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HISTORICAL INSTITUTIONAL ABUSE INQUIRY

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being heard before:

SIR ANTHONY HART (Chairman)

MR DAVID LANE

MS GERALDINE DOHERTY

held at

Banbridge Court House

Banbridge

on Wednesday, 17th December 2014

commencing at 10.00 am

(Day 80)

MS CHRISTINE SMITH, QC and MR JOSEPH AIKEN appeared as
Counsel to the Inquiry.

1 Wednesday, 17th December 2014

2 (10.00 am)

3 (Proceedings delayed)

4 (10.30 am)

5 Closing submissions by MR BRETT LOCKHART, QC on behalf of
6 the Diocese of Down & Connor

7 CHAIRMAN: Good morning, ladies and gentlemen. Now although
8 we will be hearing closing submissions this morning, may
9 I remind you again that mobile phones must be turned off
10 or put on "Silent", that no photography is permitted
11 anywhere in the chamber or in the premises, and also
12 that, although we are dealing with written submissions,
13 it may well be the case that the name or names of
14 individuals who have been given anonymity may be
15 referred to, and if that is the case, of course, their
16 names must not be used outside the chamber.

17 Now, gentlemen. Mr Lockhart, I think you intend to
18 go first.

19 MR LOCKHART: Yes. Mr Chairman, I appear, as you know, for
20 the Diocese of Down & Connor with Mr McKenna.

21 Mr Chairman, Members of the Panel, I am conscious
22 that the Panel has requested that oral submissions do
23 not trespass upon what has already been stated in the
24 written submissions submitted on behalf of the parties
25 and particularly the diocese. Given the sometimes

1 technical issues which the Panel, having regard to their
2 terms of reference, are obliged to consider, it has been
3 necessary to comment upon and distinguish matters which
4 at first blush may appear to be of lesser importance in
5 the overall context of what is truly important. We have
6 dealt with the more technical and legal points in our
7 written submissions and do not propose raising them at
8 this time.

9 I would not wish detailed evidence, which must of
10 necessity be commented upon, to take away from the
11 central issue as far as the Diocese of Down & Connor is
12 concerned. The gravamen of the evidence of the diocese,
13 as highlighted in the evidence of Father Bartlett, is
14 the recognition that children who were placed in care
15 were left vulnerable to physical, psychological and
16 sexual abuse.

17 Even if the diocese were minded, which most
18 emphatically it is not, to seek to legally exculpate the
19 behaviour of some by reliance on the context of the time
20 and the standards which then pertained in terms of child
21 protection, the church is always called to a higher
22 standard. It is not just the legal standard which the
23 church must meet, but the standards of the gospel, which
24 is the yardstick by which people will judge its actions.
25 When it fails in its duty, as happened at Rubane House,

1 then it must say so clearly.

2 Further, although within the terms of reference of
3 this Inquiry it is both appropriate and legally required
4 of those representing the diocese to seek to ensure, for
5 instance, that the governing arrangements which were in
6 place are accurately understood and considered, it is
7 also important to recognise the relationship between the
8 De La Salle Order and the diocese.

9 The De La Salle Brothers are not just a separate
10 organisation, who should bear alone the responsibility
11 for those times where serious misjudgments occurred.
12 They are a highly respected order within the Catholic
13 Church and in an ecclesiastical sense part of the same
14 body as the diocese. As St. Paul tells the Corinthians:

15 "All the members of the body, though many, are one
16 body. If one member suffers, all suffer together with
17 it."

18 Of course it is necessary and correct and important
19 to understand the context. The motives for the
20 establishment of Rubane House were noble ones. The vast
21 majority of the Brothers who served there did so
22 honourably, despite the difficulties and often with
23 extraordinary devotion and sometimes heroic virtue. It
24 would be remiss if, when the full story of Rubane House
25 is related, that the many instances where lives were

1 stabilised and occasionally transformed are overlooked.
2 Nevertheless too often there was a failure to recognise
3 that the welfare of children as opposed to the
4 reputation of institutions must be at all times the
5 paramount concern.

