiny in that
19 children's officers were going in to visit homes?
20 **A. Statutory homes, yes.**
21 Q. Statutory homes?
22 **A. On a monthly basis.**
23 Q. And obviously the administrating authority in voluntary
24 homes ought to have been doing that, whether they were
25 or not --

1 **A. Yes.**
2 Q. But the problem for the Department, if I can put it that
3 way, was they did not scrutinise the scrutineers?
4 **A. Absolutely and we accepted that. I think also in**
5 **relation to statutory homes, members of the Personal**
6 **Social Services Committee in the case of boards and**
7 **members of the Welfare Committee in the case of Welfare**
8 **Authorities were also visiting.**
9 Q. Yes.
10 **A. Monthly and that was subsequently reduced to quarterly**
11 **but they were going in as well.**
12 Q. Yes, so the homes were being visited but not the
13 individual children resident in them?
14 **A. No, that's right.**
15 Q. Just coming back now to the statement, what I am going
16 to call the concession statement, if I can put it that
17 way. We have now managed to get it on the screen. It
18 says:
19 "This statement is being provided on behalf of
20 Department of the Department of Health (The Department)
21 in response to question 7 of the HIAI request by e-mail
22 dated 11th March 2016. The contents of the statement
23 have been agreed by the First Minister and Deputy First
24 Minister on behalf of the Northern Ireland Executive."
25 Now obviously the office of First Minister and

1 Deputy First Minister have nothing whatsoever to do with
2 the Department in terms of it wasn't the successor body
3 of the Ministry of Home Affairs or the DHSS, so why was
4 the First Minister and Deputy First Minister signing off
5 on this statement, as it were? Could you please just
6 explain that and put it on the record as to why that
7 occurred?
8 A. **Yes. First of all, I want to offer an apology because**
9 **on reading that statement, which was approved by the**
10 **Department before it was submitted to the Inquiry, the**
11 **Department would accept that it is misleading on first**
12 **reading. In fact, if I could describe the process and**
13 **then hopefully that will clarify what the statement**
14 **meant to say and should have -- what the introductory**
15 **statement meant to say and should have said.**
16 **As the Inquiry will know, our previous Minister,**
17 **Minister Hamilton, when the concession statement was**
18 **placed before him he considered that the matters were of**
19 **such gravity, and not just the fact that a Government**
20 **department was being asked to make concessions, but the**
21 **nature of the concessions to be made were of such**
22 **a grave effect and so significant, that this was**
23 **a matter that he needed to put before his executive**
24 **colleagues.**
25 **When the new Minister also -- when this was put to**

1 **the new Minister she was clearly of the same view, and**
2 **by urgent procedure ensured that this was sent to the**
3 **First Minister and Deputy First Minister. Really the**
4 **request was about the Executive being approving, not the**
5 **statement as suggested by that introductory paragraph,**
6 **but approving her position in relation to making the**
7 **concessions, that they were content that she could make**
8 **these concessions. So they were content that she --**
9 Q. If I might interrupt you just to be clear, I think it
10 was a procedure that the Department of Health and Social
11 Services Public Safety -- I never get that right?
12 **A. They are now the Department of Health.**
13 Q. But in its former incarnation he felt that the
14 implications of the concessions that he was being asked
15 to make on behalf of the Department were such that the
16 executive needed to consider them?
17 **A. Yes. That's right.**
18 Q. And under the Ministerial Code he referred it to the
19 Executive but there is a fast track process.
20 **A. Yes.**
21 Q. If I can put it that way. I am sure I will be corrected
22 if I have got this process wrong?
23 **A. Yes, there is an urgent process --**
24 Q. Whereby the First Minister and Deputy First Minister can
25 approve on behalf of the Executive, as it were?

1 **A. Yes, that's right.**
2 Q. And that's really what happened in this case because of
3 the implications that there are as a whole for the
4 Executive by the Department of Health making these
5 concessions?
6 **A. Yes, that's right.**
7 Q. Is that it in a nutshell?
8 **A. That is it. Very well put.**
9 Q. So to be clear, the concessions that are outlined in
10 this statement are concessions on behalf of the
11 Department of Health?
12 **A. They are concessions on behalf of the Department of**
13 **Health.**
14 Q. And the Executive have agreed to those concessions being
15 made aware of the fact that there are implications for
16 the Executive?
17 **A. That's correct.**
18 Q. Now if I might then turn to them, paragraph 7.3 is
19 really where we see the first of them. Maybe just to
20 put on the record the question that the Department were
21 asked. If we can just scroll on back up, please:
22 "Having had the opportunity to reflect on the
23 evidence provided to the Inquiry, are there any systemic
24 failings the Department wishes to concede in relation to
25 the legal and policy framework for residential care for

1 children from 1922" that should read" to 1995 and the
2 funding and regulation of these Services in that
3 period."
4 If we go then to 7.30 -- I think I may just read
5 these paragraphs out, Hilary:
6 "In relation to the question of systemic failings,
7 the Department has reviewed the policies and actions of
8 its predecessor bodies, namely the former Ministry of
9 Home Affairs and the former Department of Health and
10 Social Services. The Department has sought in its
11 evidence to the HIAI to identify specific situations
12 which might have been handled differently to secure
13 a better or more timely outcome for children, but which
14 when viewed in the policy context of the day do not
15 amount to systemic failure."
16 You then give examples of some of those things. So
17 you are saying "There are things we could have done
18 better but we don't accept there were systemic
19 failings".
20 You then go on in paragraph 7.6, and I think from
21 here onwards is where you are actually making
22 concessions. In respect of legislation it says:
23 "The Department has defended its position in
24 paragraphs 1.1 to 1.18 of the Statement of 22nd April in
25 relation to primary legislation and departmental policy

1 during the 22 to '95 period in respect of their
2 implications for the residential care of children."
3 It sets out there the legislation that was majoring
4 at that time. If we scroll down, it says:
5 "The Department has noted that the education
6 (Corporal Punishment) (Northern Ireland) Order 1987
7 abolished corporal punishment in all grant aided schools
8 and accepts that in light of this a review of the
9 provisions in the 1975 direction and the 1975
10 regulations regarding corporal punishment should have
11 been undertaken by the DHSS with a view to revoking them
12 at that stage."
13 So, in other words, when they were abolishing
14 corporal punishment in schools they really ought to have
15 abolished it in residential homes for children?
16 **A. Yes, that's right.**
17 Q. Then paragraph 7.8 and 7.9 go on to talk about
18 inspection and related matters. It goes on to say, 7.9:
19 "The Department accepts, however, from the evidence
20 of senior DHSS officials to the Hughes Inquiry that in
21 1976 weaknesses must have been identified in the status
22 quo with regard to this policy."
23 That's the SWAG visits we were talking about:
24 "As a consequence SWAG resolved to make a full
25 annual report on each home. According to the Hughes

1 Inquiry evidence this was not implemented due to staff
2 resourcing issues. This.situation prevailed until 1980
3 when the Kincora scandal broke and the DHSS subsequently
4 established a rigorous inspection programme. Had the
5 agreed appropriate action been taken in 1976 to
6 strengthen the DHSS scrutiny, this might have helped
7 minimise further opportunity for abuse to occur within
8 children's homes."
9 That was what we were looking at earlier, that there
10 was certainly a four-year gap there when things might
11 have improved for children?
12 **A. Yes.**
13 Q. Then at 7.10 you say:
14 "In tandem with the consideration of the inspection
15 programme, the Inquiry has identified a lack of
16 reference within the Ministry of Home Affairs and SWAG
17 reports to the regulatory duty of administering
18 authorities.
19 The matter was raised by the Hughes Inquiry, which
20 found that the Ministry of Home Affairs and SWAG did not
21 consider whether this and a similar duty imposed on
22 statutory bodies in respect of statutory childrens'
23 homes was being discharged in a satisfactory manner.
24 The findings were that in a number of cases it was not.
25 This provision was an important safeguard for children,

1 having the potential to alert those ultimately
2 responsible for the management and running of the home
3 to poor care or questionable practice. It was
4 a statutory requirement and a fundamental matter that
5 should have been checked during each Ministry of Home
6 Affairs or SWAG inspection/visit to each home."
7 So again not properly scrutinising the scrutineers,
8 as it were?
9 **A. Yes.**
10 Q. Paragraphs 7.12 to 7.13, you talk about migration of
11 children and the policy in respect of that. You
12 essentially accept that the migration of children was
13 a misguided policy and endorse the apology that was
14 given by the then Prime Minister Gordon Browne on behalf
15 of the UK Government when he apologised to former child
16 migrants from the United Kingdom who had been sent to
17 Australia and other British colonies. As you said in
18 Module 2, and certainly you will reiterate that this was
19 a systemic failing which the Department accepts its part
20 in that scheme.
21 Those are essentially the concessions that the
22 Department are prepared to make; isn't that correct?
23 **A. Yes.**
24 Q. If I might just look at a couple of other matters
25 briefly. At GOV797 you gave us a supplementary

1 statement, as I say, in response to the Health & Social
2 Care statement. At paragraph 4.1 of this you are
3 addressing some of the things that Fionnuala McAndrew
4 said in evidence in her statement to the Inquiry. You
5 talk about the organisational changes that there were in
6 1973 through to 1995. You say that you don't want to
7 detract from the impact that the significant
8 organisational change may have had on individuals, but
9 the changes were not introduced as whims of the
10 Department, but they were implementing key UK Government
11 policies aimed at strengthening and improving the health
12 and personal Social Services' environment. You talk
13 about the consultations that there were.
14 I just wanted to be clear. Is it the case that the
15 Department is saying that while it imposed these
16 changes, it just left the responsibility for
17 implementation at the door of the Health & Social Care
18 Board, or what did the Department see as the position?
19 A. **Absolutely not. I think the Department had**
20 **a responsibility to ensure that the organisational**
21 **changes took place smoothly, that people were aware of**
22 **their responsibilities and discharged their duties and**
23 **responsibilities effectively, and the Department was**
24 **concerned to ensure that there was a proper support**
25 **mechanism for them to do that. And if I could refer**

1 **back to the evidence given to the Hughes Inquiry, when**
2 **Dr Hayes, for example, pointed out that in those early**
3 **days of the organisation he did accept that there were**
4 **significant changes, that there was upheaval in many**
5 **services, but he did point out that there were regular**
6 **meetings with, for example, board officers, in**
7 **particular Chief professional officers, twice monthly**
8 **I think he stated the regularity was. There was**
9 **a constant flow of communication.**
10 **It is evident that the Department was on hand to**
11 **provide advice, for example, in relation to the duties**
12 **of the Health & Social Care Committee and the people who**
13 **took on the responsibilities of the Children Officer**
14 **duties within the 1975 direction, the former Children's**
15 **Officer's duties within the 1975 direction. So there**
16 **was constant communication. It was evident that there**
17 **was a climate that the boards could seek advice, and in**
18 **relation to training matters, again we have evidence**
19 **that where boards and, indeed, the Department identified**
20 **matters that were concerns for regional training, that**
21 **the Department funded and established regional training**
22 **programmes to help develop staff skills.**
23 **I am just thinking, you know, for example, the new**
24 **focus on child protection. We did establish regional**
25 **training programmes for there. Had there been serious**

1 **concern on the part of the boards reflected to the**
2 **Department that people were unsure of what their roles**
3 **and responsibilities were, I have no doubt that the**
4 **Department would have provided the fora and training, if**
5 **necessary, for those to be addressed. But it is clear**
6 **that during that period, admittedly a period of**
7 **considerable upheaval, that the Department did not just**
8 **sit back and allow people to get on with it. There was**
9 **frequent and continuous communication.**
10 Q. Paragraph 5 of your statement, Hilary, if we scroll down
11 to that. I am not quite clear -- just the next page,
12 where you talk about statutory responsibility for
13 children in residential care. You say that:
14 "The Board has stated that the Department held
15 ultimate responsibility for residential child care and
16 the children placed therein."
17 Again you are referring to Ms McAndrew's evidence.
18 You go on to -- I don't mean to -- you know, if
19 I have got this wrong, please correct me, but you seem
20 to suggest that the Department's role was to provide
21 homes for the boards to run and that was it in
22 a nutshell. They delegated responsibility for the
23 running of the homes to the boards, but there is
24 a distinction between statutory homes run by boards and
25 the voluntary homes, because the boards certainly had no

1 role to play in the registration of those homes, for
2 example. The monitoring statements that you refer to in
3 that, again that came about in the mid '80s post the
4 Kincora scandal again, the monitoring standards guidance
5 that was given.
6 In paragraph 7.6 of the statement you talk about
7 reviewing registration, and again I am summarising here,
8 but you say in the absence of any communication to the
9 DHSS from the boards about the functioning of
10 a voluntary home, there was to reason to formally review
11 the continuing registration, and I referred you back to
12 the Nazareth Lodge issue where the boards were
13 communicating that there were complaints about Nazareth
14 Lodge. You were saying the reason at 8.1 that there was
15 no deregistration of Nazareth Lodge was these were
16 complaints of a historical abuse. Nazareth Lodge had
17 been inspected just before the complaints came out and
18 there was no reason to be concerned about how the home
19 was being run at that time.
20 When we were talking about this earlier, I think
21 what I was trying to say to you was; well, no matter
22 what the boards were doing on a day-to-day basis,
23 whether in terms of monitoring their own homes or in
24 terms of monitoring the care of their children in
25 voluntary homes, the children that were placed there by

1 the latter end of the Inquiry's work -- they were all
2 placed there by Health & Social Services Boards -- that
3 nevertheless the Department had this overarching
4 registration duty -- duty is perhaps not the right
5 word -- but responsibility to ensure that it only
6 registered and continued to register those homes that
7 were fit for purpose, that were fit for children to be
8 admitted to?
9 **A. Uh-huh.**
10 Q. And looked after in?
11 **A. Uh-huh.**
12 Q. And I just wondered, there was never any formal review
13 established; isn't that correct?
14 **A. Uh-huh. Well, yes, but if I might address some of the**
15 **points you made earlier there in terms of the role of**
16 **the Department. The Department accepts that it did have**
17 **ultimate responsibility for the care of children in that**
18 **general sense. However, the primary duty for the care**
19 **of children in residential care rested with the boards,**
20 **welfare authorities and boards in the case of statutory**
21 **homes, and the administering authorities in the case of**
22 **voluntary homes. That does not mean the Department had**
23 **no responsibility. I would see that that responsibility**
24 **on the part of the Department was to ensure that the**
25 **statutory and voluntary bodies were discharging their**

