

1 a position to address yesterday, but we will take  
2 a short break before we do that.

3 (11.25 am)

4 (Short break)

5 (11.45 am)

6 MODULE 14

7 Discussion of administrative matters

8 MS SMITH: Good morning, Chairman, Panel Members. We were  
9 hoping to start our 14th module into governance and  
10 finance yesterday. As you are aware, because we have  
11 not received a final statement from the Department, we  
12 were unable to do that. We intend to proceed, however,  
13 today with the evidence of Miss Fionnuala McAndrew on  
14 behalf of the Health & Social Care Board in respect of  
15 this module, certainly in part. I understand that  
16 Mr McGuinness can update the Inquiry as to why we have  
17 yet not received the final departmental statement.

18 CHAIRMAN: Yes, Mr McGuinness?

19 MR MCGUINNESS: Chairman, I will not rehearse what  
20 I indicated yesterday in relation to the background to  
21 the matter. I will say that it is a matter of regret  
22 that the Inquiry is inconvenienced in relation to this,  
23 not only the -- not only the Panel, but also counsel,  
24 the team and the core participants.

25 What I will say is that since yesterday, sir, I can

1 say that the Minister has considered the submission. As  
2 a result of the consideration that was given he has  
3 sought an urgent meeting with departmental officials.  
4 The first time that he is available to meet with  
5 departmental officials to discuss the issues in what is  
6 a significant statement insofar as it relates both to  
7 past practices and potentially has future implications  
8 for the Department is 9.45 on Thursday morning.

9 So the position that I am in this morning, sir, is  
10 that I can give you that update and indicate that there  
11 will be discussions taking place with the Minister  
12 tomorrow morning at 9.45.

13 CHAIRMAN: Well, is there any indication as to when these  
14 discussions will bear fruit in the sense of the Inquiry  
15 receiving the statement it asked for six weeks ago?

16 MR MCGUINNESS: All I can say, sir, is that the matters will  
17 be discussed on Thursday morning. I am not -- certainly  
18 I have no insight into the Minister's thinking. I am  
19 not clear what issues may appropriately be raised by  
20 him. So certainly what I can very much say is that the  
21 Department and the Minister are very much aware of the  
22 urgency of the matter and of the -- and of the -- your  
23 remarks yesterday, Chairman.

24 CHAIRMAN: Thank you. Well, as always, Mr McGuinness has  
25 been frank and helpful to the Inquiry, as have those

1        been who are here on a day-to-day basis or standing  
2        behind him providing information in answer to the  
3        Inquiry's requests. It is, to say the least, profoundly  
4        unsatisfactory that this module, the penultimate module  
5        of the Inquiry's programme, is not merely being  
6        inconvenienced but is being seriously obstructed by the  
7        inability of the Department to produce a statement some  
8        six weeks or thereabouts after they were told that it  
9        would be required by Friday of last week.

10        The Inquiry has been told that this is being  
11        addressed as a matter of urgency. All I can say is the  
12        Department and the Minister personally appear to have  
13        a different concept of urgent to the Inquiry's and  
14        I imagine anybody else's. It is not a satisfactory  
15        position. It is not a question of the Inquiry's  
16        convenience. It is that we are working to an extremely  
17        tight timetable imposed by the Northern Ireland  
18        Executive, of which the Minister is a member.

19        We had intended to deal with issues of  
20        an overarching nature in relation to finance and  
21        governance this month so that we could then turn our  
22        attention to preparing for the last module relating to  
23        Kincora. We will not now be able to do that without  
24        leaving behind unfinished business, and that is  
25        profoundly unsatisfactory.

1           If and when the Department produces this statement,  
2           it will have to be considered not merely by the Inquiry  
3           but by anybody else who may have a legitimate interest  
4           in commenting upon the contents of that statement, such  
5           as the Health & Social Care Board, for example. We will  
6           do what we can to find a time convenient to the Inquiry  
7           in June to fit in any further hearings that are  
8           necessary. No further time will be allowed to the  
9           Department or its officials in relation to the timing of  
10          that; in other words, it will happen when the Inquiry  
11          says it happens, and if anyone is not available, if they  
12          don't make themselves available, we will go on without  
13          them.

14          Not the least unsatisfactory aspect of this position  
15          is this is the second time in the course of the Inquiry  
16          that I have had to draw attention to the fact that,  
17          unlike everybody else, the Department has been unable to  
18          comply with the Inquiry's timetable, for reasons which  
19          the Inquiry does not find satisfactory.

20          I hope my remarks will be drawn to the attention of  
21          the Minister personally before he has his meeting  
22          tomorrow morning in the hope that that will instil some  
23          urgency into the process.

24   MR McGUINNESS: Sir, I will ensure I certainly pass on that  
25          clear representation, and if I can say, sir, I am

1 obliged that the Panel will in June consider this issue.

2 CHAIRMAN: Very well. Well, we will do what we can today  
3 with Miss McAndrew to deal with such other issues as we  
4 can, but I think the question of funding will probably  
5 have to be left to another day.

6 MR McGUINNESS: I am obliged, sir.

7 MISS FIONNUALA McANDREW (called)

8 Questions from COUNSEL TO THE INQUIRY

9 MS SMITH: Fionnuala, you have given a statement on the  
10 issues of finance and governance, which can be found at  
11 GOV632 to 677. This is in response to a specific  
12 question where the Health & Social Care Board was asked  
13 whether they wished to concede any systemic failings on  
14 behalf of their predecessors in respect of the work of  
15 this Inquiry.

16 Paragraph 3 of your statement you recap the  
17 legislative background and history of the provision of  
18 residential child care in Northern Ireland within the  
19 Inquiry's terms of reference, and you make the point  
20 that over a period of forty years there were no less  
21 than five major reorganisations of health and social  
22 care provision in Northern Ireland, one of those falling  
23 outside the terms of reference, but within our terms of  
24 reference five -- sorry -- four of those major  
25 reorganisations took place.

1 Paragraph 4 of your statement addresses the issues  
2 of finance, which you addressed in light of information  
3 that you were given by others. Now the Inquiry has  
4 received a detailed statement on behalf of the  
5 Department on the issue of finance from Tara McBride and  
6 as a result of that I know that we will receive  
7 a further statement from the Health & Social Care Board  
8 next month addressing some of the issues raised in her  
9 statement.

10 **A. That's correct.**

11 Q. It may be that we will require further evidence from  
12 a witness in respect of that, but in any event those  
13 statements will be shared with -- your additional  
14 statement will be shared with the Department and the  
15 Panel will decide whether they need to hear more on the  
16 issue.

17 If I can then move to paragraph 5 of the statement  
18 that's on the screen, and that is at page 642 -- no --  
19 644. In this paragraph you address the key duties  
20 towards children in residential care. If we could go to  
21 paragraph 5.2.3 -- I should say, Fionnuala, that  
22 although I am only going to certain parts of your  
23 statement, the Inquiry Panel and the Inquiry has read  
24 the entire statement and are aware of the contents.

25 I am simply seeking to highlight a number of issues that

1 you raise in the statement.

2 At 5.2.3 you say that:

3 "After the reorganisation in '73 the Department  
4 issued The Conduct of Children's Homes Direction  
5 (Northern Ireland) 1975, coming into effect on 1st  
6 December of that year. Section 3(2) of the direction  
7 required, inter alia, that a member of the Board's  
8 Personal Social Services Committee was to visit  
9 children's homes at least once every quarter to satisfy  
10 himself that the home was being conducted in the  
11 interests of the well-being of the children and report  
12 to the committee. 3(3) of the direction required that  
13 Boards arrange for a social worker to visit the home at  
14 least once a month to satisfy himself whether the home  
15 was being conducted in the interests of the well-being  
16 of the children and to report in writing to the District  
17 Social Services Officer to the Director of Social  
18 Services. The Director of Social Services then had to  
19 bring any matters of concern or interest arising from  
20 these reports to the attention of the Personal Social  
21 Services Committee of the Board."

22 Just pausing there before I read the last sentence  
23 on that paragraph, the direction only concerned what had  
24 been Welfare Authority homes, State-run homes. It had  
25 no bearing on voluntary homes. Isn't that correct?

1 **A. That's correct.**

2 Q. You say:

3 "The amendments to the '68 Act in 1972 removed the  
4 post of children's officer and created a lacuna in  
5 relation to statutory responsibility for visiting  
6 Welfare -- for visiting children" -- I beg your pardon  
7 -- "in Welfare Authority homes and voluntary homes."