6 The diocese recognises this fully and repeats Father
7 Bartlett's apology to the victims, which stated:

8 "In conclusion, the diocese wishes to express its
9 deep sorrow and regret that any child was abused while
10 a resident in Rubane House. Established with the sole
11 intention of improving the circumstances and
12 opportunities of the children in its care, Rubane House,
13 as with any institution founded on Christian principles,
14 should have been exemplary in love, dignity and
15 protection. Clearly for too many, and despite the best
16 efforts of many of the staff, this was far from the
17 case. It is our hope that this Inquiry will go some way
18 to helping those who experienced such abuse to have
19 their voices heard and their painful experiences
20 acknowledged and that they will be assisted in advancing
21 towards healing."

22 Finally, it is hoped that the efforts made in
23 relation to child safeguarding, which have been set out
24 in the statement of Barbara McDermott, the Head of
25 Safeguarding in the diocese, are viewed by the Panel as

1 evidence of an entirely different approach. The church
2 has often been held accountable, rightly, for many of
3 the deplorable instances of child abuse that occurred in
4 Ireland. There has, however, been a decisive response
5 by the church, not just in Down & Connor, but throughout
6 the island of Ireland. The establishment of a National
7 Safeguarding Board and the priority given to the safety
8 of children who come into contact with the church is at
9 the front and centre of all church policies in 2014. It
10 is sincerely hoped by the diocese that this radically
11 new approach will give proper and adequate protection to
12 both children and vulnerable adults in a manner which
13 can help restore confidence and trust that have been
14 seriously undermined.

15 Those are the submissions I wish to make. Thank
16 you.

17 CHAIRMAN: Mr Lockhart, can I just raise with you one small
18 point in relation to your submissions? If we look at
19 page 15, that's Bates number 9282, paragraph 51, this
20 relates to the wider issue of the administering
21 authority.

22 MR LOCKHART: Yes.

23 CHAIRMAN: There are two references given to documents, one
24 on and the reference to that is
25 given in the footnote at RUB1187.

1 MR LOCKHART: Yes.

2 CHAIRMAN: Then the next reference, which relates to
3 , relates to RUB1188. When I looked at
4 those, I was not able to see that those were, in fact,
5 the documents that --

6 MR LOCKHART: There may be a mistake.

7 CHAIRMAN: I wonder could that be checked, please.

8 MR LOCKHART: Yes, of course.

9 CHAIRMAN: If there are other references, if we could be
10 notified of them.

11 MR LOCKHART: Yes. It should be, in fact, RUB11187 --

12 CHAIRMAN: I see.

13 MR LOCKHART: -- and 11188.

14 CHAIRMAN: Thank you very much.

15 MR LOCKHART: Most obliged.

16 CHAIRMAN: Yes. Now, Mr Rooney.

17 Closing submissions by MR KEVIN ROONEY, QC on behalf of the
18 De La Salle Order

19 MR ROONEY: Mr Chairman, Miss Doherty, Mr Lane, you will
20 have received by now our written submissions, which we
21 hope are comprehensive, but could I just say at this
22 stage that if there is any issue that arises out of
23 those submissions, then myself or Mr Napier are more
24 than happy at any stage, whether in writing or orally,
25 to clarify whatever issue that you do raise.

1 I would like to keep this oral submission relatively
2 short -- maybe even particularly short if my voice
3 doesn't hold up.

4 At the outset the Order made -- at the outset of
5 this Inquiry the Order made five commitments, five
6 decisions. In fact, there were many decisions to be
7 made, but there were five in particular.

8 The first decision that the Order made was to
9 cooperate fully with the Inquiry. It pledged that if
10 the Inquiry raised any issue or query or sought any
11 information, the Order would respond fully, honestly and
12 properly. The reason for this was three-fold.

13 First of all, the Order realised that this was
14 probably the last opportunity that the victims of abuse
15 would have to tell their side of the story and perhaps
16 get closure.