1 duties effectively, their duties that they had in
2 respect of the children in care within those homes.
3 I would see that as being the role of the Department.
4 We didn't actually provide homes as such. The onus, for
5 example, was on the statutory authority to provide
6 children's homes in the 1950 Act, but it was up to the
7 Department then to ensure that there was a proper
8 framework in place and that those homes were acting in
9 accordance with the duties and responsibilities placed
10 on them in relation to the welfare of children within
11 them, the duties and responsibilities placed on the
12 administering authorities and the statutory authorities.
13 In relation to the reason why I did not deal with
14 the position of voluntary homes in that statement,
15 I can't quite remember, but I think I was addressing a
16 specific criticism by the Department. Again the
17 Department accepts that it had a general duty, a general
18 responsibility towards children, but it discharged that
19 responsibility by ensuring that those responsible within
20 the primary legislative context were actually adhering
21 to those responsibilities and discharging them
22 effectively.
23 Now the Department accepts that we did fail in that
24 respect and we have accepted that, but I would see that
25 as, you know, those distinctions between the role of the

1 **Department vis-a-vis the general care of children and**
2 **the role of boards and voluntary organisations in**
3 **relation to the individual care of children.**
4 **In relation to the review of registration question,**
5 **it is true that the only documentation that we have**
6 **relating to a formal review of registration took**
7 **place -- I think that was in 1984. Am I correct,**
8 **suggesting that the first formal review of the**
9 **registration of all voluntary homes?**
10 **Following that review there were a series of annual**
11 **meetings set up with voluntary organisations which**
12 **actually for a time were entitled "Review of**
13 **registration meetings". This was not actually clear**
14 **when I was giving my evidence in Module 1, but it did**
15 **become apparent when we received more documentary**
16 **evidence. So there was a system for review.**
17 **In relation to the formal review of registration we**
18 **have examples of the Department raising -- the Ministry**
19 **of Home Affairs, for example, raising questions as to**
20 **whether a home should continue to be registered, and**
21 **I would suggest that the Ministry of Home Affairs'**
22 **programme of visitation and inspection was, in fact,**
23 **a de facto form of registration in that implicit within**
24 **that would be if an inspector found conditions to be**
25 **such, as indeed was the case in Manor House Home, then**

1 **that would precipitate the question, you know, an answer**
2 **to the question as to whether the home should continue**
3 **to be registered.**
4 Q. But I think the point I was making to you earlier was
5 that it is one thing to have an annual report and to be
6 looking at whether the registration should continue
7 after 1984 when the whole landscape has changed in any
8 event after the Kincora scandal and we know that?
9 **A. Yes.**
10 Q. But would it not have been a proper thing for the
11 Department to have done to have had a formal
12 registration scheme to ensure that standards were being
13 met consistently across the board in respect of
14 children's homes?
15 **A. Certainly from the perspective of today that would have**
16 **been, you know, an important element, an additional**
17 **element of safeguarding and, as you pointed out earlier,**
18 **it would have precipitated kind of a formal review of,**
19 **you know, of what was happening within homes and the**
20 **standard as per the registration criteria, but we are**
21 **dealing with a day when there were not any specific**
22 **registration criteria. That appeared to be the standard**
23 **of the day, and I would suggest that the inspection**
24 **programme, the visiting programme, which we knew did**
25 **happen fairly frequently during the '60s at least, that**

1 **that was a form of scrutiny and monitoring and there**
2 **were questions raised about the continuing registration**
3 **of certain voluntary homes.**
4 Q. My final question is, and I think you have accepted, the
5 Department accepted that they had the ultimate
6 responsibility for child care in Northern Ireland, and
7 to an extent that certainly extended to ensuring that
8 the safeguarding and welfare and promotion of children,
9 as well as just their material needs and professional
10 care standards in residential homes were met. You put
11 it to me as the responsibility of the Department was to
12 ensure that there were proper processes in place to
13 ensure those who had primary responsibility for the care
14 of the children were met?
15 **A. Yes, that's right.**
16 Q. And the Inquiry will no doubt look at whether or not
17 those proper processes did, in fact, exist over the
18 period of time that it is looking at, but I just
19 remember the question I did want to ask you, which was
20 in connection to Kincora, before I hand you over to the
21 Panel, Hilary, and that was in respect of the visitors'
22 book. You talked about the fact that the first time
23 your name appeared in the visitors' book was when you
24 came to the home with someone else, but you had been
25 visiting and it just wasn't being recorded in the

1 visitors' book?
2 **A. Yes.**
3 Q. I mean, how reliable, can I put it that way, were
4 visitors' books generally in homes?
5 **A. Not very reliable, because different staff had different**
6 **policies of whether or not they would ask people to sign**
7 **the visitors' book and, you know, if you will notice**
8 **from the visitors' books a number of entries were**
9 **actually made by Mr Mains' himself. You know, visitors**
10 **themselves didn't sign. In fact, that particular visit**
11 **I am talking about, that visit was entered by Mr Mains.**
12 **That was not the handwriting of myself or my colleague**
13 **who visited on that occasion.**
14 Q. That might have been something he was doing at the end
15 of the week, say, when he had a spare hour to do it?
16 **A. It might be, and perhaps related to the times he was on**
17 **duty, but it didn't mean then that other staff were**
18 **doing the same were or reporting who had visited. Now I**
19 **am not saying they were completely unreliable by any**
20 **means, but it is really just as reliable as the staff**
21 **operating the system and, you know, the extent to which**
22 **the policy of signing people in was adhered to.**
23 Q. Well, thank you very much, Hilary. That, I hope, is the
24 last question I will ever have to ask you, but I will
25 hand you over to the Panel.

1 Questions from THE PANEL
2 CHAIRMAN: Well, Dr Harrison, you may take it that we have
3 read your various submissions and therefore it is not
4 necessary to go over them again with you. Some at least
5 have been gone over on other occasions in essence,
6 although not perhaps in every detail that has been
7 reflected in today, but if I could just take you back to
8 your personal experience at Kincora, because, if I may
9 say so, without being in any way offensive, it is a long
10 time ago and you must have been there as a young social
11 worker.
12 **A. Yes, newly qualified.**
13 Q. And it is easy to forget that we are asking people, as
14 we have emphasised again and again in relation to
15 Kincora in particular, to try and remember details of
16 things that were happening in this particular instance
17 I am about to ask you about, more than 40 years ago?
18 **A. Yes.**
19 Q. So a professional lifetime has passed since those days,
20 but when you were arriving at the home, as I understand
21 it, one thing that has stuck in your mind since is that
22 the door was always secured?
23 **A. Yes, that's right.**
24 Q. In other words, it wasn't just out of politeness you had
25 to wait at the door for someone to let you in, as might

1 be the case even if you are visiting in an official
2 capacity where there was not a lobby and reception desk
3 and so on. Did that strike you in any way as unusual or
4 unique to Kincora, as compared to say Bawnmore where
5 I think you may have gone?
6 **A. Yes.**
7 Q. Or Macedon, where I think you had occasion to go?
8 **A. Yes.**
9 Q. I know it was run by Barnardo's, but just taking those
10 two as examples?
11 **A. Yes, it was unusual and I think for that reason that**
12 **fact sticks in my memory, and the other slightly unusual**
13 **bit was that the door was always opened by a member of**
14 **staff. Now the key was in the inside of the door inside**
15 **so it would have been perfectly possible for boys in the**
16 **hostel to have turned the key and opened the door, but**
17 **it seemed to be a policy within the unit -- again I am**
18 **only speaking from the times that I visited, other**
19 **people may have a different experience, and we have to**
20 **remember too that most of my visits, a lot of my visits**
21 **would have been in the evening, that it did seem**
22 **unusual, and quite honestly I don't ever remember asking**
23 **why that was the case. I assumed it was to do with**
24 **security precautions, the age of the young people in the**
25 **home and the fact that, you know, we were in a very**

1 **difficult situation in relation to, you know, the**
2 **Troubles at the time. You know, I don't believe**
3 **I thought to ask why that was the case. I assumed it**
4 **was to do with the safety of the young people inside.**
5 **Having said that, once inside the home there was no**
6 **sense at all that young people were restricted in their**
7 **coming and going. There was no sense that they weren't**
8 **allowed to leave the home. There were no kind of what**
9 **I would call authoritarian process in place that they**
10 **had to give account of their whereabouts or anything**
11 **like that. So I assumed it was a security measure.**
12 Q. And the general atmosphere that you have described in
13 those words you have just used, would it be fair to
14 suggest that coupled with what you said about being
15 invited spontaneously to remain for a meal, it would not
16 be right to say that there was an unwelcoming attitude
17 or a feeling of discouraging visitors or keeping
18 visitors, whether actually or metaphorically, at arm's
19 length from the children?
20 **A. I have never experienced that at all. I didn't get that**
21 **impression and, in fact, from my recall of the times**
22 **that I did share a meal with the young people there was**
23 **very free, open discussion about all sorts of issues and**
24 **there was no attempt to keep me away from other young**
25 **people or anything like that.**

1 **I have to say that I do appreciate that memory is**
2 **very -- well, we know from the evidence that memory can**
3 **be quite unreliable, and the point of the fact that I am**
4 **recalling events 40 years ago but, of course, in 1980**
5 **the news about Kincora was so stupendious that naturally**
6 **then all of the experience that one had of that home**
7 **then remains firmly entrenched in the mind. So I can**
8 **recall those details quite clearly.**
9 Q. And you referred to visits in the plural. I am not
10 asking you, of course, to remember whether it was five
11 or 70 or whatever, but would you have been there more
12 than let's say half a dozen times throughout the four
13 years we are talking about?
14 **A. Oh, yes. Oh, much more than that. On occasions I have**
15 **been there maybe twice a month at least, yes. The**
16 **particular boy that I had long-term supervision for, his**
17 **understanding was he had been placed by Barnardo's and**
18 **I am not sure where. Now I can't actually recall**
19 **whether he was being paid for by the welfare**
20 **authority -- by the board. There was a situation where**
21 **at one stage the board could hand social work**
22 **visitation, responsibility for calling reviews on**
23 **certain children over to Barnardo's and they took on**
24 **responsibility for the fieldwork and the social work**
25 **support of the boy -- not just of the boy, with other**

1 **children.**
2 **This particular young man had two sisters in Larne**
3 **who were fostered, and I think those may have been**
4 **foster carers recruited by Barnardo's. So part of the**
5 **reason for visiting, and visiting this particular boy so**
6 **often, would have been to ensure that he maintained**
7 **contact with his sisters who were placed at quite**
8 **a distance away. Aside from that experience I did place**
9 **boys in Kincora on a short-term basis. I can't remember**
10 **their names.**
11 Q. No. We will come to the short-term basis in just
12 a moment, if you may. The boy you were referring to
13 I think you said he was in Kincora for several years?
14 **A. A few years, yes. I would need to check that, but his**
15 **statement actually gave the dates -- the statement to**
16 **the police gave the dates.**
17 Q. We will be able to do that from the material we have --
18 **A. Sure.**
19 Q. -- gathered, but the point is one of some importance,
20 because if I understand what you are saying correctly,
21 it is an indication, for what it is worth, that here was
22 one boy who first of all clearly had in terms of time
23 a lengthy association?
24 **A. Yes.**
25 Q. Did you regard your relationship with him one that you

1 hoped he would confide in you if he had been subject to
2 some forms of sexual abuse?
3 **A. Yes, I would have expected that that would have been the**
4 **case, because he did raise a minor issue with me in**
5 **relation to an incident that happened in the home. So**
6 **I would have found it very surprising if there were**
7 **other matters that he didn't, you know, more serious**
8 **matters that he didn't raise with me. He was actually**
9 **quite an articulate, quite a volatile personality, and**
10 **I would have been very surprised. Now this particular**
11 **person did say in his statement to the police, but one**
12 **has to take account of the fact that this was after the**
13 **Kincora scandal broke and rumours were rife, that he had**
14 **heard rumours about Mr McGrath inappropriately touching**
15 **some boys, but he had never said that to me, and I would**
16 **be obviously concerned if he had made any disclosures to**
17 **that effect. He personally claimed not to be a victim**
18 **of abuse, and after the Kincora scandal broke -- I will**
19 **not say where this boy was employed, but you will see**
20 **from the statement, but he called me from England to say**
21 **that he was completely amazed that this could have**
22 **happened, and I did meet with him afterward when he was**
23 **in Northern Ireland for a short time and, you know,**
24 **where he discussed the fact that this had happened and**
25 **he didn't have any knowledge of it.**

1 Q. So this was not the same type of assertion by boys that
2 we find in many of the police statements, because they
3 are asked a formal question to this effect. This is
4 someone who spontaneously rang you to say --
5 **A. Yes.**
6 Q. -- how surprised he was?
7 **A. Yes.**
8 Q. By these developments?
9 **A. Yes, yes. Now he would have been discharged from care,**
10 **of course, by that stage.**
11 Q. Yes.
12 **A. I didn't have a formal relationship with him, you know,**
13 **continuing formal relationship with him. So, yes, he**
14 **did call because he was so surprised and wanted to check**
15 **out that it was the same home and so on. He shared**
16 **a bedroom. Of course, he was in a three-bedded bedroom**
17 **to the best of my recall, because I did see it. So**
18 **there were other boys in that bedroom and it is not as**
19 **if they were -- you know, he didn't have occasion to be**
20 **in very close contact with other residents.**
21 Q. I am sure that with your very extensive experience in
22 this whole area for many years you would agree that
23 some, particularly -- perhaps more than now, but some
24 adolescents could be more naive than others?
25 **A. Oh, of course. Yes.**

1 Q. Was he somebody who would have been at that time in more
2 towards the naive end of the spectrum?
3 **A. Oh, no, no.**
4 Q. He would he have been very streetwise?
5 **A. Yes, astute, yes. Very astute.**
6 Q. It is perhaps obvious-
7 **A. Perhaps that's one of the things that protected him.**
8 Q. The significant point you have just made about being
9 protected perhaps is important for us to bear in mind,
10 because much of the evidence that has been gathered and
11 that we have heard now many years later is to the effect
12 that not every boy was abused. Not every boy was the
13 subject of an approach that might have led to abuse, and
14 many of those who went through the home, and there were
15 a great many of them over the 22 years of operating?
16 **A. Yes.**
17 Q. A little more than 22 years, had no conception that this
18 type of dreadful abuse, which is now an established
19 fact?
20 **A. Of course.**
21 Q. Because of the prosecutions and convictions and pleas of
22 guilty was happening at all?
23 **A. That's right.**
24 Q. So far as Mains is concerned you have said that he was
25 good at finding employment for the boys, and we have

1 seen at least one example in detail of where that
2 happened, someone who has given evidence to the Inquiry,
3 but was that part of his expected duties in a formal
4 sense or was it something he took on himself over and
5 above what he was expected to do?
6 **A. Oh --**
7 Q. Or can I put it another way round?
8 **A. Yes.**
9 Q. Was someone who was the warden of a working boys
10 hostel --
11 **A. Uh-huh.**
12 Q. -- required as part of his or her work to take on that
13 function, if necessary?
14 **A. Yes. I don't know whether he was required to take on**
15 **that function. I just could not answer to that. If he**
16 **wasn't required, he certainly did take it on and**
17 **actually performed it very well.**
18 Q. Did he take it on for many children to your knowledge?
19 I appreciate some boys may have been found a job by
20 their social worker, but ...?
21 **A. Yes, yes. I think in the main now I would have been**
22 **aware that where boys had lost jobs and some of these**
23 **boys were not the easiest to place in employment, that**
24 **he often had networks he could call. In fact, I think**
25 **I remember being in his office when he was trying to get**

1 **a boy placed. He probably had more networks, more**
2 **employment networks than social workers at the time.**
3 **I noticed from the reports of the inspectors that each**
4 **time they reported, Miss Hill and Mr O'Kane, all of the**
5 **boys who were of working age were in what appeared to be**
6 **stable employment situations with the exception,**
7 **I think, of one who actually had just done 'O' levels**
8 **and was going on to do 'A' levels. So that seemed to be**
9 **characteristic of the way the hostel was run, and**
10 **I think we accepted that certainly he would have had**
11 **a lot more networks than I, as a young social worker,**
12 **would have had at that stage. One of the issues**
13 **I noticed that Mr O'Kane pointed out was that the boys**
14 **had very little -- were being given very little**
15 **preparation for independent living, and obviously that**
16 **again at that time, '79, I think there was concern about**
17 **the fact generally that children who had been in**
18 **long-term care were not being given sufficient**
19 **preparation for life on their own. So, you know,**
20 **obviously there was some consideration as to what the**
21 **home might do so enable independent living, but sadly**
22 **then, of course, the news came a year later about the**
23 **abuse that was taking place in the home.**
24 Q. You have said that the material standards in the home
25 were good. You described in what way that was the case.