8 You go on to say:

9 "Mr Bunting included this responsibility in the  
10 Eastern Health & Social Services Board policy and  
11 procedure in '73."

12 Now speaking about the lacuna that existed, although  
13 there was no longer a Children's Officer required to  
14 visit the homes, it is nonetheless the case that The  
15 Personal Social Services Committee member had to visit  
16 quarterly, and social workers, who had children placed  
17 in either the statutory homes or the voluntary homes,  
18 would have been visiting monthly, and in practical terms  
19 then there was still a responsibility to ensure that  
20 those statutory homes were being well run. Isn't that  
21 correct?

22 **A. I think clearly there remained a statutory duty, as you**  
23 **outlined, in relation to the visits by the**  
24 **committee member and the social worker. I think the**  
25 **point being made here, and it is a time of**

1 reorganisation, that a particular post was then removed  
2 from the legislation. That didn't mean to say that  
3 homes weren't being visited in that intervening period.  
4 My understanding, it took until 1975 for that amendment  
5 to be made in terms of legislation. I have no  
6 first-hand evidence to offer the Inquiry as to the  
7 extent of the visiting arrangements during '72 and '75,  
8 but certainly it is something, if the Inquiry wishes, we  
9 could look further into.

10 Q. But I think the point you are making here is that by  
11 removing the Children's Officer there was someone who  
12 had within the Board essentially ultimate responsibility  
13 for ensuring that these homes were looked at.

14 A. In statute.

15 Q. Yes.

16 A. I think the point I am making is that whilst the removal  
17 in statute, I can't answer the fact that they nominated  
18 somebody --

19 Q. To do it.

20 A. -- with that responsibility in that intervening period.  
21 I just don't know whether that was the case.

22 Q. If we move on to paragraph 5.2.8, you say that:

23 "Despite some regional variation in the approach to  
24 the monitoring function, the Board's reading of the  
25 Hughes Report is that The Hughes Inquiry generally found

1 that while there had been a failure to consistently meet  
2 statutory requirements, visits by The Personal Social  
3 Services Committee members and line management of the  
4 home were unlikely to detect homosexual abuse in the  
5 absence of a complaint or seeing a physical presentation  
6 of the child."

7 You say:

8 "The Board considers this would equally extend to  
9 other forms of abuse."

10 I was asking you in discussion earlier this morning  
11 whether or not if there had been regular visiting, was  
12 that not more likely to pick up on practices that were  
13 perhaps conducive to abuse?

14 **A. And my response to that earlier was it's a stretch --**  
15 **a bit of a stretch to say that that in itself would have**  
16 **detected abuse. I mean, there are a range of**  
17 **considerations, as the Inquiry knows, in relation to**  
18 **children disclosing abuse. It is highly unlikely they**  
19 **would disclose it to a stranger or someone in the**  
20 **position of a committee member, and the contact with**  
21 **their own social workers would be more relevant in my**  
22 **view and more important.**

23 I also think there were other things that were  
24 happening around that time in relation to complaints  
25 procedures, etc, that would have been helpful in that

1           **regard, but I think we have to understand that comment**  
2           **in the context of how children disclose abuse.**

3       Q.   So essentially what -- if I have got you right, you are  
4           saying that even if there had been the regular visits as  
5           envisaged, it wouldn't really have picked up on what was  
6           happening in the homes?

7       A.   **It wouldn't necessarily have. It may have resulted in**  
8           **some indicators that needed to be represented or**  
9           **mentioned to the committee for further scrutiny, but**  
10          **I would -- it would be difficult for me to say**  
11          **absolutely that it would have picked up abuse.**

12      Q.   In paragraph 5.3.5 you discuss the improvements that  
13           were made to the larger homes, the large institutions.  
14           Just there you say:

15                 "The Board is of the view that the voluntary  
16           children's homes used by Welfare Authorities and Boards  
17           were too large and due to their size and institutional  
18           nature they were not conducive to providing a homely  
19           environment for children when considered. However, the  
20           Board recognises that adaptations were made to Rubane  
21           and the Nazareth homes to organise care on a smaller  
22           group living basis and considers that these adaptations  
23           went some way to mitigate the disadvantages of  
24           institutional life for children."

25                 I just wanted to tease that out a little bit more

1 just to remind the Inquiry essentially when the 1950  
2 Children & Young Persons Act was passed, the State  
3 started to provide their own children's homes  
4 effectively. They were always designed on a smaller  
5 basis. They were more community homes. They took less  
6 children. They were smaller units than the large  
7 institutions that were then in existence, particularly  
8 in the voluntary sector. Isn't that correct?

9 **A. That's my understanding.**

10 Q. And the recognition was in the 1950s that smaller was  
11 effectively better, because it was more likely to  
12 replicate what children experienced in a family  
13 environment.

14 **A. I think -- I think that might be right. I think that**  
15 **the context is worth remembering as well, that we were**  
16 **coming out from a scenario around the workhouse and the**  
17 **welfare system, which was really very large institutions**  
18 **and with very little care being provided. So I think**  
19 **there was a major cultural shift at the time where it**  
20 **was being recognised that a more homely environment --**  
21 **if you could replicate for children as near as possible**  
22 **to a family environment, that that was more beneficial.**

23 Q. Yet that was in the 1950s --

24 **A. Yes.**

25 Q. -- when the Act was passed and it was some twenty or

1 thirty years before the larger institutions moved  
2 towards that model, and the Inquiry has learned that it  
3 came essentially very late in the life of some of those  
4 homes that the -- Nazareth Lodge, for example, splitting  
5 into smaller homes within the one physical building.  
6 There seems to have been a degree of reluctance on the  
7 part of the church and Orders to move to that model.

8 I think, when we were talking earlier, you said that  
9 there would have been an attempt at persuading them  
10 along the route towards that over the period of years.  
11 Would that be fair?

12 **A. I think that's a presumption on my part. Clearly**  
13 **I haven't, you know, read detail of that conversation,**  
14 **but I think that there would have been a lot of**  
15 **dialogue. What you were doing here was changing**  
16 **a system, not just changing individual children's homes.**  
17 **I am sure there were lots of factors that were presented**  
18 **by the voluntary organisations in terms of cost, in**  
19 **terms of the ability to adapt the building. I am sure**  
20 **there were a number of factors that were discussed and**  
21 **addressed, but I accept what you are saying. It seems**  
22 **to have taken a number of years before there was**  
23 **a reduction in size of some of those homes.**

24 **Q. At paragraph 5.5.6 you make the first concession on**  
25 **behalf of the Board. If I can just go to that, please:**

1            "This Inquiry has heard evidence about boys from  
2            Nazareth Lodge in Belfast being routinely placed in  
3            Rubane once they reached secondary school age and  
4            largely dependent on their performance in the transfer  
5            examination. The Board accepts that this was not in  
6            keeping with the need to consider the individual needs  
7            of each boy and in some cases would inevitably have had  
8            a deleterious effect upon the growth of sibling  
9            relationships and friendships that the boys had  
10           developed during their time ..."

11           I think that would have been "in Nazareth Lodge"  
12           rather than "House".

13           "The Board accepts that this arrangement extended to  
14           boys that were in public care and to this extent the  
15           Board is of the view that steps should have been taken  
16           to challenge this happening on a routine basis for  
17           children in public care. It is noted that in his  
18           evidence to The Hughes Inquiry Mr Bunting, then the  
19           Assistant Director of Social Services in the Eastern  
20           Board, deprecated the practice of automatic transfer of  
21           children between homes and hostels."

22           You give the page reference for that.

23           "This was identified by Mr Bunting in 1972, who then  
24           took steps thereafter to seek to address this."

25           We know that the automatic transfer of boys to

1 Rubane did end. I think the reference here is to the  
2 Nazareth Lodge example going to Rubane, but from  
3 discussion it wasn't just the Catholic Church that  
4 employed this routine transfer of children. We know  
5 that children moved at a certain age into hostels, for  
6 example. Boys moved into Kincora, which we are going to  
7 hear about in due course. So it wasn't just the  
8 Catholic Church that employed this practice of moving  
9 children at a certain age. Isn't that so?

10 **A. That's my understanding. It seems to me that it was**  
11 **custom and practice at the time that the age of the**  
12 **child determined that move.**

13 Q. And why do you say that the -- I mean, you have said  
14 that the Boards ought to have challenged it. Why do you  
15 think that wasn't done?

