HIA REF: [ ]

NAME: NL 223

DATE: [ 12 February 2015. ]

# THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

## Witness Statement of NL 223

I, NL 223 will say as follows: -

1.0 Between 1981 and 1987 I was a Principal Social Worker in [redacted]. One of the children who was in the care of the Unit of Management and for whom I had managerial and professional responsibility, was HIA 210.

1.1 In October 1971 I was employed by the [redacted] as a Graduate Trainee Social Worker, having graduated earlier that summer.

1.2 I undertook my professional Social Work Training in 1973/74 obtaining my Certificate Qualification as a Social Worker (CQSW) in 1974.

1.3 By then, following the introduction of Direct Rule, my employment had transferred to the [redacted] – [redacted]. I worked there, until early 1981, being promoted twice. I was a Senior Social Worker (Team Leader) from 1975 to 1978 and an Assistant Principal Social Worker Residential and Day Care Services from 1978 – 81. This latter role involved services to all client groups and not just child care.

1.4 In 1981 I was appointed to the post of Principal Social Worker Fieldwork Services in [redacted] and remained in this post until 1987.

1.5 Subsequently, I transferred at the same grade, to a newly created post, supporting the Assistant Director of Family and Child Care Services at [redacted] and [redacted]. This post involved policy formulation, the development and planning of new services and the monitoring of performance of the various units of management.

1.6 In 1990 I was appointed to the role of Assistant Director of Social Services Elderly and Disabled Services, reporting to the Director of Social Services.

1.7 In 1993 I joined the newly established [redacted] later became the [redacted] My role was as a [redacted]. Following the obtaining of Trust status, I also fulfilled the role of Trust Director of Social Services.

1.8 In 2002 I was appointed Director of Social Services [redacted] until I retired in May 2009. In that organisation I was the Lead Director for services to the [redacted] and [redacted]. [redacted] was my colleague the Director of Nursing, however, I would have informally led on matters of child protection or child care nature.

1.9 I was appointed the [redacted] for Northern Ireland in July 2011 and retired from this role in November 2014. In this role I was accountable to the [redacted]

## 2.0 Organisational Structures in 1981 - 1987

2.1 At the time of my appointment to the Principal post, [redacted] was one of 6 Districts, which made up the [redacted] which in turn was one of [redacted] At some time during my period as Principal, the District became a Unit of Management, I believe in 1986. The implication of this was the delegation of authority from the centre to the Unit of

Management particularly in relation to budgetary control and the organisation of services.

2.2

The Service was designed on an integrated Health and Social Care Model, but in practice was managed upon professional lines, with doctors, nurses, social workers being accountable to the relevant Director. Each Board had a Chief Executive and a Senior Team of a Director of:-

- Medicine
- Nursing
- Social Services

As well as a range of Administrative Functions such as Human Resources, Finance, General Administration. This structure was generally replicated at District level.

2.3 The Director of Social Services had 11 Assistant Directors / District Social Services Officers who reported to him. One in each of the 6 Districts:-

- North & West Belfast
- South Belfast
- East Belfast & Castlereagh
- North Down & Ards
- Down
- Lisburn

At Headquarters there were 5 Assistant Directors with specialist responsibilities for:-

- Family and Child Care
- Elderly Services*
- Disability Services*
- Mental Health and Learning Disability

- Training

*Shortly afterwards these posts were merged.

2.4 In [redacted], I reported directly to the District Social Services Officer who was later to become the Assistant Director. He was part of the District's Senior Management Team, with I believe at that time, a rotating Chair of the multi-disciplinary team.
I was one of [redacted] (Fieldwork Services). [redacted] and was a recognition of the size, demand and complexity of that District.
In addition there was:-

- a Principal Social Worker (Health Care) and
- a Principal Social Worker (Residential and Day Care).

2.5 The [redacted] Social Workers Fieldwork Services were responsible for all services delivered, to the citizens of [redacted] from local offices.
This included services for:-

- Families and Children
- Those with a Mental Illness
- The Elderly
- The Disabled
- Those with a learning disability and
- Work aimed at developing local Communities' ability to respond to their own needs.

2.6 Each of these services was delivered from five local offices, which were in turn managed by a local Assistant Principal Social Worker:-

- [redacted]

My colleague Principal managed the first 3 offices and I the last two offices. Additionally, there was an Adoption and Fostering Service, provided Unit wide, which she also initially managed but which overtime transferred to my management.