17 Secondly, the Order realised again this was probably
18 the last opportunity that the Order had to call evidence
19 about life in Rubane from the perspective of the
20 Brother. Many of the Brothers who served in Rubane are
21 now deceased, but thankfully BR2, who was and is still
22 alive, the Order knew that he would be able to provide
23 valuable insight into life at Rubane, warts and all.

24 Thirdly, the Order recognised that this was probably
25 the last opportunity that the Order would have to allay

1 rumour and suspicion in respect of Brothers who have
2 been wrongly accused and whose reputations have been
3 tarnished.

4 The second commitment that the Order made was to
5 ensure that it would provide the Inquiry with all
6 documentation which it had in its possession, control
7 and its power. The documentation is voluminous. Within
8 that documentation the Order provided BR2's private
9 diaries, various private papers from the heads of the De
10 La Salle Order and private letters to Rome and received
11 from Rome.

12 Now the Order realised, recognised that some of this
13 documentation would be used to level criticism against
14 it. That was never an issue with the Order. The Order
15 realised that if this Inquiry was to serve its purpose
16 in identifying systems failures, that there had to be
17 transparency and there had to be a spirit of openness
18 and honesty.

19 So, for example, last week when Mr Aiken took Dr --
20 Brother Manning through his evidence, the documents --
21 the documents which form the basis of the Order's
22 failings with respect to the and allegations,
23 those documents were the private papers which were in
24 the possession of BR19 and also the private papers to
25 and from Rome, and also the documentation which had been

1 used to some extent to criticise the Order's failure to
2 report excessive physical behaviour, that came from
3 BR2's diaries. Again the Order would say there is
4 nothing wrong with that. That's exactly what it
5 intended would happen. There would be truth and there
6 would be transparency.

7 The third decision that the Order took was to
8 identify at the outset those Brothers whom it believed
9 were guilty of abuse. It identified BR2 -- BR17.
10 That's "BR17". It identified BR15, "BR15", BR14, "BR"
11 -- I beg your pardon. He is BR14. BR15 is "BR15", and
12 BR1, "BR1".

13 Now the question may be asked, "Why did the Order
14 not make this disclosure earlier?" The answer is
15 simple. In respect of BR17 and BR15 it was only in
16 recent time that the Order has come to recognise that
17 these men were abusers. This information was gained
18 principally from two sources: first of all, from the
19 civil claims that were brought against the Order. The
20 Order was able to see from the allegations that were
21 made in the civil claims the pattern and the consistency
22 in allegations that were made. On that basis the Order
23 quite rightly made awards of compensation. The second
24 source of information was this, was those ex-residents
25 who have on a private basis come to the Order and told

1 the Brothers as to what happened to them in Rubane. The
2 Order has believed what they have had to say and they
3 have taken every word that they have said and they have
4 used that as a basis for the decision and commitment to
5 disclose to the Inquiry those Brothers who they say were
6 abusers. The Order has been consistent in its
7 condemnation of these men, the damage that it has done
8 to the children and also, of course, the fact that they
9 have tarnished the De La Salle Order's reputation.

10 The fourth decision that the Order made was to make
11 a sincere and unreserved apology. It made this apology
12 at the outset of the Inquiry and, of course, it has made
13 this apology during the course of this module, both in
14 writing and in evidence.

15 Now there are two aspects -- two aspects to any
16 apology. The first is an acknowledgment and acceptance
17 that a wrong has been committed. Secondly, there is an
18 expression of deep regret for pain and suffering caused
19 by the wrong.

20 Now the Order recognise that this apology will be
21 interpreted in different ways. You have heard evidence
22 that some applicants totally rejected the apology.
23 There were others who felt the apology was insincere.
24 There were others who felt, "Well, the apology should
25 have been made at an earlier occasion" and that now it

1 was too late. However, the Order has hoped that there
2 will be some understanding and that the Order has deeply
3 and sincerely regretted the wrongs it committed, and in
4 some small measure this would go some way towards
5 healing and closure.