16 **A. Well, I think that we were -- the Boards were -- staff**  
17 **and social work and residential care was increasingly**  
18 **moving towards a much more child-centred approach in its**  
19 **processes and in its arrangements for children. So that**  
20 **was a journey that they were on. I expect that it's**  
21 **a system, it's probably a culture and a mindset that you**  
22 **are trying to change here. My view is that maybe that**  
23 **could have been challenged more robustly than it was and**  
24 **perhaps earlier on, but that's the benefit of looking at**  
25 **this as a reflection of what was happening at the time.**

1 I think the context that staff were working in was that  
2 maybe they felt that this was the accepted practice.

3 Q. The Inquiry has been keen to ensure that we don't judge  
4 practices --

5 A. Yes.

6 Q. -- of the past by today's standards. So, I mean, in  
7 making this concession I just want to be sure,  
8 Fionnuala, that the Board is not doing that.

9 A. No. I think -- I think it would be reasonable to expect  
10 that there would be some challenge where it was not in  
11 the interests of some of the boys or some of the  
12 children that this was the situation, and if child in  
13 care reviews were taking place, that would have been the  
14 arena in order to do that. So I would stand by that as  
15 a concession.

16 Q. Then if we could go to 5.7.1, please, this is in respect  
17 of social work visits to children. You say:

18 "There was no statutory requirement to visit  
19 children in residential care, nor was there any regional  
20 guidance from the Ministry of Home Affairs (and later  
21 the Department), who had overarching responsibility for  
22 policy and services to children and ultimate  
23 responsibility for the children placed in residential  
24 care. I have noted that recommendation 40 in the Hughes  
25 Inquiry report is that 'Monthly visiting by field social

1 workers should be continued and made a statutory  
2 requirement'. No such legislation was enacted during  
3 the time frame under consideration by this Inquiry.  
4 However, the Department accepted this recommendation and  
5 hoped to legislate for it post Black Committee and  
6 Hughes' recommendations. That was ultimately overtaken  
7 by the Children's Act in England and Wales and  
8 subsequent 1995 Children Order."

9 Now the fact that there was no legislation did not  
10 on the ground mean that social workers did not continue  
11 to visit monthly and presumably the Department would  
12 have known that that was being done?

13 **A. Yes. I imagine that any information that was being sent**  
14 **to the Department would have contained that information.**

15 Q. I am just going to look -- in one of her statements  
16 Dr Harrison, if we can look at GOV682, please,  
17 paragraph 1.16, she talks about the major initiatives  
18 that in this time period the Department was engaged in  
19 post Hughes. If we can just scroll to -- yes. It said  
20 -- going back to the previous page, if I can just go  
21 there to 1.16, she said:

22 "The Black and Sheridan reports together with the  
23 Hughes Inquiry report, the 1985 DHSS paper ..."

24 If I can just scroll back up, please, because we can  
25 find out that that paper was, in fact -- if we can just

1 pause -- I think it is up. Yes, it is on the preceding  
2 page. At 1.12 there she says:

3 "The departmental statement to the Inquiry noted the  
4 concern in 1985 pending the publication of the Hughes  
5 Inquiry report to address the financing and wider future  
6 of the voluntary sector residential child care  
7 provision. It led to issue a 1985 paper entitled 'The  
8 statutory/voluntary relationship in the provision of  
9 residential child care'. Boards were required to  
10 address the issues identified within the document and  
11 agree a way forward."

12 If we can just scroll back then to 1.16, Dr Harrison  
13 says that that, together with the Black and Sheridan  
14 reports and the other initiatives which she outlines in  
15 the preceding pages:

16 "... had significant impacts for the DHSS as well as  
17 statutory and voluntary practice in residential child  
18 care. The Department believes that together these had  
19 the effect of raising standards in this important area  
20 of children's social care services to a level beyond  
21 that which would have been accomplished by the  
22 introduction of further primary legislation during the  
23 '68 to '95 period. These initiatives also led to  
24 a residential child care work force which had the  
25 highest proportion of professionally qualified work

1 staff of anywhere in the UK."

2 Then if we go to the next page, please, she says:

3 "The above measures helped to improve the standard  
4 of care in residential establishments. In this context  
5 it is important also to consider the policy initiatives  
6 of the Department in relation to child protection, from  
7 the issuing of the first guidance in 1975 to the  
8 publication of the Children Order guidance in '7..." --  
9 sorry -- "in '96. Together with the complaints  
10 procedures introduced for children and their parents,  
11 the child protection procedures served to improve  
12 awareness of the potential for abuse, strengthen the  
13 structures and processes for dealing with this issue and  
14 improve staff skills in the care of children who had  
15 suffered abuse, many of whom were and still are admitted  
16 to the care of children's homes."

17 So the point that Dr Harrison is making is that, in  
18 fact, legislation would not have achieved perhaps what  
19 was achieved by these policies and initiatives, and  
20 I wondered if you wanted to make any comment about that.

21 **A. Can I make two comments, please? The first is that**  
22 **I actually came to work in Northern Ireland in 1996 and**  
23 **took up a post in the Registration Inspection Unit and**  
24 **took on board the beginnings of the inspection of**  
25 **children's homes by that unit, which was transferred**

1 from the Department. I can honestly say that the  
2 outworkings of the Hughes Inquiry and the comments that  
3 Dr Harrison makes were evident in the inspections that  
4 I conducted. I was able to compare what I'd left in  
5 England to the situation in Northern Ireland and I have  
6 to advise the Inquiry that there was significant  
7 difference in the standard and quality of residential  
8 childcare from what I had experienced. So that is just  
9 the first comment I want to make. So clearly the work  
10 of the policies and procedures was being effective.

11 My point about --

12 Q. Can I just pause there?

13 A. Yes.

14 Q. When you say there was a difference in standard, are you  
15 comparing Northern Ireland favourably with what was in  
16 England?

17 A. Yes, yes. Sorry. I didn't make that clear. Absolutely  
18 favourably with what was -- what I left in England.

19 The point about legislation, I just want to make the  
20 point that I think the statutory responsibility is at  
21 the heart of why we need regulation and legislation, to  
22 avoid confusion, to be clear about accountability and  
23 who has the authority to undertake what function. In my  
24 view the statutory -- the legislation and accompanying  
25 regulations are critical particularly in the area of

1       **family and child care. So whilst I agree, I still think**  
2       **that the governance issues might have benefitted from**  
3       **revision of the legislation.**

4       Q. If we can go back to your own statement, please, at  
5       paragraph 5.7.6, which is at page 656, and in this  
6       paragraph you make the second concession on behalf of  
7       the Board. You say that:

8                "In light of the finding of the Hughes Inquiry that  
9       is referenced above, which has been further evidenced by  
10      the information received by this Inquiry, the Board  
11      accepts that for a period before 1968 the policy and  
12      practice of regular monthly social work visiting to  
13      children in residential care was under-developed in  
14      Northern Ireland by comparison with other regions in the  
15      United Kingdom and the Board recognises this to be  
16      a failing on the part of its predecessor organisations.  
17      However, the Board is of the view that some  
18      responsibility for this state of affairs must also  
19      attach to the legislature, who placed different  
20      statutory safeguards on children who were boarded out as  
21      opposed to those in residential care. After 1968 and  
22      until 1985 the failure attaches to a lack of regional  
23      consistency and a lack of full implementation of the  
24      policy, the latter being a finding of The Hughes  
25      Inquiry."

1           You cite the paragraph there. Essentially you are  
2 saying that the practice of visiting children in care  
3 was deficient on the part of the Board's predecessors,  
4 but also you are saying that the legislature bears some  
5 responsibility, because they differentiated between the  
6 rules and requirements in respect of those children who  
7 were placed in foster care in comparison to those who  
8 were placed in residential care.

9   **A. Yes. I think that's a correct summary of what I have**  
10 **said. I think really I am enjoining the board and the**  
11 **Department in the fact that the processes were**  
12 **under-developed and relying on the findings of the**  
13 **Hughes Inquiry to make this concession.**

14   **Q.** Then if we can go, please, to paragraph 5.8.5, we get  
15 the third concession on behalf of the Board. If I can  
16 perhaps summarise that, essentially -- well, it is in  
17 short form in any event:

18           "The Board accepts that where periodic child in care  
19 reviews were not held this was not in keeping with their  
20 own minimum standards set and as such reviews (sic) that  
21 this was a failing on the part of the Board's  
22 predecessors."