1 Would it be a fair observation to say that when one
2 looks at Mr Mains' stewardship of his responsibilities
3 in the widest sense of the word, and if, and it is very
4 difficult to do this because of what he admitted that he
5 had done to the boys in his care, but if one puts that
6 to one side for the moment, the rest of what he did and
7 the way the home as a unit on the ground was run, how
8 would you describe that?
9 **A. I would have described it as a very efficiently run home**
10 **with an officer in charge or superintendent who gave the**
11 **impression of being extremely competent. He was very**
12 **good at communicating with social workers in relation to**
13 **what was happening with the boys in his care. Other**
14 **homes you know, we might have had to make a bit of**
15 **effort to get the information, but Mr Mains was very**
16 **diligent about communicating information back on**
17 **significant events or anything like that. I know he**
18 **wasn't trained by any means, but certainly apart from**
19 **one incident, an incident very early on I had no reason**
20 **to doubt that he was extremely competent and this was**
21 **an incident where very early on in my social work career**
22 **as a fully qualified social worker I remember my first**
23 **exchange with Mr Mains was -- well, first difference of**
24 **opinion was I had admitted a boy in an emergency**
25 **situation under Section 103, which was a voluntary**

1 admission and the boy was admitted with agreement of his
2 parents. This boy had a particular problem with running
3 away and he was not -- I think it was a weekend.
4 I think it was coming to a weekend and he was determined
5 that he was going to take off at the weekend. We were
6 very concerned about his security and safety. We didn't
7 know what he was doing, and he was about I think he
8 maybe was about 14. I admitted him and then I got
9 a call on I think it must have been the Friday -- I got
10 a call on the Monday morning to say that the boy was no
11 longer there because the parents had come along on the
12 Saturday or Sunday and decided they had changed their
13 mine. They didn't really want him to be in care, they
14 wanted to take him home. My concern with Mr Mains was
15 that he had not in any way attempted from the
16 information I received, had not in any way attempted to
17 dissuade the parents from doing that. He had more or
18 less said "That's okay. He is in under 103, I have no
19 responsibility for keeping him here. He can go home".
20 Now that, in fact, was true, he didn't have authority to
21 keep the boy there, but I was a bit concerned that there
22 had been no attempt to persuade the parents otherwise,
23 and the boy did take off then and was missing for the
24 rest of the weekend, and that was my first -- well, my
25 only -- my only apart from the incident reported to me

1 **by the boy who I had long-term responsibility for. He**
2 **accepted what I was saying. You know, we agreed that**
3 **that would not be a way of working and I think he had my**
4 **home phone number and, you know, he agreed that that**
5 **would not happen again and that, you know, there would**
6 **be a different way of approaching that situation if it**
7 **ever happened again. That was very early on but he was**
8 **quite right. He didn't have the authority. I was more**
9 **concerned about the fact that the boy seemed to have**
10 **been handed over without any decision.**
11 Q. It may seem a dramatic way to put it, but taking into
12 account everything you have said, would it be fair to
13 say he was a Jekyll and Hyde character. One part of him
14 is a very effective, hardworking, good person who gives
15 every sign of being not merely conscientious but being
16 competent?
17 **A. Yes.**
18 Q. In discharging his responsibilities to the child, and
19 unknown to you and many others at the time the scenario
20 he had taken advantage of his position on a good many
21 occasions to gravely abuse his truth and sexually abuse
22 children in his care even if it was a question of
23 corrupting them rather than forcing them?
24 **A. Yes. Absolutely. I think that's what's so distressing.**
25 Q. Thank you.

1 MS DOHERTY: Thank you, Dr Harrison. Can I just ask,
2 I mean, we know that for a significant period Mr Mains
3 was working in the hostel alone and this would have been
4 during the period when Miss Hill was visiting. Are you
5 aware of any concerns being raised by the Ministry in
6 relation to that level of staffing where he was on duty
7 all the time without any other support?
8 **A. Yes. That was really very concerning. I fully accept**
9 **that. Unfortunately other than the 1965 inspection**
10 **report, by which time there were more staff in post,**
11 **sadly we don't have the reports of visits or inspections**
12 **done before that, and so it's impossible to tell whether**
13 **this was a matter raised by the inspectors during the**
14 **50s, '60s. It would be unthinkable I think that an**
15 **inspector would go to a home and find that there was**
16 **only one member of staff, and apart even from the kind**
17 **of level of supervision then -- the kind of impossible**
18 **level of supervision that that created for the children,**
19 **the burden on that particular staff and the fact that he**
20 **was having to be there and sleep in every single night.**
21 **I saw bizarrely a letter on file from the Welfare**
22 **Authority I think excusing him for having been absent.**
23 Q. For an evening?
24 **A. For an evening and not disciplining him. So that is**
25 **just unthinkable.**

1 Q. I would consider it unthinkable, but if it continued it
2 would suggest that even if it was raised by an inspector
3 it did not result in any action?
4 **A. Yes, for a long time. Yes, that's right.**
5 Q. For a long time?
6 **A. Uh-huh.**
7 Q. I was going to raise the issue about Mr O'Kane's
8 perception about the issue about preparation for leaving
9 care, because I thought it was quite interesting what he
10 commented was it wasn't just about a lack of
11 preparation, he thought there was a dependency culture
12 being created because the boys needs were being met in
13 terms of domestic needs and whatever. I wondered if
14 that your experience?
15 **A. Yes, up to a point. What we have got to remember is**
16 **that a lot of these boys went home. They were not being**
17 **discharged into single independent living situations.**
18 **They were not all being discharged that way. Also**
19 **a large number of them went to further institutions like**
20 **the Army, the Navy, the Merchant Navy, Royal Navy from**
21 **what I can gather, from the evidence that I was reading.**
22 **So they went from one institution essentially into**
23 **another, and to be fair, it was only around about the**
24 **1970s that social work in general began to wake up to**
25 **the fact that there were a large number of children who**

1 **maybe didn't have homes to go to and who, having been**
2 **institutionalised, were ill-equipped to live on their**
3 **own.**
4 **I think Mr Bunting at one stage referred in his**
5 **statements to the Board then encouraged organisations**
6 **like Barnardo's to establish homes that would actually**
7 **have an element as part of their purpose and function,**
8 **an element of independence training, and the home that**
9 **I would have been responsible for in Barnardo's I think**
10 **had been ongoing since the '60s. Now I didn't work in**
11 **the home but it was part of my management**
12 **responsibility, but it was the first unit in Northern**
13 **Ireland to have first of all, a self-contained flat**
14 **within the hostel and then some like kind of apartment**
15 **type accommodation with a common kitchen and so on. Of**
16 **course, we then went on to develop that into sheltered**
17 **housing, but I think people were only beginning to wake**
18 **up to that fact. The Members of the Panel with their**
19 **vast experience will maybe know differently, but that is**
20 **my sense.**
21 Q. I mean, I appreciate that when you were giving evidence
22 today and trying to look at the issue about why were the
23 guidelines less than Castle Priory, and one of the
24 things you said was there is a possibility that it could
25 have been about faith-based services?

1 **A. Uh-huh.**
2 Q. And an expectation you would have nuns or brothers
3 actually working longer hours and whatever. I mean, not
4 putting you on the hop, but in a sense is that a good
5 recipe for good care that you are actually expecting
6 people, I mean, we have heard about Termonbacca, two
7 nuns looking after 80children. If the policy was
8 dependent on that would that be a good policy?
9 **A. No, of course not. We know that in some of those**
10 **institutions not only were they working long hours in**
11 **residential care, but some of the staff had teaching**
12 **responsibilities as well.**
13 Q. That's right. We have gone through Seebohm quite a lot
14 and through correspondence and whatever, but just to
15 kind of clarify and confirm the understanding from
16 today's evidence, that if it was Seebohm that influenced
17 it, that in Northern Ireland it went further than what
18 actually happened in England. In England where you had
19 annual visits where you had the ability to follow up in
20 terms of child care branch, and whatever, we didn't have
21 that in Northern Ireland and that was indeed a failure
22 at that time?
23 **A. I think yes, I would draw the distinction between having**
24 **a policy and knowing that there was definite adherence**
25 **to that policy. We have no evidence to suggest that we**

1 **had a policy of annual visitation, so we are, yes,**
2 **different from England in that respect, but --**
3 Q. And we do have evidence --
4 **A. Of homes that weren't visited.**
5 Q. So we know that there are homes that were not visited
6 for a number of years?
7 **A. Certainly according to the Hughes evidence the voluntary**
8 **homes were visited more frequently than statutory homes,**
9 **but --**
10 Q. -- statutory homes. That relates to the point, you
11 know, where you set out the respective responsibilities
12 and you are saying the Department's responsibility is to
13 make sure in a sense, the boards meet their
14 responsibilities in relation to children and monthly
15 visiting and whatever, but if the inspectorate is not
16 actually visiting how do they ensure those
17 responsibilities are being met, because that's their
18 main channel for doing that?
19 **A. Yes. Well, that and monitoring information,**
20 **documentation being returned to the Department as to**
21 **visits, and again it's probably a weak argument, but we**
22 **have to remember too that in the case of the statutory**
23 **homes, the Children's Officers had to make reports to**
24 **the welfare committee and subsequently the board**
25 **officers had no make reports then to either the PSCC**

1 **Committee or the equivalent committee within the**
2 **district. The Department got copies of all of those**
3 **reports, the Welfare Authority reports. I need to make**
4 **it clear that the Department got copies of the Welfare**
5 **Authority Committee meeting minutes. The reports by the**
6 **Children's Officer then did not have to be written**
7 **reports. They could be clearly given verbally, but**
8 **within those minutes the Department had access to the**
9 **Children's Officer's report about each of the homes and,**
10 **you know, what they found. I am not saying it's**
11 **a substitute for visiting, but I am just saying it was**
12 **an element. It was another piece of information --**
13 **a piece of information that they did have to hand.**
14 Q. Within the Department was there a formal process for
15 consideration of those reports?
16 **A. I can't speak for former days, but I certainly know that**
17 **the Board Committee minutes were circulated to Social**
18 **Services Inspectorate, inspectors in my day, and we**
19 **could comment on anything that we felt needed further**
20 **questioning and --**
21 Q. But in your day you were also inspecting?
22 **A. That's right.**
23 Q. And in a sense you could pick things up?
24 **A. Yes. There must have been some level of scrutiny of**
25 **those otherwise one would hope --**

1 Q. And that would be another conversation to be had
2 completely?
3 **A. Yes.**
4 Q. Okay. Thank you very much for all your evidence. Thank
5 you.
6 MR LANE: Just to follow up again on the question of
7 preparation for independence. It was obvious the home
8 was criticised for that in one of the reviews, but was
9 that something that struck you as a visiting social
10 worker at all?
11 **A. No, because I am not sure that in those early days**
12 **I would have been particularly aware of that myself.**
13 **You know, I didn't have any experience of young people**
14 **at that stage having to leave and live independently.**
15 **Most of my young people were going home.**
16 Q. The boys you had there, presumably their cases were
17 reviewed?
18 **A. Yes. Yes.**
19 Q. Where did you hold the reviews and who would have
20 attended them?
21 **A. Now that's an interesting question. I think at the**
22 **beginning there were paper reviews. I am trying to**
23 **think if Mr Bunting had introduced a series -- a three**
24 **monthly review paper review process where we had to list**
25 **the number of times we visited the child. There was**

1 **a review on each child, what the salient features were.**
2 **And I should say that in the case of the Eastern Board**
3 **that if you had missed out on those visits, even though**
4 **those reports went to the district Social Services**
5 **Officer who had executive responsibility for services,**
6 **Mr Bunting, you know, would have been wanting**
7 **an explanation for that. Now I think those were paper**
8 **reviews in office. As we began to have more**
9 **understanding of the preview process and parents and**
10 **children became involved, then my recall is that**
11 **certainly I remember some reviews being held in Kincora,**
12 **and that would have been the procedure for most of the**
13 **other children's homes too, the reviews were actually**
14 **held within the children's home.**
15 **In terms of who was there, there would have been the**
16 **equivalent of Assistant Principal Social Worker,**
17 **Ms McGrath, for example, who was the visiting officer**
18 **for Kincora and other senior members of staff within the**
19 **home.**
20 Q. And you would have been presenting to them how the case
21 was proceeding?
22 **A. Yes, that's right. I think at the time that was**
23 **happening it was a six monthly he review process. It**
24 **moved from three month to six monthly review process.**
25 Q. Mr Mains wouldn't have been there or anybody else from

1 the hostel?
2 A. **No. Again I hope I am not misrepresenting practice, but**
3 **my understanding was that we completed a paper review**
4 **but we liaised with the home staff as to progress and so**
5 **on and relied very much on their information and the**
6 **information from the parents about, you know, what we**
7 **needed to -- and the child -- what we needed to be**
8 **putting in the review.**
9 Q. Did anybody else at the hostel have to present a short
10 report on progress?
11 A. **No. I don't remember that happening, but that's not to**
12 **say it didn't happen.**
13 Q. There were at least a couple of other hostels run by the
14 Eastern Board?
15 A. **Yes. Ettaville Girls's Hostel.**
16 Q. Did you visit that hostel?
17 A. **Yes. Ettaville Girls' Hostel. I did, yes.**
18 Q. How did that compare with Kincora, was it run along the
19 same lines, the same levels of staffing?
20 A. **I cannot be definitive about that.**
21 Q. Right?
22 A. **Material standards maybe weren't quite as high as they**
23 **would have been in Kincora, but in terms of staffing,**
24 **I remember in the case of the girls' hostel there was**
25 **also one particular prominent member of staff who we**