6 The fifth decision or commitment that the Order made
7 was to defend those Brothers who it believes did not
8 abuse and whose reputations have been damaged. False
9 accusations have been made previously against the De La
10 Salle Brothers. We know this from the trial and
11 the rejection of these allegations by Sir Declan Morgan,
12 the Lord Chief Justice. The trial involved
13 allegations against a Brother who is still living and
14 a Brother who was dead and, as emphasised in the
15 trial, it is very easy to condemn a person who is dead,
16 who has no voice and who cannot defend themselves.

17 Now during the course of the evidence the Inquiry
18 has heard some distressing, very credible accounts of
19 both sexual and physical abuse. The Inquiry has also
20 heard accounts from honest witnesses who for one reason
21 or the other were genuinely mistaken. However, the
22 Inquiry has also heard what we feel were untrue
23 allegations. We know that this is not a time to assess
24 each and every allegation. We have done that in
25 chapters 8 and chapters 9 of our response, and we

1 acknowledge it is a difficult task for the Inquiry to
2 assess each and every applicant in respect of their
3 credibility and honesty. However, the Order urges the
4 Inquiry to be very slow to condemn any Brother unless
5 there is clear and uncorroborated -- I beg your
6 pardon -- corroborated evidence of abuse and wrongdoing,
7 and this applies particularly in respect of deceased
8 Brothers.

9 I would just like to finish off by highlighting one
10 aspect of the evidence which we feel is important. The
11 De La Salle Order was and is a congregation of teaching
12 Brothers. They are dedicated and have been dedicated to
13 improving the education of neglected, orphaned and
14 under-privileged children. When Rubane opened, the task
15 of the Order was both to teach and to care for those
16 children. Between 1950 and 1953, when the numbers were
17 small, the Brothers managed this dual role perfectly
18 well, but then the numbers increased. The diocese
19 continued to send more and more children. The welfare
20 authorities continued to send more and more children.
21 Quite simply, there were too many children for the
22 number of Brothers. The resources were clearly
23 inadequate, both in terms of the numbers of staff but
24 also in respect of the required expertise.

25 The witnesses to this Inquiry have described Rubane

1 as a "dumping ground for difficult children". The Order
2 dislikes intensely the term "dumping ground", because it
3 implies that children were cast away as worthless.
4 However, there is an element of truth with this label.
5 Very disturbed children were sent to Rubane. These
6 included children whose behaviour was out of control,
7 children who had been previously sexually abused and
8 then who went on to sexually abuse, children who were
9 vulnerable due to emotional neglect in their early ages,
10 children who would be described today as having learning
11 disabilities, children with a propensity for violence
12 and criminal behaviour. One witness described this as
13 "a toxic mixture". The profile of children described
14 would never be cared for together in the present day.

15 The Brothers were teachers. They were not trained
16 carers or social workers. To undertake this new role
17 they needed guidance. They needed advice. They needed
18 good practice guidelines. They needed clear protocols.
19 They really needed as much help as they could get.
20 Unfortunately they didn't get much.

21 Could I just finish off by maybe quoting
22 paragraph 5.16 of our written submission? It reads:

23 "The reality of Rubane was one of vast
24 over-occupancy and insufficient resources, managing
25 a mix of learning disabled and educationally normal

1 children, a range of vulnerable childhood histories,
2 including abandonment, poverty, abuse and neglect with
3 associated challenging behaviour. This context may go
4 somewhat to explain the emphasis on discipline and the
5 widespread use of corporal punishment, and while it can
6 never justify sexual, physical or emotional abuse of
7 children, it does describe a context which allows for
8 things to go wrong."

9 Thank you.

10 CHAIRMAN: Thank you, Mr Rooney. Ms Smyth.

11 Closing submissions by MS MOIRA SMYTH on behalf of the
12 Health & Social Care Board

13 MS SMYTH: Members of the Panel, thank you for giving me the
14 opportunity of making some oral submissions today on
15 behalf of Health & Social Care Board. You have my
16 written submissions, and in addressing you today,
17 I intend only to highlight some of the key points I have
18 raised in the paper.

