HIA REF: ___ _____

NAME (In full): TL 4

DATE: 18 November 2013

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT OF

TL 4 (Insert Name), will say as follows: -

My knowledge of Termonbacca and Nazareth House is based on my posts with [redacted]

[redacted]

i. In my early period as [redacted] my direct management responsibility covered the statutory homes, i.e., Fort James, 15 Ardmore Road, Derry and Harberton House Assessment Centre, 106 Irish Street, Derry. I am not sure about the statutory responsibilities in relation to St. Joseph's Termonbacca or Nazareth House, Bishop Street, Derry. I recall being asked to introduce practices to both in terms of reviewing the progress of residents in line with the developing practice within the statutory homes. With my managers in the statutory homes we offered advice and guidance to the Sisters, who ran each Home. At some stage (I don't know when) I involved them in the child review arrangements and also the monthly monitoring reports I carried out in relation to each residential facility.

ii. I recall that, during my period of involvement, responsibility for inspection rested with the Social Services Inspectorate of the Department of Health and Social Services.

iii. During my period of involvement, there was a move towards identifying social workers for each child in St Josephs and Nazareth House. After St Joseph's closed I am certain that each child in Nazareth House had a nominated Social Worker from the Unit of Management/Trust.

iv. During my initial period of involvement, I am not aware of the recruitment arrangements within the homes. I do not recall any HSC involvement in recruitment/vetting and I do not recall that there were formal vetting arrangements until the introduction of the Pre. Employment Consultancy Checks.

v. I am aware in my early involvement that these homes were lowly staffed with a dependence on volunteers or low-paid staff. In the early – mid 1980's, the Western Health and Social Services Board (with the LLS Unit of Management) recognised the low funding base of support. Steps were taken at that stage to provide an appropriate funding arrangement for Nazareth House, Bishop Street, (St. Josephs was closed at this time) to enable them: -

a) To provide a staffing level / staff-child ratio in line with the expectations of existing statutory homes; and
b) To pay staff the equivalent salaries of staff in statutory homes.

In addition funding was made available to enable residential staff in Nazareth House, Bishop Street to undertake Social Work training, resulting in a high proportion of staff being Social Work trained by the time of its closure. Many of them then transferred to employment in the Trust's expanding residential provision.

vi. In my period of involvement, the Unit of Management / WHSSB increasingly monitored and supported Nazareth House and established similar responsibilities for standards / good practice as being developed in the statutory homes.

vii. I cannot comment beyond my comments to question (v).

viii. In my period of involvement, Nazareth House became increasingly included in the responsibilities to, and practice standards of residential care, i.e., administrative arrangements, staffing ratios/requirements, monitoring, child review arrangements. The development of a child review system provided opportunities for concerns to be articulated and addressed. Monthly monitoring reports involved consulting with children who were resident. Standards required by statutory homes were also required and monitored, including the existence of a Complaints Procedure.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed TL 4

Dated 18-11-13

HIA REF:
NAME: TL 4
DATE:

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

WITNESS STATEMENT OF TL 4

I, TL 4, will say as follows:-

1. I was employed as below:-

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

2. Purpose of Contact with St Josephs, Termonbacca and Nazareth House, Bishop Street, Derry

2a My contact with St Joseph's Home, Termonbacca after my appointment was fairly limited as it was in the process of closing down. My role at this stage would have been:-

- To offer advice to the Sister-in-Charge about care practices becoming aligned with those in the statutory homes at Fort James and Harberton House.
- To initiate an overview of care-planning/review of those children placed by the Board with the Sisters in St Joseph's.

Up to this point, my sense was that planning for individual children was not undertaken in a structured fashion, unlike the expectations of current planning for looked-after children.

2b Visits to Nazareth House were carried out for the following reasons:

- Reviews of individual children that were required to happen one month after admission, within a further three months and thereafter, as required, but not less than every six months.
- Visits re: untoward events/complaints as required.
- Support visits re: introduction of new procedures/practice developments.
- Support visits at the request of the managing Sister to discuss her plans for improvement.
- Monthly meetings held by the Programme Manager (Child Care) with the Sister-in-Charge and the Team Leaders of each unit to monitor and address
  - Children awaiting foster-care
  - Level of fieldwork visits
  - Complaints
  - Accidents
  - Untoward incidents
  - Significant events
  - Training undertaken by staff
  - Admission/discharges

  [Sample copies of minutes is attached by way of illustration relating to [redacted] – APPENDIX 1]

In addition, I would have been asked to meet occasionally with their Management Committee to discuss issues arising from my monthly visits or in relation to funding issues. I knew all of the children in residence and met with them on my visits eg I sat with them at mealtimes occasionally, to engage with them in a less formal way and to observe the practices. My formal visits would also have covered the different times of the day/week to ensure that I had a knowledge of the life of the unit. I would also have visited every [redacted] as I did with all residential facilities.