1 **related to who would have been the equivalent of**
2 **Mr Mains in the boys' hostel, yes.**
3 Q. One of the elements in calculating whether staffing is
4 adequate is obviously how many hours the workers are
5 expected to do. Now I can speak from the point of view
6 of England, but I think it was about 1972 that a 48-hour
7 working week was introduced which then gradually got
8 reduced down to 45 and 40, and at that stage a lot of
9 the homes had to have much increased staff?
10 **A. Yes, that's right.**
11 Q. Because they relied on people working quite unreasonable
12 hours. Do you know what the situation was in Northern
13 Ireland, or whether limits like that were introduced?
14 **A. Well, I wasn't in a management position in the boards,**
15 **but I was in middle management in Barnardo's and I do**
16 **recall that -- again because I was responsible for the**
17 **oversight of that project which contained a residential**
18 **home. I do remember that there were agreements about,**
19 **for example, not just the numbers of hours staff worked,**
20 **and this would have been in the late '70s, early '80s.**
21 Q. Uh-huh.
22 **A. But things like staff should have days off together.**
23 **They shouldn't, you know, have one day off and then, you**
24 **know, four days off and another day off. Where possible**
25 **days should be given together. There should not be**

1 **split shifts, which was a big problem in terms of**
2 **attracting -- well, all of those conditions were**
3 **problems in relation to attracting people to work in**
4 **these homes in a very, very demanding, intensive**
5 **atmosphere. The staff were not to work in -- you were**
6 **not to be off, away at 9 o'clock in the morning only to**
7 **be back on duty at 5.00. So Barnardo's certainly tried**
8 **to adhere to those standards, and I am sure that was**
9 **reflective of practice -- I shouldn't say I am sure, but**
10 **I would imagine that was reflective of practice**
11 **throughout the Province really in the statutory sector**
12 **as well. Whether other faith-based voluntaries met**
13 **those standards quite so quickly or not I am afraid**
14 **I can't say.**
15 Q. Thank you very much?
16 **A. Right.**
17 CHAIRMAN: Dr Harrison, could I perhaps just ask you about
18 one more thing which I overlooked? One of the children
19 that you placed there was still under a school age?
20 **A. At least one, yes.**
21 Q. At least one?
22 **A. Yes.**
23 Q. Now this was designed to be operated as a working boys'
24 hostel for boys over school leaving age; isn't that
25 right?

1 **A. That's right.**
2 Q. In general terms in your experience why would children
3 under school age be placed in Kincora at all, and if so
4 was that suitable and for how long?
5 **A. In my experience Kincora was only ever used as an**
6 **emergency stopgap when no other places could be found --**
7 **no other suitable places were available for underage**
8 **boys. And in my experience children were there for**
9 **a matter of days, it wasn't weeks, and I said earlier**
10 **that, in fact, Mr Mains himself would have been the**
11 **first on the phone if he felt there was not an exit**
12 **strategy for a younger boy. The boy whom I mentioned**
13 **earlier, he would have been one of the ones that was**
14 **underage and there was a problem with him running away.**
15 **You know, there was no kind of central bed bank in those**
16 **days, so it was very much up to social workers to ring**
17 **round the various homes. If you were faced on**
18 **a situation on a Friday evening, for example, when**
19 **places were closed, there were no mobile phones. There**
20 **was nothing. You really had to ring round several**
21 **homes, you know. You might have been told "No, we**
22 **can't, because we have already got three children over**
23 **our quota as it is. We have had to squeeze them into**
24 **bedrooms," and so on. So it really was the only really**
25 **available choice and, no, it wasn't, it absolutely**

1 **wasn't suitable for young children to be placed there**
2 **but in my experience it was a matter of expediency and**
3 **in my experience those children were moved on very, very**
4 **quickly.**
5 Q. And may we take it that at least one of the reasons why
6 it was not suitable was is that if you say you have a 13
7 or 14-year-old boy going into an establishment where
8 many, if not the preponderance of the other young men
9 are effectively almost adults, and in practical terms
10 are adults, they are working?
11 **A. Yes.**
12 Q. They are coming up to 18. They have maybe been out of
13 school two or three years. There are a number of
14 problems that can arise. You can get bullying,
15 introducing them to bad habits, underage drinking?
16 **A. Yes.**
17 Q. Gambling and then, of course, there is the risk we now
18 know of peer sexual abuse?
19 **A. Absolutely, yes.**
20 Q. You said really that was a last resort. In that context
21 can I ask you specifically, I think we have heard
22 somewhere that there was a problem with the Palmerston
23 Assessment Centre?
24 **A. Yes.**
25 Q. Which in geographical terms --

1 **A. Was very close.**
2 Q. -- was off the Holywood Road?
3 **A. Holywood Road, Yes.**
4 Q. In a different module we have heard an indirect
5 reference I think to what one might nowadays describe as
6 bed blocking?
7 **A. Yes.**
8 Q. You know, or silting up I think was the expression
9 social workers used?
10 **A. That's right.**
11 Q. Because one might have assumed many of these admissions
12 might have gone to Palmerston first. Is that a fair
13 comment, or is it perhaps incorrect to make that
14 assumption?
15 **A. Palmerston, again I was acquainted with Palmerston.**
16 **Palmerston was established as an assessment unit, but**
17 **that did not mean that it was meant to take emergency**
18 **admission. The idea was that a child would be admitted**
19 **to some form of care, possibly foster care, or another**
20 **residential unit. Once problems became evident that,**
21 **you know, the fact that the child had greater issues**
22 **than perhaps the traditional homes were capable of**
23 **dealing with, then there would have been a referral to**
24 **Palmerston, which was a multi-disciplinary assessment**
25 **unit, you know, Dr John Barcroft was the psychiatrist**

1 **there. As far as I remember he assessed virtually all**
2 **children coming to the unit. There was a psychologist**
3 **as well. Then, of course, experienced residential care**
4 **staff. So it wasn't being used for emergency**
5 **admissions. I am not saying that didn't happen, but**
6 **certainly we wouldn't have seen that as an appropriate**
7 **place to admit a child in an emergency.**
8 **The reason for the bed blocking or silting up, was**
9 **that when assessments took place much like Harberton**
10 **House, then the pressure on the Service was such that**
11 **there may not have been an immediate, you know, place**
12 **for that child to go if, for example, it was determined**
13 **that the child needed specialist foster carers and, you**
14 **know, there needed to be a waiting period before those**
15 **people might be recruited, or again if residential care**
16 **was needed again, further periods in that or, indeed, if**
17 **work with the family was required in order to**
18 **rehabilitate the child back home. Sometimes those**
19 **issues could not be resolved quickly while court cases**
20 **were pending and so forth. So, yes, but I didn't ever**
21 **see it as an emergency admission facility.**
22 Q. And I promise this is the question last question, last
23 topic. Were you ever aware of a significant problem of
24 boys absconding from Kincora? There must have been
25 occasions?

1 **A. There must have been, yes.**
2 Q. We know of at least one?
3 **A. Yes, yes. I personally wasn't aware of that, but**
4 **I didn't have an overview of the home. I didn't have**
5 **a formal overview of the home. So it certainly wasn't**
6 **ever reflected to me as being a problem.**
7 Q. Thank you very much. Well, we are very grateful to you,
8 Dr Harrison. I think you have had the unenviable
9 distinction of being the person who has been called most
10 often to give the view of the Department in, I think,
11 every module, or almost every module, and we are very
12 grateful to you for doing that. And also, as is evident
13 from the lengthy questions we have asked of you, you are
14 one of the very few people who is able to give their
15 personal experience from a social worker perspective of
16 Kincora and, indeed, you also found yourself in the same
17 perhaps rather unenviable position in the Barnardo's
18 module.
19 **A. Yes.**
20 Q. But thank you very much for all the assistance you have
21 given to us?
22 **A. Thank you. Thank you very much.**
23 **(witness withdrew)**
24 MS SMITH: Chairman, Dr Harrison was our hopefully last
25 witness certainly today.

1 CHAIRMAN: Yes. Well, ladies and gentlemen, we have now
2 completed the finance and governance module, which
3 unfortunately we were not able to bring to a conclusion
4 earlier. We will now revert to the Kincora module, and
5 what we propose to do is now rise for an hour or so to
6 2.30. At this stage, as in every other module which we
7 have dealt with in the Inquiry, we propose to invite the
8 representatives of each core participant to make short
9 oral closing submissions and, as in every other module,
10 or the great majority of them in recent times, we will
11 provide an opportunity to each core participant to make
12 more detailed written submissions if they so wish, and
13 that I think you have already been notified about. This
14 afternoon from 2.30 onwards those who wish to make short
15 oral submissions will have the opportunity to do so. So
16 we will rise now until 2.30.
17 (1.35 pm)
18 (Lunch break)
19 (2.30 pm)
20 CHAIRMAN: Now, ladies and gentlemen, we have reached the
21 stage in the Kincora module where I propose to offer the
22 core participants the opportunity to make a short
23 closing oral submission, bearing in mind, I hope, that
24 you will all be able to write in greater detail those
25 matters which you wish to draw to our attention

1 subsequently.
2 Now, Ms Smith, the Health & Social Care Board in
3 a sense should go first --
4 MS SMYTH: That's fine.
5 CHAIRMAN: -- because we opened the module with your
6 clients. So if you wish to either speak from where you
7 stand or come forward to the lectern. You may choose
8 whichever you find more convenient.
9 Closing submissions on behalf of
10 THE HEALTH & SOCIAL CARE BOARD
11 MS SMYTH: I will come forward, Chairman.
12 Chairman, Members of the Panel, this submission
13 addresses the abuse that occurred in Kincora. Other
14 issues which concern the running of the hostel including
15 the staffing and issues in relation to underage
16 admissions will be developed in a written submission to
17 be filed by the Health & Social Care Board by 22nd July.
18 Kincora opened its doors in May 1958, a Welfare
19 Authority hostel for working aged boys. The first of
20 its type in Northern Ireland. According to a report in
21 the Belfast Newsletter on 7th May 1958, Kincora was
22 officially opened by the Lady Mayoress of Belfast,
23 Mrs Cecil McKee, on behalf of Belfast Corporation
24 Welfare Committee, on which occasion she said:
25 "I hope that Kincora will be to the residents a true

1 home in every sense and that its influence on their
2 lives will be a lasting one for good".
3 From October 1973 the responsible authority for
4 Kincora was the East Belfast & Castlereagh District of
5 the Eastern Health & Social Services Board. Kincora
6 then closed its doors in October of 1980, its three
7 caring staff members having been placed on precautionary
8 suspension from March of that year following complaints
9 that each of them had sexually assaulted boys in their
10 care. Each of those three staff members were
11 subsequently convicted of multiple sexual offences
12 against the boys who were entrusted to their care and
13 supervision, and they lost their jobs.
14 Whilst most of the 329 residents of Kincora passed
15 through the hostel without evidence of harm, the
16 convictions of Messrs Mains, McGrath and Semple are
17 a grave and permanent reminder that the aspiration of
18 Mrs McKee all those years ago were not fulfilled.
19 Rather, since the newspaper report in 1980, Kincora has
20 become synonymous with abuse and has attracted ongoing
21 widespread public interest and debate.
22 Throughout this module the Inquiry has kept a clear
23 focus on the facts, on finding out what happened and why
24 things happened the way they did. Mr Aiken posed the
25 following questions in his opening of the Kincora

1 module:
2 Who was abused?
3 By whom?
4 Who knew about it?
5 What did they know?
6 When did they know about it?
7 What did they do with that knowledge?
8 What ought they to have done with it?
9 Always coming back to the central question of
10 whether system failures by the State caused, facilitated
11 or failed to prevent abuse occurring in Kincora.
12 Aided by the forensic approach of the Hughes
13 Inquiry, as evident in the transcripts of evidence and
14 the Hughes Report itself, the Health & Social Care Board
15 filed a written statement with the Inquiry before the
16 public sittings of this module began, acknowledging nine
17 missed opportunities by its predecessor organisations to
18 prevent abuse occurring at Kincora across two decades.
19 In other written statements, amplified in oral
20 evidence by Ms McAndrew, the Health & Social Care Board
21 also identified multiple system failures attaching to
22 the same period. As the Panel knows, many of these
23 failings relate to aspects of good social work practice:
24 record-keeping, communication, making referrals to the
25 police and operating a monitoring system designed to

1 ensure that the hostel was being run in a manner so as
2 to further the well-being of its residents.
3 It is clear that practice in these areas fell short
4 in respect of Kincora and its residents too many times,
5 and in the Health & Social Care Board's submission many
6 of the missed opportunities and failings have their
7 roots not just in the structures but also in the
8 decision-making, some of the people who worked in the
9 structures at the time.
10 The care giving staff in Kincora, Messrs Mains,
11 Semple and McGrath, abused their position of trust in
12 harming boys placed in their care and placing other boys
13 at sexual risk of harm.
14 It is known that Mr Mains, warden of the hostel, did
15 not report abuse to his superiors. This no doubt was
16 a significant personal failing on his part. However,
17 the care giving staff were only part of the system.
18 They worked within a wider system of monitoring and
19 supervision which ought to have provided vital
20 protective mechanisms for the residents in Kincora. Yet
21 these systems failed to protect residents of Kincora,
22 and the Health & Social Care Board has identified that
23 there were deficits in the monitoring activities of its
24 predecessor organisations.
25 Crucially monitoring reports did not communicate

1 vital information of a child protection nature to people
2 who needed to know at board headquarters level.
3 The Health & Social Care Board has accepted that the
4 systems to implement statutory monitoring during
5 Kincora's operation were underdeveloped and the Inquiry
6 has heard from Mr Bunting, a most experienced and highly
7 regarded practitioner in this field, who has said he
8 regards the lack of policy for monitoring post
9 reorganisation as a significant flaw in the system.
10 There are other significant failings, however, in
11 the areas of record-keeping and communication. There
12 was a lack of effective working together, as vital
13 information was not shared between different levels of
14 management within the Health & Social Care Board's
15 predecessor organisations, and from senior management to
16 Committee and board level.
17 The lack of records about key matters such as what
18 happened after Mr Mason's August 1971 memo was sent to
19 the Town Solicitor leaves unanswered questions about why
20 no further action was taken, and this is unacceptable.
21 The lack of record about the outcome of the 1971
22 complaint also signalled the beginning of an
23 uncoordinated individualised response to similar fact
24 allegations. This might have been different if a
25 process was put in place in 1971 to ensure that the

1 previous matters would be looked at again if more
2 matters of concern came to light.
3 In the Health & Social Care Board's submission the
4 failure to draw together the complaints and put in place
5 a process for dealing with subsequent complaints chimes
6 with practice evident from other modules when serious
7 complaints made by children in care in the pre-Kincora
8 era were handled on an individual basis with the
9 possibility of institutional abuse not appearing to
10 register as a cause of concern.
11 The Panel will recall the response to allegations
12 made in Rubane in 1980, April of 1980. This response
13 was on an institutional scale, with practically all of
14 the boys in residence being interviewed by police. This
15 coincided with the police investigation into Kincora,
16 and in the Health & Social Care Board's submission this
17 may signal a watershed in the evolving state of
18 knowledge about institutional abuse of children in care.
19 As the Panel knows, events at Kincora first came to
20 public attention in January 1980, when two social
21 workers spoke to the press. They have said they felt
22 driven to take this step as nothing appeared to have
23 been done to resolve the suspicions about the hostel
24 which had been known to them in the late 1970s through
25 their involvement with Richard Kerr.