19 You will see that at the beginning of my written
20 submissions I set out some of Ms Smith's closing remarks
21 in Module 1. She said the systemic failing by the State
22 constituted a failure to ensure either (a) that the
23 institution provided proper care, or (b) that the
24 children in that institution would be free from abuse,
25 or (c) that it took all proper steps to prevent, detect

1 and disclose abuse in that institution, or (d) that it
2 took appropriate steps to investigate and prosecute
3 criminal offences involving abuse. In making these
4 submissions today, Members of the Panel, I am very
5 mindful of that definition.

6 You will also see from my written submission that
7 I refer to the fact that you, Members of the Panel, will
8 consider all the evidence and judge it by the standards
9 at the time.

10 In paragraph 2.8 of my paper I refer to the
11 Rolleston report, which was submitted to the Ryan
12 Commission in the Republic of Ireland. It said this:

13 "There are two key points to keep in mind. First,
14 'abuse' as a word and a term with the particular
15 significance it has for us today was not recognised or
16 used at any time in this period."

17 The period under consideration by Ryan was, of
18 course, 1948-75.

19 "Prior to the mid-1980s there was little
20 professional or adult sensitisation either to the word
21 or to the possibility of abuse. Care must be taken,
22 therefore, as to how the term is used retrospectively
23 and especially as more recently constructed. Thus the
24 second point, namely, it is essential to avoid the trap
25 of potential excesses of judging this period now past by

1 today's standards, although this does not prevent
2 looking for lessons about matters that arise centrally
3 across all new periods."

4 My written paper also refers to the 1952 Home Office
5 memo, which we know from Module 1 was circulated to all
6 residential homes in Northern Ireland. This document
7 provides detailed guidance, which I submit gives a good
8 insight into acceptable childcare practices and
9 standards at that time.

10 In the area of sexual risk you will also see that
11 I have mentioned another Home Office memo that was
12 circulated to the heads of approved schools in England
13 in 1952, drawing their attention to what should be done
14 when indecent practices were committed on boys either by
15 other boys or staff. This guidance was mentioned in the
16 Rolleston report that I referred you to earlier. This
17 report said that, once circulated, it seems to have sunk
18 without trace. It was then discovered over forty years
19 later by an English researcher carrying out research
20 into residential care.

21 There is no evidence that this guidance or anything
22 like it was circulated in Northern Ireland, or to Rubane
23 in particular, but it does suggest that there was
24 awareness of the risks of sexual acts being committed on
25 boys by other boys or staff in the Home Office at least

1 in 1952.

2 In paragraph 2.84 of my written submissions I have
3 also mentioned a record of a meeting between the
4 Ministry of Home Affairs, the Diocese of Down & Connor
5 and De La Salle Order in 1963, when the danger of
6 undesirable practices was discussed between those
7 present at the meeting in the context of a debate
8 between dormitory versus smaller bedroom accommodation.
9 It is admitted that this record shows that there was
10 an awareness of the risks of undesirable sexual
11 practices between boys at Rubane. However, importantly,
12 there is no indication that this knowledge extended to
13 an understanding that some undesirable practices between
14 boys would be abusive as opposed to experimentation in
15 the course of adolescent development.

16 It is submitted this is an important point, which is
17 in keeping with what the Inquiry has heard from
18 professional witnesses in this module and also in Module
19 1 about the evolving nature of social work knowledge and
20 understanding of abuse over the decades. In my
21 submission this body of evidence suggests that it was
22 not until the 1980s that sexual abuse of children was
23 really identified as a major child protection issue in
24 the social work profession generally.