23           So the Board set minimum standards for periodic  
24 reviews for children in care and failed to meet those  
25 standards in some cases.

1     **A. That's correct, and where they failed to meet the**  
2     **minimum standards, then clearly they weren't adhering to**  
3     **their own standards and their own policies, and I would**  
4     **see that as a failing.**

5     Q. Can I take it that that was a failing that may have led  
6     to abuse not being picked up on?

7     **A. I think that there is a possibility that because the**  
8     **child was not being reviewed in a holistic sense and**  
9     **inputs from, you know, the various people who were**  
10    **involved with the child's life, I have to say that there**  
11    **is always that possibility.**

12    Q. The fourth concession is at paragraph 5.9.5.  
13    Essentially it is:

14            "It seems, therefore, that there was a lack of  
15    consistency in policy and practice regarding the  
16    befriending of children in public care who were placed  
17    in residential homes. Where there was a lack of policy  
18    about befrienders and/or there was an inconsistent  
19    application of a policy that was in existence the Board  
20    considers this to be a systems failing on the part of  
21    its predecessor organisations. Not least the Board  
22    considers that the befriending arrangements ought to  
23    have been considered as part of the periodic child in  
24    care reviews and appropriate assessments of their  
25    suitability carried out."

1           So essentially the approach taken by the Boards to  
2           ensure that people -- that children didn't go out to  
3           people outside the homes without proper notification to  
4           the Board and vetting of those people by it was  
5           inconsistent regionally and in practice and should have  
6           been part and parcel of the care reviews, but, of  
7           course, if you are conceding that care reviews weren't  
8           being carried out properly, then the other wasn't going  
9           to be carried out properly also. Isn't that a double  
10          whammy, if I can put it that way?

11   **A. I think that's correct. I think there was a growing**  
12   **realisation of the risk from adults to children and the**  
13   **previous arrangements of trust perhaps from some of the**  
14   **homes in terms of befriending, there was a growing**  
15   **realisation that that wasn't acceptable. You know,**  
16   **I have read information where that was being picked up**  
17   **by some of the legacy Boards. It is about the**  
18   **consistent application of a policy where there is one,**  
19   **and clearly if that's not the case, then that's -- that**  
20   **is a failure, and again if the child in care reviews**  
21   **were taking place, then this is an important element of**  
22   **their care, that they were being befriended and perhaps**  
23   **spending time with other people outside of the home,**  
24   **that could have been considered.**

25   **Q. Paragraph 6 of your statement you seek to place the**

1 concessions that the Board makes and the failings in the  
2 context of the political and civil unrest in Northern  
3 Ireland and the major organisational changes in the  
4 delivery of Social Services.

5 Paragraph 7 deals with the use of voluntary homes by  
6 the Welfare Authorities. If I can summarise what you  
7 are saying there, you are seeking to suggest that any  
8 underpayment by the Board, for example, that the Inquiry  
9 has heard about in respect of the homes run by the  
10 Sisters of Nazareth in terms of per capita payment was  
11 in part due to reluctance on the part of the religious  
12 organisations to accept funding in case it led to loss  
13 of independence on their part, but that was also  
14 encouraged by the 1974 departmental circular, which  
15 talked about maintaining the independence of those  
16 homes.

17 I am just wondering, to put it bluntly, and we were  
18 discussing this earlier, is that a convenient excuse?  
19 Was it not the case that particularly what the Inquiry  
20 has heard about in Derry that the Sisters of Nazareth  
21 and other congregations were, in fact, providing a cheap  
22 alternative to either boarding out or to either creating  
23 or providing more places in statutory homes on behalf of  
24 the Boards?

25 **A. Well, my understanding is that both scenarios were true.**

1       There were situations where the voluntary homes were not  
2       accepting additional funding because they wanted to  
3       preserve their independence, or at least that's how it  
4       was presented. Clearly I am aware that there were other  
5       discussions going on where the voluntary homes were  
6       approaching the Western Board in relation to perhaps not  
7       being able to manage with the payment that was being  
8       made.

9             My understanding is that the payments were on a  
10       capita basis, that there was agreement between the  
11       Ministry and the Boards or Welfare Authorities about  
12       what that payment should be. I would be surprised that  
13       any organisation -- any statutory body like a Board that  
14       had representation from the -- from the voluntary sector  
15       wouldn't look to see how they could assist within the  
16       finite budget that they had, but I am sure there are  
17       some circumstances where they couldn't meet the  
18       expectation of the voluntary home.

19    Q. We were talking earlier that there was a wider aspect to  
20       this and you said to me that it wasn't to be cheap at  
21       any price, that this -- a certain standard of care had  
22       to be provided and the Board would need to be sure that  
23       that was adequate.

24    A. Yes. I think that's an important point when you start  
25       to look at, you know, where the Board is getting care on

1 the cheap. There was an expectation of a standard.

2 There was no concern about the standard of care that was  
3 being provided, as I understand it, it related to the  
4 debate about the fee. And I suppose regulatory function  
5 and inspection function, if that was the case, you would  
6 expect that to pick up -- be picked up. So it wasn't  
7 getting it on the cheap at any price, but it's

8 a statement of fact that it cost more to run the  
9 statutory homes than it did to run the voluntary homes.

10 Q. And in that regard it suited the Boards to rely on the  
11 voluntary homes for perhaps longer than they might  
12 otherwise have done?

13 A. Well, I would struggle to say it was purely on cost.

14 I am sure that it was a number of factors why there was  
15 a reliance on the voluntary sector, not purely that it  
16 was cheaper, but that it was providing a service, maybe  
17 its locality and geography and the needs of the  
18 children. So I would be reluctant to confirm that it  
19 was purely on cost.

20 Q. The next section of your statement, Fionnuala, goes on  
21 to -- goes beyond the question of concessions and makes  
22 certain points and criticisms of the Department. If we  
23 might look at some of those, if we go to  
24 paragraph 8.1.3, and again if I may summarise, you are  
25 seeking to say in this section that the ultimate

1 responsibility for child care rested with the  
2 Department. As agents of the Department, the ultimate  
3 responsibility for failings on the part of the Board's  
4 predecessor also lies with the Department, because it  
5 had a general oversight responsibility. Is that a fair  
6 summation of what you are saying?

7 **A. Yes, I think it's fair.**

8 Q. You say that you took this from the response to The  
9 Hughes Inquiry by Dr Maurice Hayes from the Department,  
10 where he appears to accept that that is the position.

11 **A. That's correct.**

12 Q. At paragraph 8.2.2 you attack the Department for failing  
13 to systematically review registration. Now the  
14 Department would contend that inspection, whether formal  
15 or a more informal type, was, in fact, a review of the  
16 registration, and the Inquiry has certainly seen at  
17 least in the case of Manor House Home that the Ministry  
18 did seek to withdraw registration from that particular  
19 home at one point.

20 The point you are making is that that was a rare  
21 case and there doesn't appear to you to have been any  
22 formal system whereby the continued registration of  
23 every home was reviewed periodically, judged by  
24 objective standards.

25 **A. That's correct. At the time of writing this statement**

1       **that's what I believed to be true.**

2       Q. We know from again Dr Harrison's statement, if we can  
3       look at that at 693, she points out in this, which was  
4       an additional statement given to the Inquiry at the end  
5       of the -- of Module 1, when we were looking at the  
6       Sisters of Nazareth home in Derry, she points out in 2  
7       here, if we can just scroll down slightly, that:

8               "The Department undertook a review of the  
9       registration of voluntary children's homes in 1985. As  
10       part of that process management committees were required  
11       to submit to the Department substantial factual  
12       information regarding the operation of the home,  
13       following consideration of which the Department  
14       confirmed the registration of each home. This  
15       information was separate from the annual monitoring  
16       statement already supplied to the Department by each  
17       home."

18       Now -- and she makes reference to another page,  
19       which -- I am not sure if we have the SND bundle  
20       uploaded, but the reference is 9150. It was a letter of  
21       10th May 1985 sent to the Chairman of the Management  
22       Committee of each voluntary home by Mr Buchanan from the  
23       Department indicating essentially what Dr Harrison is  
24       saying in this paragraph, that the -- because I am not  
25       sure we have the SND bundle, maybe if I just read part

1 of it out:

2 "My letter explained the Department would wish to  
3 receive annually certain factual information relevant to  
4 the operation of each voluntary children's home. This  
5 would be distinct from the annual monitoring statement,  
6 which would evaluate various aspects of the residential  
7 child care services provided by each voluntary  
8 organisation."