3. **Advice and Guidance offered to Nazareth House, Bishop Street**

My role in relation to Nazareth House, included providing advice and guidance on the following:

(i) **Procedural issues relating to planning/reviewing individual children's care plans.** This was aligned with developments for all children in residential care from the Social Services catchment area for which I had responsibility and reflected an increasing attempt to avoid "drift" for children in care. This was achieved through regular planning meeting with multi-agency contributions.

(ii) **Practice issues in relation to residential care.** The senior staff from Nazareth House were included in local meetings of residential managers to work on strategic planning and the improvement and development of good practice. An illustration of this would be the Western Board's publication in 1988 of a "Residential Child Care Policy" that provided guidelines for staff. It outlined guidance on:

- Care issues in relation to residents
- Practice Issues
- Staff Issues

It also outlined the Board's view of the role of residential care and what both children and staff have the right to expect [APPENDIX 2].

In 1987, the Board had provided an explanatory booklet for children coming into residential care and their parents – "Guide for Children and their Parents". Nazareth House managers had been involved in the development of this booklet which included a pre-paid Complaints Card for use by children or their parents. They also contributed to the development of an explanatory video that explained the process of care-planning/reviews and how to raise issues about which they were unhappy.

I also worked closely with the Sister-in-Charge to develop an in-house approach to helping young people prepare for moving on into adult life (this will be addressed later).

(iii) **Organisational issues in relation to management, staffing and monitoring.** The Board had been undertaking developments in terms of reviewing minimum staffing levels. Managers in Nazareth House were included in this work and efforts were made to incrementally move from a low staff base with no qualifications to a staffing level that met all requirements and which was largely a qualified social work service. These developments included a review of the role of Sisters (including the management role carried out by the Primary School Principal) and the introduction of waking night staff (as a result of untoward incidents occurring during the night).

In terms of monitoring, the Management Committee was responsible for appointing members to undertake monthly monitoring visits to each unit in line with statutory requirements. I provided guidance and support to the Management Committee in sustaining their monitoring arrangements including the provision of a monitoring template based on that used by me within the statutory homes in my role as [redacted]

(iv) **Funding Issues** were a recurrent issue in discussions between Nazareth House and the Western Board and the development of staffing levels at different stages had funding implications. I will address these later but it is fair to say, that Nazareth House met the need first and subsequently sought the funding to cover the additional cost.

(v) **Training Needs Identification.** As part of the development of practice issues within the residential care workforce (in both statutory and voluntary homes), I negotiated with the Social Services Training Team about the provision of training to meet identified priorities. Nazareth House staff were included in the broad range of training provided to address these priorities. All staff undertook a basic "Caring for Children and Young People" (Open University) to introduce them to general values and practice issues. This was supported by access to a range of practice courses.

A major development for residential staff in Nazareth House was access to the Certificate in Social Services (CSS), an employment-based route to a professional Social Work qualification. This was undertaken over a number of years, and by the time that Nazareth House closed in 1998, the proportion of qualified Residential Social Worker staff was higher than in any of the statutory homes.

In general terms, the Sisters were open to the developments that were taking place. SR 2 was a strong advocate for children in Nazareth House and challenged Board managers if she felt that "her children" were being disadvantaged in any way compared to children in statutory homes.

The managers of Nazareth House i.e. Sister-in-Charge and Team Leaders were involved in the strategic planning for child care, both relating to residential care but also related to the wider planning for children's services. There was a support relationship, particularly across residential care managers in terms of dealing with common issues or concerns. Over this time, the context of children in residential care was changing, with more complexity being recognised. Mutual support in addition to training was regarded as a means of improving staff resilience.

My relationship with managers in Nazareth House was, in my opinion, a positive and supportive one. For SR 2, in particular, I acted as a mentor at her request to regularly plan for improvement or to consider ways of addressing emerging issues/difficulties. She presented as a warm and caring person with insight into the complex influences on each child. As stated previously, she advocated for her residents and regularly challenged the statutory sector to treat her residents equitably if she considered that they were being disadvantaged.