25 Members of the Panel, I draw your attention also to

1 DL517's evidence on Day 77, when in relation to this she
2 explained the state of knowledge in the late 1970s and
3 early 1980s in the following terms:

4 "It wasn't called child sexual abuse at that time.
5 In training you would have got training in what was
6 called incest. So it was very much family-based.
7 I knew about child sexual abuse as it related to
8 families, but we would not have been aware of the idea
9 of it being so public, if you like, or that it would
10 happen in residential staff. It was more thought to be
11 an individual being sneaky, if you like, and taking
12 children. The idea that it was public and
13 institutional, it was kind of more than one or possibly
14 organised, things like that would never have been on the
15 radar at the time."

16 From the evidence heard so far, Members of the
17 Panel, it is also my submission that the concept of
18 institutional abuse is also relatively recent and it
19 appears that the possibility of sexual and physical
20 institutional abuse simply did not register as a risk in
21 social work professionals involved in Rubane before
22 1980, when some boys began to talk to their social
23 workers about coming to physical harm by BR77. Before
24 1980 it appears that cases of physical and sexual abuse
25 were dealt with as one-off or isolated incidents.

1 In respect to sexual abuse I submit this is well
2 demonstrated by the incident involving BR14, which
3 was misleadingly reported to Ministry officials as
4 a single incident with one boy only. As the
5 documentation available demonstrates, this case was
6 dealt with as an isolated incident, which removed any
7 focus on the possibility of more widespread deviancy or
8 abuse. It appears that this was indeed an opportunity
9 lost, as Dr Harrison suggested in her evidence on Day
10 78.

11 Regarding physical abuse, you will see from
12 paragraph 4.22 of my written submission that the
13 response of HIA225's social worker to an account of
14 physical abuse in , whilst effective for HIA225, did
15 not consider the wider picture, and it would appear that
16 the possibility of institutional abuse did not register
17 with her at that time.

18 Thus it was in the 1980s that institutional abuse in
19 Rubane was first highlighted by a number of social
20 workers with responsibility for children placed there,
21 and you know that the complaints being raised by the
22 social workers at that time included physical care --
23 and I refer you to 's memo of 10th
24 November 1980, which raised concerns in relation to
25 clothing, footwear and pocket money -- and also physical

1 harm, and Members of the Panel will remember DL517's
2 evidence about how a child in her care told her about
3 being strapped on the back by BR77 in the laundry.

4 It is also submitted that the 1980 police
5 investigation, which was brought about by a referral by
6 the Eastern Health & Social Services Board, also played
7 a significant role in uncovering the institutional abuse
8 in Rubane, because it was in the police interviews that
9 large numbers of boys talked about being assaulted or
10 witnessing physical assaults by BR77, being indecently
11 touched by BR77 -- BR1, and engaging in sexual activity
12 between themselves, some of which was not consensual in
13 nature.

14 However, it is now clear that before 1980 there was
15 a catalogue of abuse that was not made known to social
16 workers who had responsibility for boys placed in
17 Rubane, even though it was known to the officer in
18 charge of the home at the time. This includes the
19 sexual allegations in and , the physical abuse
20 of boys by staff in Rubane by both Brothers and
21 civilians, as recorded in BR2's personal diary, and
22 sexual behaviour between some of the boys themselves,
23 which BR2 knew about, but he did not tell the social
24 workers involved with the boys about.

25 In his evidence on Day 75 BR2 said that many of

1 these matters were treated as an internal affair. Now
2 in my submission this is a significant failing, as it
3 meant that social workers who were working to further
4 the best interests of boys in the care of the welfare
5 authorities did not know they were placing boys into
6 a situation of such risk, and it is in this context that
7 institutional abuse in Rubane was allowed to persist for
8 so long.

9 In terms of the response of the Board's predecessors
10 to allegations of abuse which were made known to them,
11 you will see from my written submission that there are
12 some cases in which the Board accepts there was not
13 a prompt or rigorous enough response. These are set
14 out, Members of the Panel, in paragraph 4.2 of the
15 paper.