1 Just prior to this R18's social worker told her
2 managers about her concerns regarding Mr Mains and
3 Mr McGrath, which were appropriately passed on to those
4 with supervisory responsibility for the hostel. You
5 will see that the knowledge or lack of knowledge held by
6 the many social workers that visited Kincora over its
7 years of operation is a matter that will be developed
8 further in the written submission to be filed by the
9 Health & Social Care Board.
10 It is, however, important to say at this juncture
11 that the Inquiry's detailed analysis of what the
12 residents themselves have had to say lends weight to the
13 secret nature of the sexual abuse that occurred with the
14 three members of staff operating as individuals within
15 Kincora and reflecting on all the evidence, the Health &
16 Social Care Board's view is that those who were abused
17 in Kincora were not abused as part of a vice ring or
18 child prostitution, rather, this was abuse of individual
19 boys by individuals.
20 In the Health & Social Care Board's submission there
21 needed to be stronger, lateral and vertical
22 relationships within its predecessor organisations
23 encouraging the sharing of information and an effective
24 monitoring and investigation process. However, there is
25 no evidence that indicates there was any effort, attempt

1 or decision to cover up the activities in Kincora by
2 staff in management positions within the welfare system.
3 There was further no evidence that actions were taken
4 with a deliberate intent to protect the institution.
5 It is important to remember, however, that this is
6 a reflection upon the past. Systems in place today are
7 unrecognisable with major developments and multi agency
8 working, particularly through joint protocols between
9 police and Social Services to investigate complaints of
10 abuse.
11 It is with sadness and regret that the Health &
12 Social Care Board recognises that the systems in place
13 to protect children in care failed to protect those
14 residents of Kincora who experienced abuse, and that
15 repeated opportunities were missed over a prolonged
16 number of years to detect and prevent abuse and report
17 complaints of abuse by some former residents to the
18 police.
19 As was said by Mrs McKee all those years ago, the
20 intention and aim was that all Kincora residents would
21 have a true home which would have a lasting good
22 influence on their lives. This chimes with the Board's
23 intention when receiving these children into care, which
24 was to offer them support and protection, and the Health
25 & Social Care Board is sorry that abuse occurred which

1 has had such devastating impact on the lives of some
2 former residents.
3 The Health & Social Care Board, therefore, offers
4 a whole-hearted apology to all those former residents of
5 Kincora that suffered abuse.
6 Chairman, Members of the Panel, that concludes the
7 submissions of the Health & Social Care Board.
8 CHAIRMAN: Thank you.
9 Now, Mr Robinson, I think that in one sense the RUC,
10 for whom you appear in the guise of the Police Service
11 of Northern Ireland, must conveniently follow Ms Smith
12 and then I will invite Mr McGuinness to speak on behalf
13 of the Department.
14 Closing submissions on behalf of THE RUC
15 MR ROBINSON: I am obliged, Mr Chairman and Members of the
16 Panel. If I can firstly start by recognising the work
17 conducted by your team, and I wish to thank both counsel
18 and your team of solicitors and researchers. I would
19 also like to thank the team on behalf of the PSNI. We
20 had a disclosure team, a liaison team and also analysts
21 that have worked and lived in these papers in excess of
22 two years. Certainly my task has been made a lot easier
23 using their work and meeting with them and discussing
24 the case. I hope when the materials are published on
25 the website it will be clear to the public just the

1 level of cooperation and dedication exhibited by the
2 PSNI to assist the Inquiry.
3 The approach of the PSNI has been to provide the
4 utmost cooperation to the Inquiry far beyond merely the
5 provision of the disclosure, and letting the Inquiry
6 work away with that. It has been there to answer
7 queries, explain the contents of documents and provide
8 context to those documents.
9 It was important to the PSNI to set out at the start
10 of DCS Clarke's witness statement where the police stand
11 now in relation to these issues, and that essentially
12 shows a stark contrast between what takes place now, the
13 multi agency approach, the communication. I think
14 that's a key theme throughout this module;
15 communication.
16 The system now involves dedicated officers who have
17 been trained. They are aware of these issues. They
18 liaise with Social Services and the aim, as you heard
19 from DCS Clarke, is to ensure as much as possible that
20 this does not happen again.
21 It is also important on behalf of the Police Service
22 to highlight the context within which policing existed
23 at that time in the '70s. People were being bombed and
24 maimed and killed on a day-to-day basis. In 1974 there
25 were 220 victims arising from 185 terrorist incidents,

1 89 of which were in Belfast. In 1976 there were 289
2 victims arising from 213 incidents, 13 deaths within
3 Belfast. That excludes people who are injured and
4 maimed. I would wish to draw the Panel's attention to
5 paragraph 19 of DCS Clarke's statement in which he said:
6 "Routine policing would frequently have been
7 secondary to dealing with, whether responding to or
8 seeking to prevent murder and violence that was so
9 common."
10 If I may touch on three issues that arose in the
11 oral evidence for the PSNI. There was the anonymous
12 call in May 1973, 23rd May. Constable Long was tasked
13 to go and investigate that. He was essentially given
14 possibly the weakest form of evidence of evidence of an
15 offence, an anonymous call. You cannot go back and
16 speak to that person to get further details. You don't
17 have an injured party to obtain a statement from to put
18 that before a court. Constable Long was then faced when
19 he attended Kincora with Mr Mains, who was the head of
20 the house, who vouched for Mr McGrath. At that stage
21 Mr McGrath was in his 50s. He was married with three
22 children. He was a religious man. The view of the PSNI
23 is that at that stage the way in which that call was
24 dealt with was appropriate and reasonable in those
25 circumstances.

1 The second issue touched upon in oral evidence was
2 linked to Detective Superintendent Graham and his
3 contact with Valerie Shaw in June of 1974. DCS Clarke
4 was in agreement with the criticism of Detective
5 Superintendent Graham in the Terry review. He failed to
6 pass on the information he received. He was a senior
7 officer. He failed to engage a skilled officer to take
8 charge of the investigation, and he failed to record any
9 information.
10 The third area of concern for the Inquiry and the
11 PSNI was the inter-relationship between Detective
12 Constable Cullen and ACC Meharg. That was explored not
13 only in the Hughes Inquiry, but through the Terry
14 report. The view of the PSNI is that DC Cullen was not
15 the right person for this task. To quote DCS Clarke:
16 "It was the investigation -- his task was not within
17 his province of knowledge or expertise. It may well
18 have been a more appropriate matter for a generalist
19 detective CID officer."
20 The training that DC Cullen had returned from in
21 early 1974 was his initial training as a detective.
22 This task was simply beyond him. That failing was added
23 to by the lack of any structure imposed by ACC Meharg.
24 We heard very clear evidence from DCS Clarke that the
25 ACC is not there to supervise an investigation on a

1 day-to-day basis. He should have put someone in the
2 layers of rank below between him and DC Cullen to look
3 after this and that did not happen.
4 Mr Aiken drew attention to the acknowledgment by ACC
5 Meharg in the Hughes Inquiry as to his failings. It
6 will not gain anything from repetition today, but the
7 Inquiry will remember a couple of days ago the frank
8 admissions from ACC Meharg that more should have been
9 done and back in 1974.
10 Now an issue arose during the course of the Inquiry
11 about the Cullen documents that he refers to in the
12 Hughes Inquiry and whether or not his three reports from
13 January 1980 were actually part of the Caskey
14 investigation, part of the Sussex investigation. Work
15 was conducted to look through the papers again to find
16 the various links, and the PSNI have produced to the
17 Inquiry the documents that evidence, in fact,
18 a direction -- the Irish Independence article was 24th
19 January 1980. There was a conversation when ACC Meharg
20 returned from Scotland. That conversation was condensed
21 into writing, and the second item on that list was that
22 DC Cullen was to update his 1974 report.
23 Also in that memo he states that Cullen is to obtain
24 a copy of what we now know as the Mason report from
25 Mr Bunting and provide that. Also in that paragraph is

1 mentioned by ACC Meharg that he had no recollection of
2 receiving that, and that DC Cullen claims he sent it but
3 had no copy of that.
4 So to dispel the suggestion of a cover-up, that's
5 the ACC putting in black and white at the start of this
6 investigation that there was an issue about the
7 communication of that report, and it certainly does not
8 smack of someone who is attempting to cover up that
9 aspect.
10 Now we then have the three documents that were
11 compiled by DC Cullen and they are at 50573 of the
12 bundle. They were compiled by DC Cullen. They are
13 dated 26th January. They are labelled Intelligence
14 Documents, because they were first of all six years old
15 and the contents of the documents related to previous
16 interaction between Mr Garland and Mr McGrath in the
17 '60s. We see reference to that made in DC Cullen's 30th
18 April statement to Caskey where he actually talks about
19 receiving information from Garland. Then states:
20 "There was no evidence William McGrath has been
21 involved in any irregular behaviour at Kincora Boys'
22 Home. All the Intelligence", and I stress that word,
23 because this was background information, "related to two
24 events that were not current. They were not current
25 information and did not relate to any direct allegations

1 of any irregularities at the Kincora Boys' Home other
2 than what had already been investigated."
3 I looked over the 24th January 1980 newspaper
4 article. There were current allegations of a vice ring
5 and boys being abused by way of prostitution. That's
6 what Caskey was investigating at that time. The
7 information from Mr Garland was from an alleged injured
8 party who had married, had a new life and was not going
9 to provide a witness statement about that abuse. So it
10 was background information.
11 Now we have cross-referenced Mr Caskey's journal and
12 we have exhibited that. We have sent that through to
13 the Inquiry. That details a meeting on 29th January
14 with Cullen, and we can't imagine any other reason but
15 to discuss the contents of his report. We then have
16 investigations carried out on 30th April. He provides
17 the statement. Phase One results in convictions on 16th
18 December 1981. Into 1982 was the start of Phase Two of
19 Caskey's investigations.
20 Now what we do have is a letter he sent to Special
21 Branch on 1st March 1982, and there was a suggestion
22 that the Cullen documents did not make their way to
23 Caskey or Sussex, but this Caskey letter to Special
24 Branch, it is sent to ACC Crime. It states:
25 "In view of the recent allegations in the press it

1 may be necessary to further some inquiries before
2 re-interviewing the defendants in the Kincora case
3 Mains, Semple and McGrath. I would appreciate some
4 background information from Special Branch on the
5 following persons."
6 Now there is a list of 17 individuals. When one
7 compares that list to the Cullen documents, they are
8 lifted from the Cullen documents. Crucially, Members of
9 the Panel, I draw attention to the very last sentence in
10 that communication:
11 "Please see attached Intelligence log provided by
12 D/Con Cullen on 26th January 1980."
13 So he is not referring to a report dated 26th
14 January. It is provided on, and that attached the
15 document that's set out at 50573 of the bundle. So it
16 was known to Caskey, and when the allegations moved from
17 simply the vice ring in Phase One to a wider aspect of
18 prominent individuals, that's when he used this document
19 to seek further background information.
20 We cross-referenced that communication with
21 Mr Caskey's journal entries and we find for the very
22 first number of days of March 1982, and that's the same
23 date as this memo to Special Branch, he's briefing the
24 Sussex team all over the early days of March 1982, and
25 they were there to oversee what he was doing. So that

1 must have been an issue that was discussed at the time.
2 We also have a response from Special Branch on
3 4th March 1982 as well answering the queries relating to
4 the 17 individuals. So that's clearly background
5 information that Caskey was seeking through his
6 investigation.
7 We also have at 40736 of the bundle Flenley's
8 statement. He meets Detective Constable Cullen on
9 12th March 1982 and it expressly records him receiving
10 the three Cullen documents. That ties in, Mr Chairman,
11 Members of the Panel, with a communication at 79261 of
12 the bundle from Vincent Lynagh, who was the legal
13 adviser to the police at the time of the Hughes Inquiry.
14 When the issue regarding JC1 through 8 was raised in the
15 Hughes inquiry the question was raised whether or not
16 they reached Caskey and whether or not they reached the
17 Sussex team.
18 The response from Legal Services was that they had
19 been compiled and sent. They are addressed to Meharg.
20 It was unknown whether or not he got them, but they were
21 sent to the investigators conducting the investigation
22 at the time, which is Caskey's team. So that appears to
23 logically fit, that Caskey had them and then deployed
24 them in 1982 when the investigation expanded.
25 Members of the Panel, I don't intend to go into

1 detail on any other aspects and I will reserve those for
2 the written submissions. What I can say is that the
3 evidence before the Panel shows what failings can take
4 place when there is a lack of communication. I know
5 that the Inquiry's report will be a communication to the
6 public about the truth of Kincora, and no doubt that
7 your counsel has explained that all the allegations are
8 going to be set out clearly from every individual
9 complainant. I think that will bring clarity for the
10 public to demonstrate exactly what was alleged, because
11 there will be an absence of the vice rings, the
12 prostitution, the prominent people, and it will dispel
13 the sordid headlines that have reached the press and
14 fuelled this ongoing episode.
15 No doubt where there are failings the Panel will
16 highlight those so the public can learn what exactly
17 went wrong. I hope that the cooperation of the PSNI and
18 the frank acknowledgment of those failings forms part of
19 that report and the PSNI welcome that.
20 Where there is evidence of false perpetuated
21 allegations I would invite the Panel to strike them
22 down, because they serve no further purpose except to
23 prolong the torment experienced by the abused. The
24 whole episode from the 1980s has been fuelled by the
25 actions of a small number of individual who have failed

1 to cooperate with this Inquiry, their one chance, their
2 venue to vent every aspect of their allegations.
3 Finally, Mr Chairman, Members of the Panel, I hope
4 that the Panel find that the PSNI have assisted to the
5 utmost degree, and that assistance will continue until
6 the end of the Inquiry's journey and the report is
7 completed.
8 Unless there is anything further?
9 CHAIRMAN: Thank you. Mr McGuinness?
10 Closing submissions on behalf of
11 the DEPARTMENT OF HEALTH, SOCIAL SERVICES & PUBLIC SAFETY
12 MR McGUINNESS: Chairman, Members of the Panel, the Inquiry
13 has now heard the evidence in relation to this module
14 relevant to Kincora and Bawnmore. The Department of
15 Health who I represent have not sought in this module
16 or, indeed, in any of the other modules to challenge the
17 evidence of any of the complainants in relation to their
18 allegations of abuse or the extent of that abuse, and we
19 trust the Inquiry will, like in all of the modules, turn
20 a forensic eye to all of the allegations, but it is
21 important to note at the outset that the Department of
22 Health regret the abuse which undoubtedly took place in
23 relation to this module, and condemns both the
24 perpetrators of the abuse and any others who by act or
25 omission allowed abuse to take place.