9 So in 1985 they are devising a two-prong system: the  
10 monitoring arrangements, which would evaluate what was  
11 going on, but also this registration review effectively  
12 based on other factual information.

13 Now unfortunately I can't remember, as I stand here,  
14 whether we looked at that in any greater detail in  
15 Module 1. I am sure it is something that we can ask  
16 Dr Harrison about in due course, if we have the  
17 opportunity to hear from her again, but you were not  
18 aware that there had been that step taken in 1985?

19 **A. No. The first I saw that was this morning when you drew**  
20 **it to my attention, and I suppose the interpretation --**  
21 **there are two elements. It seems that there was**  
22 **a one-off exercise at a point in time. I think the**  
23 **point that we are making is that there wasn't regular**  
24 **renewal of registration, and I am not sure then as**  
25 **a consequence of that letter whether that came into**

1           **being or not.**

2       Q.   Certainly 1985 was when Hughes was reporting as well.

3       A.   **Yes.**

4       Q.   So it tallies with --

5       A.   **Yes.**

6       Q.   -- what the Department may have felt might be coming out  
7           of that report?

8       A.   **Yes.**

9       Q.   Paragraphs 8.4.7 to 8.4.9 you make the point that the  
10           Boards relied on the fact of registration to place  
11           children in voluntary homes.  Sorry.  That is in your  
12           own statement.  If we can go back to that, please, at  
13           668.  You say they relied on the fact of the  
14           registration to place children in voluntary homes as  
15           well as local knowledge and the fact that the voluntary  
16           sector was in general held in high regard by the Boards.

17           You go on to be further critical of the Department  
18           for failing to ensure that voluntary homes complied with  
19           the regulations prior to the Hughes Inquiry.  You say  
20           that that was not something over which the Welfare  
21           Authorities and Boards had any control.

22           At 8.4.1 -- I think I am jumping backwards here --  
23           you are critical of the Department in that Welfare  
24           Authorities could not inspect, only the Department  
25           could, and you make the point that you had no rights

1 over those children who were privately placed, but you  
2 did have duties towards those children who were in the  
3 care of the Boards and placed in voluntary homes.

4 Is it not the case that any failings that were  
5 identified by people visiting those homes to visit those  
6 particular children ought to have been drawn to the  
7 attention of the Department?

8 **A. I -- in considering the point you made to me earlier,**  
9 **I think that we need to set it in the context of the**  
10 **time and the duties and responsibilities that the**  
11 **individual social workers had to the children. So**  
12 **I could envisage circumstances where there was a concern**  
13 **that a social worker was made aware of that they dealt**  
14 **with with the voluntary home, with the manager or the**  
15 **staff in the home as a one-off event and that was**  
16 **resolved. My expectation would be that where perhaps**  
17 **there were a series of events with an individual child**  
18 **or there were a series of events with a group of**  
19 **children that further consideration would be given to,**  
20 **"Is this something within the culture or the practice of**  
21 **the home that should be escalated?", ie through the line**  
22 **management responsibilities within the Boards and**  
23 **ultimately to the Department, who, as I understand it,**  
24 **had the regulatory function of these homes at the time.**

25 **Q. Well, paragraph 8.4.5 you say that it was wrong of the**

1 Department not to share inspection reports with the  
2 Welfare Authorities and Boards in respect of voluntary  
3 homes, because social workers then didn't know about any  
4 concerns that those inspection reports might have  
5 highlighted.

6 However, there was evidence given to the Hughes  
7 Inquiry by Mr Carroll of the Western Health & Social  
8 Services Board and that can be found at KIN74328. He  
9 said that he relied on his own officers' assessments of  
10 the voluntary homes and he had seen some Social Work  
11 Advisory Group reports, and he also said that if he had  
12 any concerns about the standards in the home, he would  
13 quickly get on to the telephone or write, and thought  
14 that that was a reasonable approach to take. He said  
15 that at KIN72328.

16 The Inquiry has heard from Board witnesses that the  
17 relationships between the Board and the Department were  
18 generally good and the lines of communication were open.

19 Dr Harrison in her statement -- and I don't think we  
20 need to go to this -- at 694, she talks about sharing  
21 inspection reports with the homes -- sorry -- the  
22 inspection reports being shared with the homes  
23 themselves. I think that took some time before the  
24 homes themselves got to hear what the inspectors were  
25 saying about them.

1           We know that, for example, Rubane wouldn't agree  
2           to -- when the Board wanted to know -- having suspended  
3           the use of Rubane as a place in which to put children,  
4           the Eastern Health & Social Services Board wanted access  
5           to the 1981 SWAG report, but that was refused by the  
6           Department on the basis that the voluntary home wouldn't  
7           agree to it being shared.

8           So there was a difficulty there in terms of the  
9           Department not having ultimate control over the -- as  
10          the Department saw it, not having ultimate control over  
11          these voluntary homes. Nonetheless it was  
12          a departmental report, and I take it from what you have  
13          said in your statement that it is your view that really  
14          the Department still had the authority to share it with  
15          the Boards whether there was consent or not from the  
16          home?

17       **A. Well, that's my understanding, but I suppose what**  
18       **I would say is I am sure there was a system at the time**  
19       **where there were agreements about how the reports were**  
20       **to be handled, and it didn't -- it doesn't appear to me**  
21       **that that system -- the arrangement in the system meant**  
22       **that they were routinely shared with people who had**  
23       **responsibility for the welfare of the children.**

24           If -- I have no doubt that relationships were good  
25       **both with the Department and probably with the voluntary**

1        **sector at times, but a system shouldn't rely on**  
2        **relationships is the point that I'm making here. It**  
3        **should be very, very clear what the process is, who has**  
4        **authority to do what and how the information will be**  
5        **shared for the welfare of the children.**

6        Q. Paragraph 9.5 of your statement you essentially say that  
7        the ultimate responsibility for monitoring and upholding  
8        standards of the voluntary homes rested with the  
9        Department.

10      **A. Yes. That's my understanding, yes.**

11      Q. In paragraph 10.5 you do not accept -- I am summarising  
12      what you say about social workers -- you don't accept  
13      that social workers themselves should be criticised for  
14      failing to recognise that complaints might have been  
15      indicative of wider abusive practices because of the  
16      practices and understanding, first of all, in the 1970s,  
17      and then in the 1980s you would suggest that the Board  
18      rather than the Department was more alert to the  
19      systemic abuse as evidenced by the events in Nazareth  
20      Lodge in 1986, and even in the 1990s you would say that  
21      the Department were not examining the wider practice  
22      issues that were raised by the investigation into the  
23      actions of SR18. Is that a fair summary of  
24      paragraph 10?

25      **A. I think it's a fair summary. I mean, clearly I wasn't**



1 somebody was responsible for that type of visiting  
2 process. So that disappeared, but Mr Bunting  
3 reestablished it, or perhaps more accurately continued  
4 it without statutory backing in the Eastern Board's  
5 procedure. Is that correct so far?

6 **A. That's correct. My understanding is in the legislation**  
7 **the person who was responsible was named and that later**  
8 **was removed.**

9 Q. Yes. So before that was changed there was  
10 an identifiable officer, not the individual, the post  
11 they held --

12 **A. The post, yes.**

13 Q. -- who was responsible for certain things. That went,  
14 and the risk, of course, when that happens is that it  
15 may not be continued by somebody else.

16 **A. That's correct.**

17 Q. But in the Eastern Board Mr Bunting ensured that it was  
18 continued.

19 **A. That's correct.**

20 Q. The question I would like to ask now is: are you aware  
21 what happened in the other Boards or may we assume from  
22 the fact that you have only mentioned the Eastern Board  
23 there's no evidence that the other Boards followed the  
24 Eastern Board's line?

25 **A. I would like to confirm that position with the Inquiry.**

1 I am not sure, as I sit here, what the arrangement was  
2 in each of the other Boards. So if you don't mind --

3 Q. Yes.

4 A. -- I would like to confirm it, so that I am not  
5 misleading anyone.

6 Q. Well, I think it would be helpful if you could, because  
7 perhaps a natural way of reading it is because you have  
8 mentioned the Eastern Board, by implication the others  
9 didn't take the same line.

10 A. Yes.

11 Q. I think it would be helpful to have that more precisely  
12 identified.

13 Then at 5.2.5 you deal with the question of each  
14 Board developing individual written procedures for  
15 monitoring and so on in 1984/'85. The point, as  
16 I understand, you are making there is that, if I have  
17 understood you correctly, it would have been preferable  
18 for a consistent policy to have been applied, and  
19 perhaps ideally that that would have been developed  
20 either by the Department itself or at least the  
21 Department taking a lead to draw together the various  
22 Boards to ensure that consistency.