16 However, there are other examples which demonstrate
17 that the Board's predecessors responded appropriately to
18 allegations of abuse by reporting them promptly to the
19 Ministry or Department and the police, notably the
20 incident and the 1980 allegations, which led to the
21 conviction of BR77 and Mr McGuigan.

22 Following the 1980 police interviews of the boys in
23 Rubane, the Panel is aware that two social workers who
24 sat in with the boys during those interviews wrote
25 a report and expressed a view that all the social work

1 staff involved with Kircubbin be made aware of the
2 police action as soon as practically possible to
3 minimise potential problems in a very delicate
4 situation.

5 However, on Day 67 -- sorry -- Day 76 one witness,
6 DL 503 , told the Inquiry that he did not know about
7 the police investigation until 1982, when a request was
8 made for his files.

9 Now this is an important piece of evidence. The
10 Board is conscious that this is the recollection of one
11 witness only, but the Board accepts that if social work
12 staff involved with Rubane were not made aware of the
13 police action, this would have been a failing on the
14 part of its predecessor organisation.

15 Members of the Panel, my written submission also
16 covers the period -- sorry -- the pattern of social work
17 visiting in Rubane from 1950 right through to 1980. On
18 the basis of the evidence available the Board's view is
19 that social work visits evolved over the decades. It
20 was in the late 1960s and into the 1970s that regular
21 social work visiting became an established part of
22 social work practice.

23 In my submission it is likely that this positive
24 development followed on from the policy initiated by
25 Belfast Welfare Authority in 1967, whereby social

1 workers had to keep regular contact with children
2 following admission to residential care by visiting the
3 child at least monthly.

4 It is submitted this was a very important
5 development, because it meant that the boys in Rubane
6 had an opportunity to build a trusting relationship with
7 someone outside the institution, in whom they could
8 confide. The Panel, of course, knows it was to social
9 workers the boys first opened up in 1980, and in my
10 submission this is surely very significant, as this was
11 the first time in the history of Rubane that
12 institutional abuse was not only disclosed but was
13 importantly acted upon beyond the isolated incident or
14 one-off approach that defined previous attempts to
15 investigate or protect.

16 The dual role of the social worker, therefore, in
17 developing a trusting relationship with the child and
18 creating the conditions whereby a child feels able to
19 disclose abuse, and then taking the appropriate steps to
20 protect the child by informing senior managers, the
21 Department and the police was key to uncovering the
22 institutional abuse in Rubane. In my submission it
23 remains a cornerstone of good social work practice
24 today.

25 Members of the Panel, that completes my oral

1 submission.

2 CHAIRMAN: Ms Smyth, can I just ask you one matter? If you
3 turn to page 29 of your written submissions,
4 paragraph 4.6 --

5 MS SMYTH: Yes.

6 CHAIRMAN: -- you will see that it starts off by saying that
7 your client's position is that the home did, in fact,
8 know about sexual activity between boys in Rubane, and
9 then it continues:

10 "The Health & Social Care Board also considers that
11 the Department of Health and Social Services had
12 a particular duty to follow this up with the home, given
13 its responsibilities as the registering and inspecting
14 authority."

15 Does that mean to imply that the HSCB is submitting
16 that the Department didn't do that and should have done
17 it? It is perhaps left hanging in the air on one
18 construction of that sentence.

19 MS SMYTH: Yes. Well, if you would agree, Chairman, I would
20 propose to return to that and I would like to look
21 closely at the 1981 SWAG report to see what it says. If
22 you would indulge me, I would perhaps file an addendum
23 submission in relation to that point.

24 CHAIRMAN: Yes. It is just it is capable of being read as
25 an implied criticism --

1 MS SMYTH: I understand.

2 CHAIRMAN: -- but I think we would like to know whether that
3 is, in fact, the right construction to place on that
4 sentence.

5 MS SMYTH: I understand, and I will clarify that, if you
6 will allow me to, in the next few days.

7 CHAIRMAN: I think we would like to have it by -- it doesn't
8 interfere with other matters -- close of business on
9 Friday.