4. Care Planning for Children in Care

The development of an increasingly structured approach to care-planning and review was enhanced by the practices in Harberton House Assessment Unit in Derry with its Core Evaluation Team meeting weekly to maintain an overview of all children resident. Its purpose was to ensure a multi-agency approach to assessment and planning and to seek to avoid 'drift' in care through lack of planning.

The development of care-planning and review involved its implementation in all residential units, including Nazareth House through the 1980's. The Residential Child Care Policy (WHSSB) published in 1988 provided guidance on the review arrangements, their function and frequency, documentation and expected attendance [See Appendix 3].

"Each child will be reviewed within one-month of admission, within a further 3 months and thereafter as frequently as appropriate but not less frequently than every 6 months".

In most cases, the initial review (or Admission Case-Conference] was held as soon after admission as possible. Throughout my direct involvement, I was responsible for chairing reviews and, through this, had a direct involvement with all residents and their care-plans. In later times (after 1999), the Trust introduced the post of Independent Chair, a number of which were responsible for chairing all case-conferences and reviews.

5. Emerging Issues in Residential Care

As stated, the complexity of issues presented by children in residential care emerged during my professional career and direct involvement. The issue of child sexual abuse had become an increasing concern during the late 1970's and 1980's. Within residential care, a number of issues emerged in terms of increasing frequency:

- Absconding/unapproved absences
- Violence and aggression toward staff
- Peer sexual activity

The recording of untoward incidents/events would have reflected the increasing incidence of these types of behaviour and would have been reported to the Board and through them to the Department. Each incident generated its own response in terms of planning and risk assessment for individual children e.g. sanctions, additional support/supervision required for a child/young person or access to specialist support. The organisational response would have been to consider developments in terms of:-

- Developing new policies and procedures to minimise risk or to ensure a balanced approach to decision-making e.g. approval for absences identified as a Review decision.

  The approval of a framework for absences/befriending was identified as a Review decision in the Western Board's Residential Child Care Policy published in 1988 [Appendix 4]. This related to all absences of one night or more and delegated approval for individual absences to field Social Work staff of a seniority dependent on the length of absence. The guidelines outlined the risk-assessment to be undertaken. It is not my understanding that overnight stays with residential keyworker staff was encouraged or promoted. However, in exceptional circumstances, where a child had a lack of family/befriender support, I am aware that approval was given for individual residential keyworkers to include this child in activities outside the residential unit. Overnight stays would have been an exception and based on a risk assessment as outlined in the Policy booklet. As residential staff, the Keyworker would have been vetted. These children would have been relatively isolated from family contact and the befriending contact would have been regarded as beneficial to their development and opportunity for "family" experiences. The befriending experience generally for children in care was subsequently given formal recognition in the Independent Visitors role identified in Article 31 of the Children (NI) Order 1995.

- Developing access to specialist support e.g. mental health professionals, "experts" eg SND 470
- Accessing appropriate training e.g. Therapeutic Crisis Intervention as an accepted method of dealing with aggressive/violence behaviour or specialist training in sexual abuse SND 470
- Improving liaison with the police.

6. Development of Leaving and After-Care Services

Through my involvement with children and young people in the care system, it became clear in the [redacted] that the transition from care to adult life was a difficult one, with inadequate support both in terms of preparation and also in the years after leaving care (generally after the 16th birthday). Legislation at the time [Children and Young Persons Act (NI) 1968] provided a duty under Section 120 to advise and befriend any child leaving care after reaching the upper limit of compulsory school age until he/she reach the age of 18 years.

The initial developments within the Western Board area focussed on Fort James Children's Home and included:-

- In 1984, a self-contained flat was developed in the top floor of Fort James to provide some preparation support for young people reaching the age of 16 years to experience what "independent living" was like.
- From 1985, outbuildings at the rear of Fort James were re-designed to provide a semi-independent living unit of 2 self-contained one-bedroomed flats and 2 two-bedroomed flats.
- A small team of residential staff was developed within the staff team to provide contact/support with care-leavers. As residential staff, they covered the working day i.e. 8.00 a.m. to 11.00 p.m. including weekends unlike traditional social work hours. This team transferred to Aberfoyle Terrace in Derry with the closure of Fort James, a more accessible base to which young people could drop-in.
- The development of Leaving Care grant to support young people in establishing themselves in their own community accommodation.