1 It may be appropriate at this stage to highlight
2 a number of aspects which have been identified in this
3 modules and in other modules in relation to sexual and
4 other forms of abuse of children. In this module in
5 particular evidence has been heard from the victims of
6 abuse, many of whom were amongst the most vulnerable in
7 our society by virtue of emotional and intellectual
8 difficulties. What is striking about the abuse
9 identified in this module is how it was perpetrated in
10 secret, even though in the case of Kincora it was the
11 three members of staff responsible for the care of the
12 children who were responsible for the abuse.
13 In the evidence of victims during this module you
14 will have heard the abusers described as cunning. That's
15 Day 209 and that's Hugh Quinn, described how they abused
16 boys when they were alone. That's James Miller and Day
17 210, and in a manner that they attempted insofar as they
18 could to ensure that nobody found out.
19 What you might regard as a striking feature was some
20 boys who were being abused were not aware that others
21 were being abused, or that other staff members were
22 abusing other boys. As Dr Harrison indicated this
23 morning, there were boys who were in the home who spent
24 a considerable amount of time there who were unaware of
25 any abuse or any suggestion of abuse taking place.

1 In relation to both of the homes in this module the
2 predecessors of the Social Care Board, that is the
3 Belfast Welfare Authority, later the Eastern Health and
4 Social Services Board and the Northern Health and Social
5 Services Board in relation to Bawnmore, had the
6 immediate and direct responsibility for the running,
7 management and monitoring of the homes. The
8 Department's predecessors, that's initially MoHA, the
9 Ministry of Home Affairs until direct rule, later the
10 DHSS and the DHSSPS had a general responsibility for the
11 provision of welfare, later the Social Services, and
12 that derives from Article 72 of the 1972 Order whereby
13 the Department was obliged to provide and secure the
14 provision of Social Services, and that included Social
15 Services for children. Obviously the Department had
16 responsibility where it delegated the duties to the
17 boards as it did in these circumstances, to ensure that
18 the duties were appropriately discharged in relation to
19 children in residential care.
20 You will have heard this morning from Dr Harrison
21 that there were concessions made by the Department in
22 relation to the manner in which they ensured that those
23 duties were being discharged, particularly in relation
24 to the monthly visiting which we have dealt with this
25 morning.

1 The Hughes Inquiry in 1984 heard evidence in
2 relation to the various statutory functions and all of
3 the other issues over a 60 day period. That Inquiry had
4 the benefit of hearing first-hand and in particular of
5 observing the demeanour of the 66 witnesses who were
6 called and extensively cross-examined. While the terms
7 of the Hughes inquiry were more limited than this
8 Inquiry you have had the advantage of hearing from
9 witnesses at a much closer remove.
10 In fact, the Hughes Inquiry has been invaluable in
11 the sense that the Department has had to rely on the
12 files that were made available to the Hughes Inquiry to
13 deal with this module. The Hughes Inquiry made a number
14 of findings in respect of the inspection regime which
15 the Department was implementing. The Department did not
16 challenge those and does not seek to resile from the
17 findings of the Hughes Inquiry, save that it feels the
18 Hughes Inquiry did not have the benefit of a clear
19 exposition from the witnesses of the role the Seebohm
20 report is likely to have had in the apparent change of
21 practice post 1972.
22 I make that point, and Dr Harrison made that point
23 this morning in particular to attempt to dispel any
24 suggestion that the retraction of inspection activity
25 was some gradual lapse into complacency rather than

1 a change in focus in which the SWAG were seeking to be
2 supportive and provide an advisory relationship with
3 social care providers with the emphasis on visits rather
4 than regimented inspections.
5 Obviously this Inquiry is not obliged to accept the
6 findings of Hughes, but it is respectfully submitted
7 that weight will be put on those findings in the absence
8 of new and compelling evidence to the contrary.
9 The most significant findings, and I propose to
10 shortly deal with some finding of Hughes in relation to
11 Bawnmore and Kincora and then comment on those.
12 Effectively they can be more generally described in
13 relation to the frequency and nature of departmental
14 inspections, in particular in relation to Bawnmore, the
15 Hughes terms of reference commence in 1960 and there
16 were 13 reports of inspection of Bawnmore between 1962
17 and 1970. I submit that given the evidence in other
18 modules in relation to annual or bi-annual inspection of
19 childrens' homes by people whose names will by now be
20 familiar to you all: Miss Hill, Ms Forrest, Dr Simpson,
21 it is likely that MoHA did carry out inspections between
22 the opening of the home in the mid 1950s and 1962.
23 Despite the criticism of the methodology which was
24 employed by the Department in Bawnmore, and the scope of
25 the inspections Hughes did find that these inspections

1 were not without effect. It is noteworthy that with
2 regard to the inspection information on Bawnmore
3 considered by the Hughes Inquiry, there was evidence of
4 inspectors' concerns having been followed up and having
5 led to improvement by the time of the next inspection.
6 That can be found at HIA867.
7 Whilst there is no reference in the Hughes Report to
8 inspections by MoHA or SWAG after 1970, the Hughes
9 Report stated at HIA867:
10 "Specifically in regard to Bawnmore we consider that
11 the record of the Ministry of Home Affairs inspectors
12 during the relevant period was more than adequate in
13 terms of frequency. Our view that the scale and nature
14 of the inspections was not entirely satisfactory is
15 qualified by the commendable frequency and regularity of
16 them. The opportunity which the Ministry of Home
17 Affairs inspectors would have had for detecting the
18 homosexual offences involved in Bawnmore residents,
19 however, was minimal."
20 Now to turn to what Hughes said in relation to
21 Kincora, you have heard this morning that there were
22 three inspections of Kincora in '65, '72 and '79, and
23 there was evidence from the record book in relation to
24 the various visits. Hughes did find that the
25 inspections by MoHA had minimal potential for preventing

1 or detecting homosexual offences against residents.
2 However, while Hughes did not believe that there could
3 be any defence of the record of formal inspections, it
4 did acknowledge that inspectors' less formal visiting
5 would have alerted them to overt signs of deteriorating
6 standards.
7 So while there may have been an issue with
8 inspection, nonetheless, this less form of visiting
9 would have alerted them to signs of deteriorating
10 standards. Hughes commented favourably in respect of
11 the intention, if it can be put that way, that was
12 evidenced in and from February 1976 to change the
13 process. It's been accepted that that change was not
14 affected. It wasn't affected because of, amongst other
15 things, constraint on professional resources, but Hughes
16 did find that the Department's evidence satisfied us
17 that the low frequency of inspections arose more from
18 constraint on professional resources than from
19 inspections being given a deliberately low priority.
20 Most importantly, it's clear from the Hughes Report
21 and it is consistent with the Department's position that
22 the Department were unaware of any of the allegations or
23 suspicions that were held by various parties about
24 Kincora before 24th January 1980.
25 A number of points can be made in relation to the

1 various conclusions of Hughes. First, it is clear that
2 the Kincora allegations and the convictions in 1981 and
3 the findings of the Hughes Report were a watershed in
4 relation to knowledge of the systematic abuse of
5 children by staff members.
6 Dr Harrison on behalf of the Department confirms
7 that whilst there may have been individual knowledge
8 amongst social work professionals of the potential for
9 abuse by adults or peers, institutional sexual abuse of
10 children by staff was not recognised as a phenomenon
11 until the early 1980s.
12 It is of note that there were a number of regular
13 visitors to the home to include social workers, other
14 staff members, all of those people who appear to have
15 been unaware of the abuse. The Hughes Inquiry noted the
16 monthly visits from the Children's Officer, later the
17 social worker of the child, and the various committee
18 members might have presented a deterrent to abusers, an
19 opportunity for atmospheres to be detected or complaints
20 receive. However, that did not occur.
21 Now, those monthly visits were found by Hughes to be
22 unlikely to have detected cases of homosexual misconduct
23 unless there was some sign of distress in a resident
24 which had become apparent or a complaint was made.
25 I respectfully suggest that whilst inspection is

1 important in the framework of factors which work to
2 safeguard children, even if SWAG inspection visits had
3 been increased, taking into account the contemporary
4 standards that were being applied at the time and the
5 cunningness of the abusers, there must be even greater
6 momentum to reach the conclusions that Hughes did, that
7 the inspections would have been unlikely to have
8 identified misconduct in the absence of direct
9 observation of abuse.
10 I wonder can I turn to how the Department responded
11 to the allegations in Kincora? In respectful submission
12 the Department responded robustly. In May 1980 the
13 Permanent Secretary of the DHSS concluded that whilst no
14 system of inspection can guarantee either to prevent or
15 detect abuse, the Department had to put the system of
16 inspection onto a more formalised and regular basis with
17 greater resources channelled into inspection. That led
18 to a more rigorous robust inspection methodology being
19 developed and a general inspection taking place of other
20 residential homes between October 1980 and March 1984.
21 Following from these inspections a further follow up
22 inspection took place to ensure that implementation of
23 any of the findings. A programme of regular annual
24 inspections of voluntary homes and three-yearly
25 inspections of statutory homes was devised and

1 implemented thereafter. This would continue to be
2 developed and adapted so that residential child care was
3 examined against defined and measurable standards of
4 quality and care until the inspection function was
5 transferred in 1986 to the board's registration and
6 inspection units.
7 Evidence of this continued to develop and to adapt
8 is found in 1986 whereby SWAG collaborated with the
9 Board to agree a comprehensive set of standards for
10 residential child care. In 1994 further standards were
11 developed for inspection and monitoring. That can be
12 found at GOV683. This latter programme included a
13 strong emphasis on the need for inspectors to speak
14 directly to children and seek confidential feedback from
15 children and their parents regarding aspect of care in
16 the home.
17 The Sheridan Report was commissioned from the DHSS
18 in England. It reported in June 1982. It's of note
19 that many of the recommendations from this report were
20 already in place before the Hughes Committee reported.
21 In January 1985 the Department issued a paper
22 entitled "The Statutory/Voluntary Relationship in the
23 Provision of Child Care". This sought to address the
24 financing and wider future of the voluntary sector
25 residential child care. The Department, as you have

1 heard from Dr Harrison this morning, embraced the
2 recommendations of the Hughes Inquiry published in 1986,
3 and this implementation is described by Dr Harrison as
4 the most significant milestone in the development of the
5 residential child care policy and practice with the
6 regulatory framework and associated guidance in Northern
7 Ireland until the 1995 Children's Order.
8 It is important to note that these initiatives led
9 from what was a difficult period to having a residential
10 child care workforce which had the highest proportion of
11 professionally qualified social work staff in
12 residential care anywhere within the United Kingdom.
13 It may well be that the Inquiry reflect that given
14 the manner in which the Department and the other
15 statutory bodies reacted to the Kincora allegations,
16 that the Department reflects on whether if missed
17 opportunities identified in the evidence during this
18 module had been brought to light, whether this is likely
19 to have brought forward the abuse and this watershed
20 moment which resulted in significant changes.
21 The Department, as I have already indicated, had no
22 knowledge of the allegations until January 1980 and
23 notes the media allegations which resulted in a number
24 of police inquiries and the setting up of the Hughes
25 Inquiry. It is unfortunate that some of those who have

1 been responsible for these allegations have not come
2 forward to give evidence and have it tested. The
3 Department, however, recognises the endeavour of the
4 Inquiry to leave no stone unturned in its efforts to
5 address these issues and is confident that a forensic
6 eye will be turned to these, like all of the issues in
7 the Inquiry.
8 In conclusion I suggest that the present child care
9 landscape bears little, if any, resemblance to the
10 landscape dealt with in this module. That's not to say
11 that statutory bodies have become complacent. Rather,
12 it is to reflect the positive change and constant
13 vigilance that is a watchword for today's residential
14 child care environment.
15 Finally -- I know I said in conclusion -- I want to
16 acknowledge the fact this has been somewhat of a long
17 march, this Inquiry, that at times it has dealt with
18 significant volumes of material and evidence, and I want
19 to acknowledge the courtesy, patience and at times
20 humour of the Inquiry Panel, counsel, staff and everyone
21 who has been working collaboratively to enable this
22 Inquiry to come to a close today.
23 Unless there's anything further.
24 CHAIRMAN: Thank you. Now, Ms Murnaghan, it falls to you on
25 behalf of the core participants on behalf of whom you

1 appear to address us in conclusion.
2 Closing submissions on behalf of
3 the NIO, the MoD, MI5 and MI6
4 MS MURNAGHAN: Yes. Chairman, Members of the Panel, as you
5 know I appear on behalf of four of the core
6 participants, that's the NIO, the MoD, MI5 and MI6,
7 which is sometimes referred to SIS somewhat
8 interchangeably. Given that I represent four of the
9 core participant, I have tried to keep my submissions as
10 brief as possible, but possibly it should come under
11 half an hour, if that's of any assistance, but do feel
12 free, Chairman, to stop me at any stage if there is
13 a perception that I am going into too much detail.
14 If I could commence by saying that critical to any
15 assessment of whether as regards my four core
16 participants there was a cover-up of abuse of the
17 children in Kincora, is the extent to which these four
18 core participants have to, in effect, prove a negative.
19 As you know, the entire exercise of proving a negative
20 goes completely contrary to the usual course of how
21 legal proceedings are conducted.
22 However, the position that these core participants
23 find themselves in is such that this is an exercise with
24 which they have embarked with gusto, and they have
25 accepted that they have had little option but to

1 approach it in the correct spirit of proving this
2 negative. To that end it is now contended that this
3 Inquiry should be able to conclude firstly, that each of
4 the four core participants knew nothing relevant about
5 child abuse in Kincora until after the scandal broke in
6 the media in 1980, and that, secondly, all of the
7 assertions to the contrary are both without foundation
8 and do not withstand scrutiny.
9 So what the Intelligence agencies knew during the
10 1970s when William McGrath was working in Kincora, has
11 been examined, as you know, in considerable depth over
12 the previous few weeks. The knowledge of each of the
13 four core participants has been analysed in the context
14 of the key questions articulated by Mr Aiken at the
15 beginning of this module, being:
16 Who was abused by whom?
17 Who knew about it?
18 What did they do with that knowledge?
19 Whether systems failures caused or contributed to
20 the problems in Kincora.
21 We have had a detailed examination of the security
22 grouping and the complex interplay of responsibilities
23 as they lay between the four core participants as they
24 were shared in the 1970s. The Inquiry has been advised
25 of how MI5 lent assistance to the MoD and the RUC, and