23 A. I think that's -- that's exactly right, that some  
24 regional guidance, some guidance from the Department  
25 would have helped to ensure consistency.

1 Q. And the difficulty, of course, with inconsistent  
2 approaches is that some approaches may not be as  
3 effective as others.

4 **A. That is always a possibility, but I think as well what**  
5 **you might be concerned about is that the experience of**  
6 **the children was the same regardless of which Board they**  
7 **were living in.**

8 Q. Exactly.

9 **A. So really having that consistency is beneficial not just**  
10 **to the staff but actually for the children.**

11 Q. Because what must never be lost sight of is the entire  
12 procedure is directed towards ensuring that the welfare  
13 of the children is adequately monitored.

14 **A. Well, in later legislation we talk about the welfare of**  
15 **the children being paramount --**

16 Q. Yes.

17 **A. -- and clearly the practitioners working at that time**  
18 **may not use the same language, but that would be the**  
19 **intention.**

20 Q. But the reality is that when you look at any provision  
21 of children's homes at any time, they are there for  
22 children.

23 **A. Correct.**

24 Q. That's their reason for existence. How that is done may  
25 differ widely depending on financial resources,

1 different approaches, different theological attitudes,  
2 and all sorts of factors may enter into the end result,  
3 but the fundamental purpose of a children's home is to  
4 provide a home for the child.

5 **A. Absolutely.**

6 Q. So that's what it is all about in the last analysis.

7 **A. That's what it's all about.**

8 Q. On that point if you could then follow to 5.2.8, you  
9 make the point, which you have I think reiterated today,  
10 about the acceptance by Hughes that there was, first of  
11 all, a failure to follow the statutory requirements for  
12 visiting on a consistent basis, but the reality is,  
13 notwithstanding that, even visits may have not picked up  
14 -- homosexual abuse was what Hughes was concerned with.

15 **A. Yes.**

16 Q. But is that entirely correct, because if one accepts the  
17 validity of the point you make about the disclosure  
18 coming from the child if the child has a relationship  
19 with the person to whom they are disclosing it, one can  
20 see the validity of that in relation to sexual abuse,  
21 but in relation to physical abuse surely an alert  
22 visitor should be capable of picking up visible signs of  
23 either physical abuse or physical neglect, poor clothing  
24 or bruising.

25 Now I mention that because allegations in relation

1 to Rubane in particular were that there was a great deal  
2 of gratuitous and severe physical chastisement of  
3 children. Now whether it always led to bruising or not  
4 we will have to decide, but if we assume for the moment  
5 that there may have been instances when --

6 **A. Uh-huh.**

7 **Q.** -- children either had visible bruises or would have  
8 appeared frightened and apprehensive, surely a visit at  
9 least increases the possibility that that type of  
10 behaviour will be detected, physical ill-treatment.

11 **A.** What I would say in response to that is that neglect, as  
12 you describe it, poor clothing perhaps,  
13 under-nourishment, children being dirty could have been  
14 picked up through a visitor. I think physical abuse,  
15 bruising, could have been picked up, but not  
16 necessarily. It depends on the nature of the physical  
17 abuse, where the bruising was, you know, whether it was  
18 visible when the child was fully clothed, and whether  
19 those children spent enough time with the visitor so  
20 that they could actually observe in detail the condition  
21 of the children.

22 I feel it is more likely that children who were  
23 traumatised and have these experiences will share that  
24 information with people that they have regular contact  
25 with, and in this situation it would have been their

1       **social worker rather than a dedicated visitor from**  
2       **a committee or some such thing. That would be my**  
3       **assessment of it.**

4    Q. Well, I don't in any way wish to be thought to be  
5       disagreeing with your fundamental thesis there, but many  
6       of the children in the homes in the 1960s did not have  
7       social workers, because they were voluntary placements.

8    **A. That's true.**

9    Q. So that particular opportunity for confidence would not  
10       be there in the case of a child whose parents had put  
11       them there.

12   **A. I take that point.**

13   Q. But I do quite take the point that bruising in  
14       particular you need to be -- there needs to be something  
15       visible. You are not going to ask every child to strip  
16       off just to check that they are not bruised, but some of  
17       the children made the point to us that there were severe  
18       beatings, and the question remains if there had been  
19       a regular outsider coming in -- and I think it must  
20       pre-suppose that the outsider had their wits about them  
21       --

22   **A. Uh-huh.**

23   Q. -- were -- had their eyes open and were alert to signs  
24       that may indicate that further questions needed to be  
25       asked -- there was at least the possibility of

1 an increased degree that somebody might have picked  
2 something up.

3 **A. I have to accept that point. It's better than nobody**  
4 **visiting --**

5 Q. Yes.

6 **A. -- and clearly if it was a consistent person that knew**  
7 **the children in the home, then there's always that**  
8 **possibility that they might have picked something up.**  
9 **So I can't dismiss it out of hand, and particularly**  
10 **where there was no social worker attached to the**  
11 **children it might have been an additional safeguard that**  
12 **would have -- might have helped, but I think it's**  
13 **difficult to draw a direct correlation between that**  
14 **visitor absolutely picking up on abuse in the home.**

15 Q. I think the most one can say is that the absence of  
16 a visitor reduced the possibility of detection, but how  
17 much more than that one can say is perhaps doubtful.

18 **A. I think that would be fair.**

19 Q. If I could then turn to the inspection processes, I was  
20 struck by -- and here if we could go to GOV667, starting  
21 at 8.4.3 -- you remind us that -- and over the page  
22 scrolling down to 668 -- that the frequency of  
23 inspections from 1987 onwards was reduced when it came  
24 to statutory homes to every three years.

25 Now if one pauses, there therefore appears from the

1 late -- in the '70s to have been no inspections in the  
2 very broad sense. Then in the early '80s in the  
3 immediate aftermath of the disclosures about Kincora  
4 there is an intense burst of activity. Every home is  
5 inspected, and clearly that has enormous ramifications  
6 in terms of the resources available to do it and the  
7 time within which it can be done. Then post Hughes --  
8 Hughes said, "Do it every year", but in 1987, I think  
9 two years after Hughes, it has dropped down to three  
10 years.

11 **A. Uh-huh.**

12 **Q.** That seems a surprising development.

13 **A. Yes. I suppose, looking at it now, it seems surprising,**  
14 **but my understanding of what I have read and people**  
15 **I have spoken to, there were lots of measures that came**  
16 **into place post Hughes, some of which Dr Harrison**  
17 **I think has referred to in her previous statements, the**  
18 **monitoring returns, etc.**

19 **So the sense of -- the system at the time was, as**  
20 **I am advised -- and I wasn't directly involved -- was**  
21 **that that was considered fairly reasonable in light of**  
22 **the fact that other monitoring systems were brought into**  
23 **place: complaints, the monitoring returns to the**  
24 **Department.**

25 **My understanding is the Department still reserved**

1 the right to inspect and could inspect at any point in  
2 time, but there was a change in the routine interval  
3 with which they would inspect statutory homes.

4 **That's -- that's my summary of what I have seen.**

5 Q. One way of looking at it, of course, might be that the  
6 Department did not attach to inspections overwhelming  
7 importance unless something went badly wrong and then  
8 there was a burst of activity.

9 **A. I am not sure about that. I think it has to be taken in**  
10 **the context of other monitoring that was being brought**  
11 **forward and a significant issue was the development of**  
12 **a complaints procedure for children --**

13 Q. Yes.

14 **A. -- around that time, and that provided children with the**  
15 **opportunity to speak for themselves, if you like, which**  
16 **I think was very important and entirely relevant.**

17 Q. If we could look then at the last sentence in that first  
18 paragraph on page 668, you say:

19 "It further appears that the inspections were always  
20 announced, which is not in keeping with recommendation  
21 32 of the Hughes Inquiry report."

22 **A. That's my understanding.**

23 Q. Again it seems a surprising departure from --

24 **A. It would seem surprising.**

25 Q. -- the recommendation. You do say in 8.4.5:

1            "In the Board's view the Department's policy of not  
2            disclosing inspection reports ... was not in the best  
3            interests of children ..."