A significant development at this time was the publication in [redacted] by DHSS of [redacted] written by FJ [redacted]. This publication examined the "leaving care" experience of young people who left care between [redacted] and [redacted] in the Londonderry, Limavady and Strabane Unit of Management. The learning from this study underpinned the local development of:-

- A structure and planned approach to leaving care and after care support beyond a young person's 18th birthday, recognising the "corporate parenting" responsibilities held by the Unit of Management/Trust.
- A pattern of young people remaining in care until 18 years.
- Resourcing to develop a dedicated team to provide leaving care and after care support.

- Resources available to support young people moving to their own accommodation.
- Partnership working with housing agencies, social security agencies and employment/training support services.

In Nazareth House, there was a strong feeling that young people living there should have access to "preparation for leaving care" support on-site to provide a degree of continuity. In response to this need, SR 2 arranged for previous staff accommodation to be converted into a self-contained flat for up to three young people, she aligned the practices with the approach being undertaken at Fort James and young people were supported financially through the provision of a Leaving Care grant from the Unit of Management/Trust.

7. Funding Issues

In my early involvement with Nazareth House, Bishop Street, Derry (From [redacted] there was a low funding base-line that reflected a number of issues:-

- A low staffing level with generally unqualified and low-paid staff.
- Costs not reflected e.g. the cost of input from the Sisters who were also [redacted]
- Costs shared with the residential care of older people that were not easily apportioned.

During most years, Nazareth House applied to the Western Health and Social Services Board for additional funding to address deficits. It was acknowledged by the Board that the capitation fee paid to Nazareth House was the lowest of all voluntary homes in Northern Ireland. I remember that the Board were making representation to the Department for a number of years for additional non-recurrent funding to address deficits or for recurrent funding to meet funding requirements.

In this process, as initially [redacted] and in my early period as [redacted] my role would have been the provision of detailed information on activity and costings to senior managers i.e. TL 17, TL 19, SND 469, SND 502, all of whom maintained a focus on securing a sufficient level of funding to maintain a valuable part of the residential infrastructure.

Work being undertaken in the statutory homes in terms of minimum staff levels was replicated for Nazareth House (excluding the cost of waking night staff). Staff cover at night was provided by the Sisters until incidents of sexual activity between residents in the early 1990's led to the use of waking night staff. The

costing of this structure supported increases in capitation fees to seek to cover the cost of additional staff paid on the same salary scales as staff in statutory homes based on a 75%-80% occupancy level. In addition arrangements were made for staff to access CSS training (an employment-based route to professional social work qualifications) with backfill costs met, supported separately from the Board's training budget.

In addition, Nazareth House was provided with an additional monthly payment in arrears to cover children's pocket-money and clothing for those resident during the previous month and in advance for Christmas and holiday allowances. In later years, each residential unit was allocated a separate budget for "Quality of Life", to support the individual interest of each child in terms of sporting or recreational pastimes.

During this period, the capitation fee rose from £116 per child per week in 1985-86 to £343 per week in 1992-93. Additional funding for deficits were needed because of:-

- Backfill funding not being regarded as meeting costs.
- The occupancy level dropping below the funded level.
- Staff developments e.g. waking night staff being introduced before a funding stream could be identified. It is acknowledged that Nazareth House responded to this need before the funding could be identified as it was the safer option. Funding of this deficit then followed.

Statement of Truth

I believe that the facts stated in this witness statement are true.

Signed: TL 4 .....

Dated: .....30/04/14.....

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MINUTE OF MONTHLY MEETING HELD IN NAZARETH HOUSE CHILDREN'S HOME ON 10 JANUARY 1994

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PRESENT:

SR 2, Nazareth House
SND 40, [redacted] Nazareth House

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SND 38 [redacted] Nazareth House
TL 4, [redacted]
SND 491, [redacted]

ADMISSIONS TO NAZARETH HOUSE:

SR 2 took the opportunity of expressing her concern about difficulties which would occur for her should the number of children in the Unit drop below the figure of 18. In such circumstances, SR 2 felt that she would have difficulty in meeting her staffing costs. TL 4 and SND 491 pointed out that in view of the proposed closure of Fort James Children's Home, it seemed inevitable that the

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demand for places in Nazareth House would increase. Furthermore, TL 4 indicated that he planned to draw up a system which mapped out future moves of children in residential care and this would enable him to make full use of the bed capacity in Nazareth House. This is a matter which will be kept under review.