10 MS SMYTH: That's fine. I will attend to that today,
11 Members of the Panel.

12 CHAIRMAN: Very well. Thank you very much.

13 Mr O'Reilly, do you wish to say anything on behalf
14 of the Department?

15 Closing submissions by MR FRANCIS O'REILLY, QC on behalf of
16 the Department

17 MR O'REILLY: Mr Chairman, unlike other modules, there has
18 not been an exchange of the written submissions as
19 between the core participants, and I was unaware of the
20 comment that appeared in Ms Smith's submissions on
21 behalf of the Board. Perhaps we will be able to obtain
22 a copy, and if you would not mind us responding to that,
23 again if you have it in sufficient time, by close of
24 business on Friday, I would like to take the opportunity
25 to do so, but otherwise I have no other submissions at

1 addition, apologies have been made both collectively and
2 individually to those who the core participants accept
3 suffered abuse. The Inquiry may determine there were
4 others. As the module comes to a close, the Inquiry
5 Panel will have to consider a large number of questions
6 that arise from the evidence in terms of analysing the
7 systems failures that affected this children's home.

8 Finally, Chairman and Members of the Panel, can
9 I again publicly pay tribute to the Inquiry staff for
10 the extent of the effort that they have made to
11 facilitate the Inquiry completing this module on time,
12 in particular the assistance that the Inquiry legal team
13 has given me in light of the scale of the task that has
14 been before us.

15 Also can I recognise the level of cooperation from
16 individuals with whom the Inquiry has come in contact,
17 including those coming forward to give evidence of their
18 experiences, and indeed those professional colleagues
19 whose cooperation has been very much appreciated to
20 ensure the smooth running of this module.

21 Unless I can assist the Panel any further, those are
22 my closing remarks in relation to Rubane House.

23 CHAIRMAN: Thank you very much, Mr Aiken.

24 Well, ladies and gentlemen, this brings us to the
25 end of the third module of the Inquiry's work, and this

1 is the 80th day of the public hearings that have been
2 spread across the entirety of this past year, 2014. It
3 is an indication of the scale of the work upon which the
4 Inquiry is engaged that, taking into account the figures
5 Mr Aiken has just given, that in the course of these 80
6 days of public hearings we have heard from no fewer than
7 158 witnesses, 98 of whom are individuals who applied to
8 the Inquiry and who came forward in order to help us
9 with our work by performing the absolutely vital and
10 fundamental burden of describing to the Inquiry their
11 experiences in the various institutions we have so far
12 looked at.

13 As Mr Aiken has pointed out, that in this module
14 alone we have had to consider in the region of 20,000
15 documents and, of course, for the three modules we have
16 dealt with so far the total is very much higher than
17 that.

18 We have in this particular module that we are now
19 finishing been given a great deal of documentary
20 material, both in the form of documents we have had to
21 consider and the very detailed written submissions that
22 have been made not just this morning but from time to
23 time during the Inquiry's work, and that gives us a
24 great deal to consider.

25 However, our task is not done, because we will

1 resume our public hearings at the beginning of next year
2 on Monday, 5th January, when we turn to consider the
3 next, the fourth module of our schedule, when the
4 Inquiry will be considering evidence in relation to two
5 institutions run by the Sisters of Nazareth, namely
6 Nazareth Lodge and Nazareth House in Belfast. On
7 Monday, 5th January at 10.00 when we resume there will
8 be the opening remarks by myself and by Counsel to the
9 Inquiry, and then on Tuesday, 6th January we propose to
10 call the first witnesses, and the scale of that module
11 is such that the hearings will extend over a number of
12 months thereafter.

13 But that brings our hearing to an end this morning,
14 ladies and gentlemen, and we now adjourn to Monday, 5th
15 January. Thank you very much for your attendance.

16 (11.10 am)

17 (Hearing adjourned until 10.00 am on Monday, 5th
18 January 2015)

19 --ooOoo--
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