4            **A. I think I have already made commentary about that --**

5            Q. Yes.

6            **A. -- and I feel quite strongly about this because of my  
7            background in inspection and regulation -- that the  
8            system should be designed to make sure that the people  
9            who need to know have the information and that we  
10           shouldn't rely on good relationships or informal  
11           communication.**

12           So if my understanding is that that was the case --  
13           and I think that there is evidence that some legacy  
14           Boards got copies of the inspection report -- I am not  
15           sure how they got that; they may have got it from the  
16           home -- but there are other situations where they were  
17           requested by a legacy Board and they weren't provided.  
18           So we seem to have a situation in my mind that wasn't  
19           entirely clear about who should have what.

20           Q. Yes, because particularly by the late '80s I think I am  
21           right in saying almost without exception, if not without  
22           exception, every child in a voluntary home had been  
23           placed there by a Board.

24           **A. That's correct.**

25           Q. So they were the Boards' responsibility and the Boards

1           were delegating the day-to-day care of the child to the  
2           voluntary home.

3   **A. That's correct.**

4   Q. Yet the regulator was coming in and in some instances  
5       saying, "This is not perhaps as good as it might be" or  
6       it may be even stronger and they say, "This is  
7       satisfactory", and yet the statutory body, whose  
8       responsibility the child was and who is funding the care  
9       of the child and who was, if the system was working  
10      properly, discharging its responsibility by visiting the  
11      child in the institution to see if the child was  
12      developing in the correct way and being looked after and  
13      so on, wasn't being told about problems that the  
14      regulator had identified.

15   **A. I think that is a possibility in terms of how the policy**  
16      **was enacted, the legislation or the system. I have no**  
17      **doubt, as previous witnesses have said, there were good**  
18      **relationships, and I am sure information was**  
19      **communicated across the system, but the point that I am**  
20      **making is that it shouldn't rely on an informal**  
21      **arrangement. It should be clear that the report should**  
22      **have been available to those who had the interests of**  
23      **the children at their heart.**

24   Q. Because if the report is formally available, then those  
25      who receive it can analyse it and decide in a structured

1 way what response is necessary --

2 **A. Yes.**

3 Q. -- and how any response is to be carried out.

4 **A. Yes, yes.**

5 Q. Well, I think that's the last question I have.

6 **A. Thank you.**

7 Q. Perhaps my colleagues have other questions.

8 MS DOHERTY: Just a few. Can I just go back? One of the  
9 points you make is that individual social workers  
10 responded to individual cases or complaints that  
11 children brought to them and wouldn't necessarily have  
12 seen the risk of institutional abuse within that, but we  
13 did see examples -- there was one in Rubane where  
14 a child actually told a social worker about a very  
15 serious assault on him, and she records that but kind of  
16 advised him more or less, "Let's see what happens and if  
17 it doesn't happen again ..." -- and checks with him that  
18 it doesn't happen again, but there was no evidence that  
19 could be put to us that she ever referred that on at any  
20 level. Another example would be Manor House, where you  
21 have a Senior Social Worker being told that a member of  
22 staff admits in the 1970s to hitting a boy with a stick,  
23 and it is accepted that that would be dealt with  
24 informally between the matron and the member of staff.  
25 Would you have expected more at that time from those

1 individual social workers?

2 A. I am not sure that I would in all honesty.

3 Q. Okay.

4 A. I would expect at that time that they would be alert to  
5 it. They would record it. I probably would have  
6 expected that they would have reported it to their  
7 line manager, at least to know that they were dealing  
8 with a difficult situation, but if it was resolved and  
9 there was no recurrence, I think that that would have  
10 been the way it would be handled at the time.

11 Q. So do you think at that time --

12 A. I mean, I think -- sorry -- I think we are talking in  
13 the '70s?

14 Q. Yes.

15 A. Yes.

16 Q. So do you think at that time there was an acceptance of  
17 physical chastisement?

18 A. I don't think there was a broad acceptance of physical  
19 chastisement from what I have seen, although I do know  
20 that there are issues about corporal punishment and the  
21 legislation around that, but I think there might have  
22 been more of an acceptance than there would be today,  
23 say, that somebody could lose their temper and hit out,  
24 but that was a one-off. I remember as a young social  
25 worker visiting parents where that had happened and

1       **really once they were counselled -- clearly they were**  
2       **monitored, but it wasn't seen in the same way as it**  
3       **would be today.**

4    Q.   I suppose the difference is children that are really  
5       vulnerable in care --

6    A.   **Oh, yes. I don't take that away. I am just trying to**  
7       **demonstrate the psyche at the time.**

8    Q.   Uh-huh.

9    A.   **So I think that the recording, the monitoring, perhaps**  
10       **an escalation to the line manager, but I would have**  
11       **thought that was probably how it was dealt with at the**  
12       **time generally.**

13   Q.   Okay. I mean, one of the issues -- you talk about the  
14       communication -- that it was still an experience in  
15       Northern Ireland and that -- you talk about, you know,  
16       the wisdom and experience and it's a small community.

17   A.   **Yes.**

18   Q.   The people knew each other and depended on that. Do you  
19       think that was a weakness as well, that there was maybe  
20       in particular a regard for religious congregations and  
21       their ability to care for children that meant that there  
22       wasn't a questioning? Was there a sense in which the  
23       relationships were too close?

24   A.   **Well, I have no evidence to suggest that, but, I mean,**  
25       **it can be that perhaps too much reliance is made on the**

1 views of staff as opposed to the views of children in  
2 any regulatory system, and I think it is very, very  
3 important that any inspection process is very clearly  
4 seeking the views of children and their families, and  
5 that's what would happen today.

6 I think a small geography where everybody knows  
7 everybody could -- and I am not saying it did -- but  
8 could I suppose see as a result that relationships were  
9 very strong, and perhaps it was more difficult to  
10 challenge what people were perceiving as perhaps  
11 untoward punishment or untoward behaviour, but that's  
12 just speculation on my part.

13 Q. I mean, one of the issues you raise also is the tension  
14 that is apparent in some of the documentation we have  
15 seen between the responsibility of the Board to be  
16 concerned about a child they place in a home and to  
17 investigate complaints in relation to that child and the  
18 overarching responsibility of the Department to have  
19 a concern --

20 A. Yes.

21 Q. -- for the standards. Do you want to say more about  
22 that just to have it on the record?

23 A. Well, I think it goes back to my points about how the  
24 system operates. I know that we are talking about  
25 governance. In an arena where you have good clinical

1 and social care governance lines of accountability,  
2 lines of authority are crystal clear. Therefore you  
3 would want that to be the case and the situation. Where  
4 they are not clear and they are not clearly defined in  
5 regulation or whatever, then I think accountabilities  
6 become blurred and you do get a situation where maybe  
7 one is thinking the other should do it and that person  
8 is thinking the other should do it --

9 Q. Uh-huh.

10 A. -- and that's not good governance in my personal view.

11 Q. And your view would be, if we look back to that, that it  
12 would have been for the Department to have gone in and  
13 looked at where there was a number of complaints in  
14 relation to children?

15 A. Yes. That's my understanding, because the Department  
16 was the regulator. The Department had the inspection  
17 function. So they would be looking at standards of  
18 care. I think in any scenario even today it is  
19 reasonable to accept that the judgment of the regulator  
20 around standards of care is the judgment of the  
21 regulator and people accept that, whether it is good or  
22 bad. So, yes, if there was any sense of perhaps some  
23 systemic concerns or issues, my expectation would have  
24 been that it would have been led by the regulator and  
25 the inspection regime.

1 Q. Okay. You refer to the fact that voluntary homes could  
2 provide cheaper care than statutory homes. Do you want  
3 to say why you think that was?

4 A. Well, I think historically there has always been  
5 a differential between terms and conditions and rates of  
6 pay between the statutory and the voluntary sector. So  
7 that might have been a factor. There will be other  
8 issues like management overheads, the nature of the  
9 buildings that they are operating in. So some of the  
10 costs of utilities and that kind of thing could be more  
11 expensive in some homes than other homes. I don't know  
12 for a fact, but sometimes voluntary organisations also  
13 have other resources that they call on. So there could  
14 be a number of factors why that was the case.

15 However, my understanding is that there was a per  
16 capita agreement at a point in time about what was  
17 reasonable to pay to the voluntary sector. I think that  
18 that was endorsed by the Ministry at the time. So there  
19 seems to have been some work done to say, "This is  
20 a fair price for what you are being asked to do".