ACCOMMODATION AT NAZARETH HOUSE:

SR 2 shared with TL 4 and SND 491 concerns that she had about the present accommodation occupied by the Children's Home in the Nazareth House complex. The children's unit is located above a primary school and adjacent to an old people's home. The school have taken over the playground that was previously used by the children's unit and they now have to avail of the play area on the Foyle Road. Furthermore, there are obvious difficulties in both elderly people and children sharing the same accommodation. SR 2 pointed out that she hoped that it would be possible at some stage in the future to

Appendix 1

MINUTES OF A MONTHLY MEETING HELD AT NAZARETH HOUSE ON [redacted]

PRESENT: SR 2, Officer-in-Charge
SND 40 [redacted]
SND 38 [redacted]
TL 4 [redacted]
SND 491 [redacted]

CHILDREN AWAITING FOSTER CARE: It was noted that there were no developments in relation to securing fostering placements for those children whose names remain on the fostering waiting list.

FIELDWORK VISITS: As noted at the last monthly meeting in October, SND 491 had written to SND 468 [redacted] in the [redacted] Office regarding missed fieldwork visits. Subsequently, SND 468 wrote to SND 491 [redacted] detailing the reasons for the missed visits. In his memo he regretted that the situation occurred and noted that he had emphasised to both the Social Worker and her Team Leader the importance of ensuring of that the monthly visits occurred on a planned and meaningful basis in future. A copy of this memo had been forwarded to SR 2.

It was noted that fieldwork visits for the month of November were all satisfactory.

COMPLAINTS: SND 96 has complained to SND 526 [redacted] that SND 527 [redacted] had "pushed him". This has been recorded in the complaints book and is being investigated by SND 526 in the first instance.

Discussion then took place regarding increased levels of violence to staff from children and young people in the unit. Of particular concern to staff is the fact that there are no clear guidelines on the appropriate method of restraint that should be used in such circumstances. SND 491 and TL 4 explained that it was their understanding that training for the therapeutic crisis intervention method was due to take place in the new year. They agreed to liaise with SND 528 [redacted] to obtain the appropriate details.

ACCIDENTS: No accidents occurred in the unit in the month of November.

procedures as appropriate. This allows a manager to identify a) lessons which may be learned and b) changes which may be necessary to existing policies and procedures.

Conclusion

Because of the risk of encountering violence, it is necessary for every staff member to take steps to prevent such situations occurring, where possible. This requires an openness and mutual trust among colleagues in a team group, a sharing of information and willingness to give and accept support. After an incident, it is useful to analyse the dynamics, not to lay blame or responsibility but to learn from the experience for future situations.

In conclusion, the general principles outlined above are applicable to threats or actual violence from not only children/young people but also parents or relatives who may be encountered in or out of the working situation.

MONITORING ARRANGEMENTS AND PERIODIC REPORTS

Under Paragraph 3 of the Conduct of Children's Homes Direction (N.I.) 1975, the Board is charged with ensuring that each residential unit under its responsibility is "conducted in such a manner and on such principles as will further the well being of the children in the Home". The Board must be satisfied that the Home is being run in the interests of the children and therefore monitoring occurs at varying levels throughout the organisation, e.g. Primary/Key Workers, senior or residential staff, visiting Social Workers, Principal Social Workers, Community Care committee members, senior management. Community Care committee members and senior management must carry out detailed audits of the care provided in each home.

Three aspects of monitoring are as below:

1. Community Care committee member. Arrangements are made for a designated member of the Board's Community Care Committee to visit the Home once every 3 months, preferably when the children are there. He will prepare a report for presentation to the Community Care Committee covering names of all staff seen, records inspected, physical condition of the Home, its furnishings and equipment, impressions of the operation of the Home and complaints made by staff or children.

2. Managing Social Worker (A.P.S.W.). The Assistant Principal Social Worker will produce a report each month which is forwarded via the Assistant Director of Social Services (Group) to the Director of Social Services. This report will comment on:

   (a) the general management of the Home;

   (b) standards of professional practice;

   (c) admissions and discharges;

   (d) staffing matters;

   (e) training;

   (f) maintenance of statutory records and compliance with Regulations;

   (g) untoward events;

   (h) complaints;

   (i) the identification of any matters requiring attention by management.

3. Senior managers, Assistant Director of Social Services (Group) and Assistant Director of Social Services (Child Care), will visit the Home at 6 monthly intervals as part of their monitoring role.

DRINKING BY CHILDREN IN CARE

1. The law is quite clear that young people under the age of 18 year should not be drinking alcohol or be in licensed premises.