1 then there was the established the Irish Joint Section
2 from 1972. The Inquiry has learnt how the IJS, the
3 Irish Joint Section, was staffed by MI5 and MI6 on
4 secondment and how operations were run both in Northern
5 Ireland and in London.
6 Although there was clearly a degree of overlap
7 between what each of these agencies did, it is my
8 contention that that particular overlap does not require
9 an analysis for the purposes of this Inquiry in any
10 greater detail.
11 Now in this submission I do not propose to conduct
12 a detailed analysis of what was known about Mr McGrath
13 and when, and by which core participant, because frankly
14 it would just take far too long. That will be dealt
15 with in written submissions. However, I do propose to
16 draw out some key themes and points in the evidence
17 which are felt merit additional particular
18 consideration.
19 Firstly, might I say that it is clear that evidence
20 and intelligence was collected in relation to the
21 organisation known as Tara. Because of his involvement
22 in Tara, evidence or intelligence was also gathered in
23 respect of Mr McGrath. This, however, should not be
24 confused with the core participants being imputed with
25 having any knowledge that as a member of this

1 paramilitary style organisation Tara, or even as someone
2 who was reputed to be a homosexual, that there was some
3 equivalence that the participants knew that Mr McGrath
4 was abusing children in Kincora.
5 As to the witnesses, the Inquiry have heard
6 a reasonable number of witnesses from the core
7 participants and been the benefit of additional witness
8 statement from others. Primarily the Inquiry benefitted
9 from the evidence given by two deputy directors of SIS
10 and MI5, who both submitted fulsome statements which
11 were added to with a number of exhibits. Both Officer A
12 and 9004 confirmed that MI5 and SIS take the issue of
13 child abuse very seriously. They also confirmed that
14 everything possible has been done to identify files to
15 support this Inquiry's investigation.
16 They further confirmed that every effort had been
17 made by their respective organisations to identify
18 relevant documentation, discovery files, using
19 experienced and trained staff. To this end Officer A
20 made three statements and in his evidence he confirmed
21 certain key factors which deserve some repetition:
22 Firstly, that Tara was not a major threat or
23 organisation in their opinion at the relevant time and.
24 Secondly, although SIS was aware of reports
25 indicating that McGrath was homosexual, the fact of

1 Mr McGrath being a homosexual was not of any particular
2 significance to SIS, and he emphasised that SIS would
3 not use someone's homosexuality, whether now or then, to
4 blackmail them.
5 In October 1976 it became apparent that there was
6 some reference held on SIS files to McGrath being what
7 was termed as a sexual deviant. That is not to be
8 equated with knowledge that he had abused boys, whether
9 in his care or elsewhere, and one might also consider
10 the fact that those same records record the following
11 year in 1977 that consideration was being given to
12 whether Tara as an organisation could be penetrated,
13 a factor which has particular vision in the context of
14 the allegations that Tara itself was a construct of the
15 Security Services and, in fact, ran it.
16 There is one lacuna, potential lacuna which remains
17 in the evidence of the SIS officer and which only became
18 apparent during the exposition of his evidence, and that
19 is the remark at paragraph 5, a remark attributed to an
20 agent made in October 1989. Both MI5 and SIS have
21 carried out extensive searches to locate any basis that
22 would support this unmerited assertion, and to this end
23 I would like to confirm that additional statements will
24 be submitted to the Inquiry illuminating and confirming
25 the extent of those searches and explaining the complete

1 paucity of any basis for that remark to have been made.
2 Now a number of individuals were referred to.
3 I don't propose to look at all of them, but I do think
4 that perhaps James Miller's case is a case that merits
5 some additional consideration. His case would seem to
6 be a paradigm example of the extremely deleterious
7 effect that the involvement of some journalists have
8 brought to bear on what has been known as the Kincora
9 scandal.
10 This was demonstrated by Mr Miller being quoted in
11 a Sunday Times article in 1987 wherein it was alleged
12 that he claimed specifically that Intelligence Services
13 had known about the abuse at Kincora for a number of
14 years and had used it as a trap. However, the evidence
15 that this Inquiry was able to access in an unprecedented
16 manner was able to conclusively show that in
17 a subsequent interview in April 1987 Mr Miller confirmed
18 that he had absolutely no personal knowledge of Kincora
19 and the entrapment story and, in fact, he had been
20 misrepresented by the press.
21 Another individual who merits some particular remark
22 is that of Sir Morris Oldfield. The evidence of the SIS
23 witness was able to demonstrate that there was simply no
24 basis on which national security had been compromised by
25 Sir Morris Oldfield, or that he had been in any way

1 connected to Kincora, but nonetheless his involvement
2 was one which was no doubt a construct of certain
3 journalists' actions in the 1980s.
4 Additionally the Inquiry was able to hear evidence
5 from the MI5 Deputy Director, that was Officer 9004. He
6 made two statements. He confirmed that MI5 had provided
7 all relevant files and that importantly the Inquiry had
8 been able to view all files that it wished to see in
9 an unredacted form. Officer 9004 spoke to the role and
10 the nature of MI5, both in the 1970s and today, being
11 that its principal concern is one of safeguarding
12 national security, and it is important that that is
13 understood in analysing and understanding MI5's actions,
14 particularly in relation to the request of Detective
15 Superintendent Caskey to interview the then ASP,
16 Mr Cameron.
17 Importantly 9004 was able to categorically make a
18 number of significant assertions. The first was that
19 MI5's first knowledge of Kincora was when the scandal
20 broke in 1980. Secondly, that no intelligence
21 operations were linked to Kincora. Thirdly, that MI5
22 was not involved in any operation to exploit abuse
23 taking place in Kincora for intelligence purposes and,
24 fourthly, that there was no involvement of MI5 in any
25 type of paedophile ring connected to Kincora.

1 So all of that is notwithstanding the fact that in
2 the 1970s there were certainly a number of rumours
3 circulating about homosexuality, and it is a point which
4 was made and bears repetition, that although there was
5 intelligence gathered about Mr McGrath, intelligence is
6 not fact and needs to be assessed. In that period there
7 was also a particular action wherein it seemed that
8 a number of paramilitaries and those involved in
9 politics were each calling each other, in an attempt to
10 smear their reputation, homosexuals.
11 The Deputy Director, 9004, also discussed the
12 perceived tensions that existed in relation to
13 Mr Cameron, and the general perception that he was
14 unwilling to assist the police investigation. The fact
15 of the matter is I hope that the Inquiry can now
16 conclude that the perfectly straightforward and
17 compelling explanation offered by 9004 was that MI5
18 quite properly was concerned at the prospect of losing
19 control over matters touching on national security and
20 the inherent security risks to agent running activities
21 in the wider context.
22 It is commendable indeed that 9004 emphasised that
23 those individuals who had trusted MI5 with their lives
24 by being sources or agents, that MI5 in return owed them
25 a very strong duty of care, and that in those

1 circumstances their actions were not only
2 understandable, but they were reasonable.
3 This current day analysis is supported by the
4 contemporaneous document, amongst which was Mr Bernard
5 Sheldon's note of 1st October 1982, wherein he accepts
6 that the reluctance to provide Mr Cameron was not to
7 impede the investigation into Kincora, but to ascertain
8 the depth of the problem and how MI5 could assist
9 without breaching issues of national security.
10 It is also relevant to note that, of course, the
11 questions from Caskey were put to Cameron. He provided
12 written answers and those answers were provided to
13 Northern Ireland, albeit it seemed that they were
14 perhaps not forwarded on to the police at the
15 intervention of the Attorney-General as being "Hearsay
16 upon Hearsay." Again this is something which hopefully
17 this Inquiry is able to conclude has been resolved
18 without any shadow of a doubt.
19 Now on a separate theme there is the evidence
20 relating to McGrath. One might question what particular
21 significance there was in the fact that MoD and MI5 and
22 SIS at various times attempted to find out information
23 about Tara and McGrath. One might ask why this was
24 done, and if there was any truth in the various
25 allegations about agents of the state or alleged

1 intelligence gathering operations in Kincora.
2 The fist evidence in relation to Mr McGrath derived
3 from an MI5 summary card in 1973, and that first
4 evidence is fairly innocuous. He was recorded as being
5 the leader of Tara, and we did see over the previous
6 weeks how that intelligence was amassed and added to at
7 various points, but importantly at no stage in the
8 gathering of the intelligence in respect of McGrath was
9 there any reference to Kincora being a place of interest
10 or that abuse was happening there.
11 Indeed, it was only in 1977 that a permanent file
12 was opened by MI5 in relation to Mr McGrath, and Officer
13 9004 explained the criteria necessary for that file to
14 be opened. It is also important to note that it was
15 because of his activities as an Irish Protestant
16 extremist rather than anything to do with children that
17 the file was opened.
18 Now another factor that has taken a considerable
19 amount of time is the extent to which the MoD knew about
20 what was happening in Kincora. The waters have been
21 somewhat muddied by a report provided by an intelligence
22 researcher called Mr Noakes and his analysis in
23 December 1982 as to a reading -- a partial reading of
24 some of the files that were available to him.
25 Now unlike Mr Noakes, this Inquiry has had

1 unrestricted access to all documents held which are
2 currently held by MoD which permits the Inquiry to reach
3 quite a different conclusion, but Mr Noakes, although
4 the MoD contends he reached an erroneous conclusion for
5 the wrong reasons, his report is nonetheless relevant,
6 because it reveals that at that time, in common with
7 some others, such as Mr Rucker, there were other MoD
8 files available to him, but it would seem that those
9 files do not and did not contain anything that would
10 impute a reference to the MoD having knowledge of abuse
11 happening in Kincora.
12 In fact, Mr Noakes' conclusion was that the only
13 document of any concern was that written by Major C of
14 6th July 1974. The Inquiry has also had the opportunity
15 to hear evidence directly from Major C, who not only
16 provided a witness statement but his oral evidence
17 hopefully has allayed any concern that this document was
18 not to indicate that he had ever, or that the MoD had
19 ever run Mr McGrath as a source. It was confirmed that
20 Major C as a desk officer and had never met Mr McGrath
21 and was purely painting a pen picture of him.
22 Major C was able to emphasise on behalf of the MoD
23 a number of significant factors; firstly, that Tara as
24 an organisation was of limited interest to the Army;
25 secondly, that the suggestion of McGrath's homosexuality

1 was not of any material importance to the Army work. He
2 also emphasised the division in geographical as well as
3 hierarchical terms between his intelligence section and
4 the location of Mr Colin Wallace in the Press Relations
5 Information Policy Unit.
6 In his statement Major C was also able to state with
7 complete certainty that he had never seen the document
8 we have referred to as GC80, which was reportedly
9 written by Mr Wallace on 8th November 1974.
10 One might also impute some significance to the fact
11 that Major C's pen picture of William McGrath drawn up
12 in 1975 revealed absolutely no reference to the document
13 which one would have expected to have been available to
14 him if it had been penned by Mr Wallace in 1974.
15 The Inquiry has also benefitted from substantive
16 statements from Mr Jonathan Duke Evans. He has
17 furnished three statement, the third of which has dealt
18 with the MoD's policy and position in relation to the
19 Government policy of neither confirm nor deny, and drawn
20 the Inquiry's attention to some factors which it
21 considers relevant as regards the missing documents.
22 And it is with all of that, Chairman, Members of the
23 Panel, that the MoD are confident that they can say that
24 the conclusions reached by Mr Rucker in his report were
25 correct, that there was no knowledge on the Army's

1 behalf of any abuse in Kincora or, indeed, of any
2 involvement with Mr McGrath.
3 The Inquiry also heard evidence from the former ASP,
4 Officer 9047, and the relevance of his evidence to the
5 Inquiry was primarily to shed some light on the confused
6 picture painted by the former Captain Brian Gemmell in
7 relation to his interaction with the then ASP, Ian
8 Cameron.
9 Additionally the ASP, 9047, was able to cast some
10 light on why Mr Cameron would have made the
11 representations to Brian Gemmell that he did. It is
12 clear that the Security Service had no interest in
13 investigating one's sexuality. He was able to directly
14 give evidence to the Inquiry that had he been in
15 Mr Cameron's position he would have acted in exactly the
16 same manner.
17 In fact, over the years Brian Gemmell has indulged
18 in much unmerited and unjustified speculation as to the
19 reason why Mr Cameron initially told him in his belief
20 not to interview Roy Garland, and then advised him to
21 stay away from matters of homosexuality. It is
22 contended that this Inquiry now can understand the
23 rationale for that in light of the evidence it has
24 received. It is also clear that Gemmell is confused and
25 has conflated a number of events, both relating to the

1 number of times that he met Roy Garland to when the
2 instruction came from Mr Cameron, and the identity of
3 the person with whom he was instructed to break off
4 contact.
5 What he has referred to as the bawling out by
6 Cameron must have happened after the initial interview
7 with Mr McCormick, when he was asked for permission to
8 interview Garland. Witness Q this morning has
9 corroborated this analysis, and importantly there was no
10 indication at that stage that Kincora had been
11 mentioned. The contemporaneously made documents that
12 the Inquiry was referred to of the Roy Garland interview
13 are worthy of particular note. Nothing in those records
14 suggests that there was any suggestion in relation to
15 Kincora or that indeed McGrath's past conduct would be
16 a good indicator of his likely future conduct.
17 Additionally there was the matter of the missing
18 four-page MISR that Gemmell claimed that he had written,
19 and it would seem that Mr Aiken after many years has
20 located that lost MISR. Perhaps predictably the lost
21 MISR makes no mention of any of the salacious
22 allegations that were subsequently made by Mr Gemmell.
23 The Inquiry has also received a statement from
24 a Mr Clifford Smyth, who confirmed that he has and had
25 no evidence for the propositions put forward in Chris

1 Moore's book "The Kincora Scandal", namely that either
2 McGrath was an agent of the state or that Kincora
3 involved an operation run by the Intelligence agencies.
4 Mr Smith categorically confirmed that he was only aware
5 of Mr McGrath abusing children in his care after the
6 scandal broke in 1980, and so had made no prior
7 allegations against him.
8 Now the last individual who merits some mention is
9 undoubtedly Colin Wallace. Colin Wallace has made the
10 greatest single contribution to the allegations that
11 abuse perpetrated in Kincora was the product of an
12 intelligence plot. It is highly significant, it is
13 contended, that Colin Wallace had considerable
14 motivation in the 1980s to exploit what he alleged to
15 know about Kincora, and that was information which he
16 blatantly attempted to use in order to ameliorate his
17 position, as it was then, in prison.
18 It is also to be noted that Mr Wallace's specialist
19 skills lay in the manipulation of media. Consideration
20 indeed of how events have unfolded since his revelations
21 in the 1980s demonstrate the degree to which his
22 undoubted skills have continued to manipulate the media,
23 but most tellingly is the fact that Mr Wallace has
24 steadfastly refused to cooperate or participate in any
25 inquiry, to include this inquiry, that was likely to

1 scrutinise his allegations with any degree of rigour and
2 the inferences that should be drawn from, in this
3 circumstance, his non-cooperation.
4 I would also like to emphasise that this Inquiry has
5 had unprecedented and encyclopaedic access to all
6 relevant document relating to the many limbs of
7 Mr Wallace's complaints which touch upon Kincora, and
8 these documents include many secret documents which were
9 never previously available and which provide the
10 clearest and most comprehensive picture of his claims.
11 This evidence reveals that Wallace's claims that the MoD
12 knew of child abuse in Kincora and/or were aware of or
13 participated in the cover-up of that abuse, are
14 completely and utterly devoid of any merit.
15 I do not propose to rehearse all of the reasons why
16 Wallace's claims are so implausible and impossible of
17 belief. However, I would make some very brief comments.
18 Firstly, any examination of the judgment in the
19 Court of Appeal reveal in his criminal case the extent
20 of his willingness to lie and deceive.
21 Secondly, Mr Wallace's propensity to lie is not
22 simply restricted to circumstances of his own particular
23 crimes. One can also appreciate his fundamental
24 dishonesty by a consideration of the volt face that he
25 made in relation to the murder of Brian McDermott.