21 Q. And that was reviewed year on year and it was --

22 A. It was reviewed year on year and my understanding is it  
23 was year on year endorsed and then in subsequent years  
24 the allocations to the Boards would have taken account  
25 of what was being agreed. That system pertains today

1       **really.**

2       Q. The last question you will be glad to hear. You talk --  
3       I mean, it would be fair to say you criticise that SWAG  
4       didn't do any inspections from its inception for quite  
5       a number of years. When we have looked at that in the  
6       past, the Department has indicated that in a way that  
7       reflected what was happening in England, that with  
8       Seaton and with a sense of a more developmental agenda  
9       in relation to inspection as opposed to "Let's encourage  
10      and go along" as opposed to maybe find fault, but there  
11      is a question about whether even in England, where  
12      voluntary homes were being registered, that they  
13      continued to be inspected.

14             I just wonder if you -- just in the sense that you  
15      came from England and whether that's something --  
16      whether you are aware that voluntary homes continued to  
17      be inspected even within that different approach with  
18      local authority.

19      **A. And the era that you are talking about is?**

20      Q. Since the 19...

21      **A. '70s?**

22      Q. Yes, '80s, when the --

23      **A. Yes. I worked in a community school with education in**  
24      **England, which would be similar to the training school,**  
25      **and I don't remember any inspections in the early '80s**

1 **from anybody.**

2 Q. And you are not aware of voluntary children's homes,  
3 whether they --

4 **A. I can't remember.**

5 Q. Can't say?

6 **A. I can't remember. I can't say.**

7 Q. Okay. It was just a chance given that you worked in  
8 England.

9 **A. Yes. No, I can't. I couldn't be definitive, I am**  
10 **afraid.**

11 Q. Okay. Thanks very much.

12 MR LANE: I would just like to go back to the question of  
13 when a complaint became a more general issue --

14 **A. Yes.**

15 Q. -- that the regulator ought to deal with. Obviously if  
16 there is one specific complaint, it may only raise  
17 a limited number of issues, but what are the criteria in  
18 your view for when something is a more general issue  
19 that the regulator ought to be investigating as against  
20 the individual social worker taking something up?

21 **A. Well, it would be a circumstance where events to**  
22 **a single child perhaps were recurrent and circumstances**  
23 **where a number of children were experiencing a similar**  
24 **event. So, for example -- and probably more the latter**  
25 **in terms of the regulator. So if we became aware that**

1 a number of children were being treated in a particular  
2 way, or punished in a particular way, or a certain form  
3 of discipline was being used across a range of children,  
4 that then begins to ask the question, "Is that the  
5 practice within this facility?", not a one-off, a member  
6 of staff did something wrong or lost their temper, but  
7 that was common practice in terms of the environment the  
8 children were living in. It is that circumstance then  
9 that I would expect the regulator to start to look at,  
10 "Well, what is the training like here? Are the staffing  
11 levels adequate so that, you know, these practices are  
12 not needed?", things like that. I suppose what policy  
13 and procedure was in the home to advise children --  
14 sorry -- staff to respond to children with specific  
15 needs.

16 Q. Would the number of Boards involved have been a factor  
17 as well?

18 A. Well, there were four Boards --

19 Q. Yes.

20 A. -- at the time.

21 Q. Who might all have placed children in one particular  
22 training school or something like this, for example.

23 A. Yes, but the regulator should have had the overview.

24 Q. I was just asking whether that was a further factor,  
25 yes.

1 A. Yes. I mean, the regulator -- yes, I think that is  
2 a factor, because the Boards then were coming at it  
3 about their specific children --

4 Q. Yes.

5 A. -- whereas the regulator should have had an overview of  
6 the arrangements in place within the facility.

7 Q. And what enquiries do you feel it would be reasonable  
8 for an individual social worker to make as against what  
9 the regulator was in a position to make?

10 A. Well, I think that they should have and could have  
11 explored the events with the staff. They could have  
12 looked at records in relation to their own individual  
13 child. They could have asked for explanations. They  
14 could have raised the issues in the child in care  
15 reviews, if they were taking place.

16 Q. Uh-huh.

17 A. So it would be a specific focus and energy on that child  
18 and that child's welfare whereas I think the regulator  
19 takes a helicopter view --

20 Q. Uh-huh.

21 A. -- about practice, about systems, about policy and  
22 procedures.

23 Q. Thank you. A separate question. We have heard that in  
24 the 1950 Act authorities were in a position then to pay  
25 for placements in the voluntary sector, but it took

1 twenty or thirty years before that had become  
2 a universal practice.

3 Do you know of any discussion that there was across  
4 the Boards, or across the Welfare Authorities it was at  
5 that stage, in the early years as to whether this was  
6 something where there was an expectation that they were  
7 going to take over that responsibility?

8 **A. I can't answer that, I am afraid. I am not aware.**

9 Q. Because it clearly had an impact on the funds available  
10 to the individual homes and that had an impact on  
11 staffing levels, and it is clear that over time  
12 standards did improve in relation to that.

13 **A. From what I have read my understanding is that the**  
14 **funding arrangement or the ability to fund the voluntary**  
15 **homes was different in relation to the Welfare**  
16 **Authorities than the legacy Boards, because there was**  
17 **a -- they could raise funding from the rates --**

18 Q. Uh-huh.

19 **A. -- as a local authority whereas later on that was**  
20 **dictated by the Department of Health. I am not sure how**  
21 **far at that transfer point consideration was given to,**  
22 **you know, the capita rate at that point.**

23 Q. Uh-huh.

24 **A. I do know -- and I think part of the finance submissions**  
25 **-- I do know that some of the Boards at that point,**

1 particularly the Western Board, were making increasing  
2 representation that they had been unfairly treated at  
3 that transfer point.

4 Q. Yes.

5 A. So they had come from a position of being underfunded in  
6 the new regime.

7 Q. Uh-huh.

8 A. There is a lot of research in more recent years around  
9 the funding of children's services and how that has, you  
10 know, through the years not grown with the need and  
11 demand of the service.

12 Q. Okay. Thank you.

13 A. I am not sure I answered your question fully, but that's  
14 all I can --

15 Q. Well, if you are unaware of things, that's fair enough.

16 A. That's all I can say.

17 Q. Thank you.

18 CHAIRMAN: Well, thank you very much for coming to speak to  
19 us today. Those are the last questions we have for the  
20 moment.

21 A. Okay.

22 Q. I have to emphasise that, because, first of all, we have  
23 these outstanding issues that may or may not be issues  
24 which we will require -- will perhaps lead you to make  
25 comments on what we hear from the Department,

1 particularly in the area of funding, and that is an area  
2 that is of considerable interest to us. We have not  
3 touched on it today, because it is not fair to ask you  
4 about that before we know what the Department's view is.  
5 We know what your view is. We don't have the other side  
6 of the coin to consider.

7 Of course, in a different aspect we may well be  
8 hearing from you either in written form or oral form in  
9 relation to Kincora, because the Board stands as the  
10 successor to the Eastern Board --

11 **A. Yes.**

12 Q. -- and as our terms of reference are different from  
13 those of the Hughes Inquiry, whilst our consideration of  
14 Kincora and Bawnmore may well cover familiar ground,  
15 there may be different issues which we have to address  
16 because of the different nature of our terms of  
17 reference.

18 So we may well have the pleasure of receiving  
19 evidence from you again some time we hope in June, but  
20 until then thank you very much.

21 **A. Thank you.**

22 **(Witness withdrew)**

23 MS SMITH: Chairman, I don't believe we can go any further  
24 with this governance and finance module at this point in  
25 time.

1 CHAIRMAN: No.

2 MS SMITH: So ...

3 CHAIRMAN: Well, it is very unsatisfactory that we have to  
4 leave a module unresolved for reasons which we have  
5 addressed this morning, for reasons that could and  
6 should have been avoided, but we will consider when we  
7 receive the Department's final witness statement on this  
8 issue what we need to do and how we will do that. It  
9 may be that there will have to be a further hearing. If  
10 so, we will try and arrange it some time in June, but  
11 that can't be predicted, nor can the date be predicted.

12 I have to say, Mr McGuinness, that if we don't  
13 receive the final statement by close of business on  
14 Friday, then no doubt there will be further strictures  
15 directed at the Department.

16 MR MCGUINNESS: I will take that on board, sir, and pass  
17 that on.

18 CHAIRMAN: Thank you.

19 (1.15 pm)

20 (Hearing adjourned until 10.00 am on Tuesday, 31st May 2016)

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I N D E X

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