   However, it is recognised that older adolescents, because of peer group pressure and for purposes of experimentation will sometimes consume alcohol. Residential staff should not condone underage drinking, should actively discourage it and provide counselling as appropriate.

2. The problems of alcohol abuse should be discussed with young people as part of an on-going health/social education programme. Support and guidance should be offered to any young person who drinks rather than resorting simply to a punitive response.

3. If a young person returns to the Home in an intoxicated state, he should be put to bed and monitored until he recovers. Counselling can then take place, taking into account the particular situation of the young person.

4. It may be necessary to inform the R.U.C. if it is apparent that individual licensed premises are regularly serving alcohol to residents. Consideration should be given to making direct contact with the management of these premises to inform them of our concerns.

FRIENDS

1. Children and young people should be encouraged to make friends in the local community and to maintain existing friendships.

2. If a child wishes to have a friend visit or to stay for a meal, he/she should have the freedom to do so, within the general limits of courtesy. Prior notice should be given, allowing sufficient time for the friend to get parental permission.

3. For overnight stays with friends, permission must be sought as for "Approval for Absences" and prospective befrienders must be advised that references will be sought from two referees names by them. Enquiries will be made from the Police and the Pre-Employment Consultancy Service.

4. The process of vetting befrienders is similar to that of prospective foster parents as follows:

   (i) the Social Worker interviews the couple or person to find out more about the family background;

   (ii) references are obtained and at least one referee must be interviewed personally by the Social Worker;

   (iii) a report is sought from the Police;

   (iv) a report is sought from the Pre-Employment Consultancy Service via Group Personnel Department;

   (v) The contact between befriender(s) and child is reviewed on a quarterly basis as an integral part of the child's review.

5. When a child is invited to visit the home of a friend, he/she should be free to do so, given that the arrangements are satisfactory to the host parents, and to the staff.

APPROVAL FOR ABSENCES OF CHILDREN IN CARE

The following policy applies to all children in care irrespective of placement (whether in foster home, Children's Home or in own home) and to all absences of at least one night's duration, either within or outside Northern Ireland:

1. **Authority for granting permission**

   The basic principle is that the regular reviews of every child in care should set the framework within which proposed absences (including holidays) should be considered. In setting this framework, account must be taken of any particular legal and professional risk factors in the individual situation, such as possible difficulties arising from the child leaving the jurisdiction. Additionally, this could involve the seeking of the permission of the High Court, e.g. Wardship cases. Once the framework has been defined, the authority for granting permission for future absences is dependent on the length of the absence in the following way:

   (a) **From 1 night to 3 nights inclusive**

   Individual absences/holidays of this length must be approved by the child's Social Worker, and must fall within the context of the agreed framework.

   (b) **From 4 nights to 14 nights inclusive**

   Individual absences/holidays of this length must be approved by the relevant Senior Social Worker (Team Leader) and must fall within the context of the agreed framework.

   (c) **More than 14 nights**

   Individual absences/holidays of this length must be approved by the relevant Assistant Principal Social Worker (Fieldwork) and must fall within the context of the agreed framework.

   One contraint on the above is that an individual cannot grant permission for himself/herself to take a child on holiday. When such cases arise (e.g. a Social Worker taking children on holiday for 1 - 3 nights), the permission of the next line manager should be given.

2. **Guildlines for approving individual absences/holidays**

   When considering the approval of individual absences/holidays within the agreed framework, the following questions should be taken into account:

   (a) In whose care will the child be?

   (b) Who else is going?

   (c) Will there be appropriate care and supervision?

WESTERN HEALTH AND SOCIAL SERVICES BOARD

MEMORANDUM

From [redacted] To SND 466 [redacted]

Ref. SB/CMcC Ref.

Date: [redacted]

This is to confirm that HIA 127 child-in-care, Nazareth House, spent [redacted] at the home of his key worker, SND 38 [redacted] SND 38 requested permission that HIA 127 be allowed to spend [redacted] with SND 38 family who have already got to know HIA 127 through visiting on a [redacted] afternoon. SND 38 parents are in their [redacted] and there are [redacted] brothers [redacted] and [redacted] at home. HIA 127 has no outside contact and this was a good opportunity for him to experience family life. I spoke to TL 4 on [redacted] expressing my satisfaction with the home situation and he gave his consent to the [redacted] arrangements.

Signed: [redacted]

SOCIAL WORKER

[redacted]