1 Thirdly, Mr Wallace has repeatedly lied about the
2 reasons why he was forced to leave the Army.
3 In this Inquiry we did consider the reasons for his
4 dismissal, and one can see now that we have seen all the
5 relevant documents, that his dismissal was not in any
6 way connected to Kincora, but rather was considered at
7 the highest level of Government across a number of
8 departments because of the very real risk that he posed
9 to security at that time. These documents contain no
10 hint whatsoever that Kincora or child abuse was in any
11 way connected to the dismissal. Rather, his dismissal
12 was solely related to the fact that the investigation
13 established that he had passed classified material to
14 the journalist Robert Fisk on a number of occasions, and
15 the Inquiry can, of course, appreciate the significance
16 of the conclusive proof that not only had he leaked
17 documents to Fisk, but that he intended to continue
18 leaking documents to Fisk before he left Northern
19 Ireland.
20 The Inquiry is now in a position to conclude that
21 there can be no credibility in Wallace's claim that he
22 was in contact with a female social worker in 1972 who
23 advised him McGrath was abusing a boy in his care.
24 Quite apart from the fact that there is no rational
25 explanation why such a social worker would have

1 approached him, none of the relevant individuals have
2 ever been located, namely, the boy, the social worker,
3 the police officer to whom she allegedly spoke, the
4 intelligence officer to whom Wallace allegedly spoke.
5 There is no evidence that he tried to alert the press,
6 as he has claimed, and it is simply not possible that
7 the document that the MoD has referred to as GC80, and
8 to that extent I would refer the Inquiry again to the
9 specific statement in relation to that document lodged
10 by Mr Duke Evans, as to how it was quite impossible for
11 the document to be authentic, namely that it was not
12 written in the Army in the 1970s.
13 Consequently we can say that there's absolutely no
14 single shred of cogent evidence that Wallace's claims
15 that MI5 were running an intelligence operation in
16 Kincora. It is quite clear that Wallace himself had
17 considerable motivation to make these allegations at
18 that time when he was in prison, and he remains
19 motivated to this day to perpetuate this myth.
20 I don't wish to rehearse the point made in relation
21 to the GC80 document. It is perhaps telling that none
22 of the journalists with whom he was in continued contact
23 after he left the Service recorded any note that he had
24 rehearsed to them the contents of GC80 and, in fact, it
25 only surfaced after the scandal in relation to Kincora

1 had emerged in the media.
2 Indeed, after Mr Wallace was arrested for the murder
3 the SIS searched his property and they were able to
4 conclude that he had had no access, and this was, of
5 course, before there was any suggestion that he had in
6 his possession the GC80 document, but that he had had no
7 access to or knowledge of Irish joint sector operations,
8 and in this context the repeated hurdles presented by
9 Mr Wallace justifying his refusal to assist the police,
10 or assist any subsequent inquiry, simply do not with
11 stand scrutiny. No-one has ever seen any of the source
12 documents for GC80 and, indeed, none of his colleagues
13 have ever corroborated that that document was in
14 existence. Even his greater supporter, Mr Peter
15 Broderick, have all denied all knowledge of GC80.
16 Now this morning the Inquiry heard evidence from
17 another Army officer, an Army officer who worked with
18 Brian Gemmell, and it is contended that it is clear from
19 Officer Q's evidence that Brian Gemmell was confused
20 about the evidence that he gave to Detective
21 Superintendent Caskey. Q was also able to accept that
22 he has erroneously conflated the abuse of Garland and
23 other boys at a religious event, or bible camp possibly
24 in Faith House, with the idea that if McGrath was
25 involved with a children's home then abuse must have

1 occurred there.
2 It is quite clear from Sergeant Q's references to
3 the involvement of both religion and the politics and
4 the future political future of the boys which McGrath
5 was said to intend abusing, are much more indicative of
6 Faith House type of environment than Kincora, a place
7 where, of course, Garland had never resided or attended.
8 It was also useful to contextualise the period in
9 which the assertions made by Roy Garland were made, and
10 his remark that if the activities recounted by Roy
11 Garland sound outrageous now, they were quite beyond the
12 pale in the 1970s.
13 He also emphasised that the abuse that Roy Garland
14 complained of was as an adult in his 20s who was making
15 allegations which, quite frankly, Sergeant Q had some
16 reservations about accepting as being entirely reliable.
17 He also cast some important light on the perfectly
18 proper instructions from Ian Cameron not to focus on
19 issues of homosexuality and recounted that, in fact,
20 Brian Gemmell himself excised parts of Garland's account
21 in the reports that were prepared for their superiors to
22 include removing parts of Sergeant Q's oral report and
23 handwritten notes from the typed report.
24 So in conclusion in relation to Sergeant Q's
25 evidence, we would say whilst it was clear he was doing

1 his best it is also clear that his recollection is
2 imperfect, and has been overlaid with current day views
3 and assumptions about child abuse and inappropriate
4 behaviour.
5 Panel, that would conclude my remarks. I would like
6 to say that for all of the above reasons the four core
7 participants that I represent, it is their earnest and
8 sincere aspiration that this Inquiry will be able to
9 conclude that there is no merit in the various
10 allegations of state involvement, and that this
11 appalling and horrific abuse suffered by the victims of
12 Kincora can finally be laid to rest with the conclusion
13 that there simply was no state knowledge of or
14 involvement in it.
15 Unless there is anything further?
16 Closing remarks by THE CHAIRMAN
17 CHAIRMAN: Thank you, Ms Murnaghan.
18 Today completes our programme of hearings which
19 started on 13th January 2014. All but a handful of the
20 223 days of hearings since then have been conducted in
21 public. On a small number of occasions we conducted
22 closed hearings from which the press and public were
23 excluded because publicity of the matters we were then
24 considering could have prejudiced criminal trials that
25 were imminent at that time. The vast majority of our

1 hearings have been open to the public and to the media.
2 The transcripts of the evidence and the documents we
3 have considered are placed on our website as soon as
4 possible after each day. This enables anyone interested
5 in our work to see the relevant evidence for themselves,
6 as indeed has been the case during Module 15, which has
7 now finished. 19 of the 20 sitting days of the Kincora
8 module, which concluded with the evidence we have just
9 been referred to that was given very early this morning,
10 have been devoted to a very public and detailed
11 examination of evidence relating to Social Services, to
12 the RUC, to the RUC Special Branch, to the Ministry of
13 Defence and Military Intelligence, to the Secret
14 Intelligence Service and to the Security Service.
15 During that process we have heard from serving
16 representatives of the Secret Intelligence Service and
17 the Security Service as well as from now retired members
18 of both services, retired former officer and
19 non-commissioned officers of the Army, and from members
20 of the then Royal Ulster Constabulary, all of those
21 people who were able to give evidence as to what they
22 did or what they learnt about the events surrounding
23 Kincora all those years ago.
24 We also heard from others such as Bob Bunting, who
25 served in the then Belfast Welfare Authority and its

1 successor, the Eastern Health & Social Services Board.
2 The Inquiry has examined and will continue to examine
3 a larger group of documents as part of its
4 investigations into Kincora before we complete our
5 report, and to which we will refer as necessary in the
6 report and publish on our web site with the report.
7 The next stage of our work will be to complete the
8 drafts of our report. These drafts will cover not just
9 Kincora, of course, but all the other homes and those
10 topics related to residential homes that we have
11 investigated so far throughout the life of our Inquiry.
12 Our terms of reference require us to deliver our
13 report to the First Minister and to the Deputy First
14 Minister no later than 18th January 2017 and then to
15 publish the report.
16 Under the Act of the Northern Ireland Assembly under
17 which we have carried out our functions, we are obliged
18 to deliver the report to the First Minister and Deputy
19 First Minister at least two weeks before we publish the
20 report. Therefore the Panel will be working over the
21 summer to prepare our draft report. Before we can
22 finalise the report Rule 14(3) of the Inquiry rules
23 states as follows:
24 "The Inquiry Panel must not include any explicit or
25 significant criticism of a person in any report of the

1 Inquiry unless:
2 (a) the chairperson has sent that person a warning
3 letter;
4 (b) the person has been given a reasonable
5 opportunity to respond to the warning letter."
6 Every organisation that has taken part in the
7 Inquiry as a core participant, and every individual
8 against whom allegations of wrongdoing have or might be
9 made, had the opportunity to participate, to give
10 evidence and to answer actual or possible criticisms
11 during the hearings. They have also had the opportunity
12 to make oral and written submissions after each module
13 that involved them and, as we have just seen in relation
14 to the Kincora and Bawnmore module, almost all have
15 chosen to make submissions.
16 A small number of individual have chosen not to
17 engage with the Inquiry. If any of them were to be
18 criticised in the report, then fairness and Rule 14(3)
19 require them to have the opportunity to respond to any
20 criticism before the report is finalised and then
21 published.
22 Once those sections of the draft report that may
23 contain any such criticism of core participants or
24 individuals, whether the individuals gave evidence or
25 not, have been drafted, then warning letters will be

1 sent to the core participant or to the individual
2 concerned. The warning letter will be accompanied by
3 the part or parts of the relevant passages of the draft
4 report. Those passages will refer to the evidence on
5 which any criticism is based. The warning letter will
6 specify the date by which the recipient must submit any
7 written response to the Inquiry. The specified period
8 will vary according to the volume of material which may
9 be referred to in the draft, but will not be less than
10 two weeks and will not be more than four weeks.
11 The actual period for each recipient will take into
12 account the evidence the core participant or individual
13 has already given to the Inquiry as well as their
14 submissions to the Inquiry. We do not expect recipient
15 of warning letters to repeat at length what they have
16 already submitted, nor will we accept any new evidence
17 not previously submitted to the Inquiry unless that
18 evidence relates to a criticism in relation to a matter
19 that the recipient did not have the opportunity to deal
20 with in their earlier evidence or submissions.
21 In what we anticipate might be a very small number
22 of individuals, namely those who may be criticised but
23 who, for whatever reason, did not or chose not to engage
24 with the Inquiry, the warning letter and the relevant
25 part of the draft of the report will be accompanied by

1 copies of any documents the Inquiry considers relevant
2 to that person, that is whether or not those documents
3 are referred to in the draft sent to that individual
4 with the warning letter.
5 Where the Inquiry considers that the individual may
6 wish to have legal advice when preparing any response
7 that the person may wish to make, then depending on the
8 person's financial means he or she may be eligible for
9 legal representation at the expense of the Inquiry. If
10 an application for legal representation at the expense
11 of the Inquiry is made, it will be dealt with in
12 accordance with the Inquiry's costs protocol and in
13 accordance with the principles already applied by the
14 Inquiry when previous awards have been made to witnesses
15 who have given evidence and have been given legal
16 representation in the past.
17 I must emphasise that the time limit for responding
18 to warning letters will be strictly enforced. Only in
19 the most exceptional circumstances will the Inquiry
20 consider responses that are received by it after the
21 specified time in the warning letter. That is because
22 the Inquiry does not have an unlimited period of time,
23 an unlimited period which can be infinitely extended to
24 engage in repeated debates with those who receive
25 warning letters. That is because, as I have already

www.DTIGlobal.com

1 stated, the Inquiry is obliged by its terms of reference
2 and the statutory framework that governs our work to
3 deliver its report by 18th January next year.
4 Once the responses have been received then they will
5 be considered by the Inquiry Panel. We will then take
6 the necessary steps to finalise the report and to
7 prepare for its publication after it has been delivered
8 to the First Minister and to the Deputy First Minister.
9 We will give further details of the publication process
10 nearer the time, but we can say that the report will be
11 published in both a printed version and an electronic
12 version which will be placed on the Inquiry website.
13 In conclusion, it would be remiss of me were I not
14 to place on public record the appreciation of myself and
15 my colleagues of the efforts made by everyone to assist
16 the Inquiry over the last two and a half years or so of
17 our public hearings. This includes, of course, the
18 applicants, other witnesses and the core participants,
19 who have all taken part in our proceedings.
20 In particular, I wish to thank on our behalf those
21 who have provided the technical and administrative
22 support to the Inquiry hearing in Banbridge, support
23 without which it would not have been possible for us to
24 conduct our proceedings in the way that we have without
25 much, much greater time being devoted to bringing up

1 documents, leafing through lever arch files and matters
2 of that sort.
3 Not only have they given technical and
4 administrative support to us, but many have given much
5 time and effort to providing sympathetic support to the
6 witnesses who have come to us to give evidence. Giving
7 evidence to a public inquiry such as ours, and in
8 particular a public inquiry dealing with the topics we
9 have been considering is, as we have always appreciated,
10 an emotional and stressful experience for so many. We
11 have done the best that we possibly can to minimise the
12 stress inherent for those who have had to give evidence
13 to our Inquiry, particularly for those who are giving
14 evidence of matters of such a deeply personal nature as
15 is included in and, indeed, dominated by the experiences
16 of those applicants who have recounted their experiences
17 to us.
18 We hope that our work and the work of our colleagues
19 who conducted the private and confidential hearings of
20 the Acknowledgment Forum has helped in some degree to
21 ease the pain and distress suffered for so long by so
22 many of those former residents who came forward to help
23 us by telling us, and through us the wider community in
24 Northern Ireland and elsewhere of their experiences in
25 residential homes and other institutions within our

1 terms of reference.
2 Thank you, ladies and gentlemen, for your attendance
3 today and throughout the work of the Inquiry.
4 (4.20 pm)
5 (Inquiry Concluded)
6 --ooOoo--
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25