2.7 Sometime in 1985, I believe, my colleague decided to retire. Although we had worked very well together, having two leaders for one service was not without its difficulties in terms of standardization and communication, so for my remaining time in this role I managed all of the Fieldwork Services. I was assisted in this by the appointment of an Assistant Principal Social Worker, whose job was to chair Child Protection Case Conferences, which was an ever burgeoning part of the role.

2.8 Despite my best efforts, I believe that the demands of the post were such, that this arrangement was not sustainable. On my transfer to a new post in late 1987, the District Social Services Officer, with my support reverted to a two Principal system.

3.0 [redacted] 1981 - 1987

3.1 In population terms [redacted] was the largest of the 6 Districts, with population then, of approximately 165,000, which was a quarter of the Eastern Board.

3.2 However, it was much more that its size, which made it complex and challenging. In the 1980s it was undoubtedly one of the areas of greatest deprivation, across the United Kingdom. High levels of unemployment, a heavy reliance on state benefits, high crime rates, poor housing, high child poverty rates and poor school attendance and attainment were all part of a picture of multiple deprivations. Successive governments recognising these issues were prepared to invest monies, often given as time limited initiatives, in trying to boost employment and create community infrastructure and cohesion.

3.3 The Troubles were particularly pronounced in [redacted] with almost

daily incidents. Troubles related research was later to show the disproportionate number of people, living in [redacted], who lost their lives or were seriously injured. Then, as now, there were tensions in interface areas, which frequently ended in violence. I believe given the relative normality we enjoy today, it is necessary to remind ourselves of how very different it was to live and/or work in such unnatural conditions, thirty years ago. From time to time the Troubles threw up a series of issues, which needed to be managed or navigated.

3.4 The demand for services was a reflection of both deprivation and the Troubles. The District / Unit of Management had the highest number of children, on the Child Protection Register and the greatest number of children in the care system. As a consequence more children were referred for assessment of their need, including their need for protection; more cases would have progressed to legal proceedings and there was a constant demand for services and interventions which put considerable pressure on the Districts human and physical resources.

3.5 At times, recruitment was difficult, and staffing levels were a problem, but generally despite the pressures staff retention was relatively good. As might be anticipated, staffing levels were much less that today's standards. Given community tensions it was often difficult to offer acceptable services to one section of our community which were located in the "others" geographical area. Services had to be localised and community based, with all of the implications this had for expertise, effectiveness and cost.

## 4.0 The Role of the Principal Social Worker

4.1 Within the context of services to families and children, amongst other things, the Principal Social Worker was responsible for:-

- Ensuring that the Unit of Management was meeting its statutory duties to children in its care or on the Child Protection Register, and complying with the Board's policy and procedures. This would include, until the appointment of the APSW Child Protection, the Principal Social Worker,

chairing all new child protection Case Conferences and the twice yearly reviews of all those on the Register within the local offices which the PSW managed. Ensuring that all children in the care system were being visited regularly and the reviews of their on-going needs were conducted at regular intervals (6 months).

- Providing advice to staff on individual cases issues.
- Supervising the work of the Assistant Principal Social Workers.
- Attending Team Meetings of the Senior Management Team and at local office level.
- Managing budgets.
- Developing links with local Communities.
- Developing new services and service models, often associated with the release of initiative monies.

Managing staff including:-

  - Monitoring trends
  - Disciplinary matters
  - Untoward incidents
  - Complaints

- Working with multi-disciplinary colleagues to develop new approaches to services provision.
- Trade Union relations.

4.2 This is not a definitive or exhaustive list of the tasks that required to be performed.

**5.0 Preparing the Statement**

5.1 I am heavily reliant on historical records and correspondence. To date I have had access to some papers, relating to HIA 210 and also some papers related to one of the other two individuals mentioned in this correspondence but not the other. As my recall of these events is vague and I have not had access to any of my own records from my time in [redacted], this Statement is based upon, the records thus far provided to me.

6.0 **Contact with Nazareth Lodge / Nazareth House**

6.1 My professional contact with either facility was limited. As a frontline practitioner, I did not have any children cared for in these homes. As a Team Leader in [redacted] there were a "handful" of children who were accommodated in these homes. To the best of my recollection I would have attended a few reviews in these facilities. I do not recall any complaints, concerns or issues over the care of these children.

6.2 As Principal Social Worker, covering in particular the [redacted] and later the Unit of Management as a whole, a number of residents of Nazareth Lodge, would have been in the care of the District / Unit of Management. As with the case of HIA 210 individual cases would have been drawn to my attention, usually in relation to incidents or concerns, as opposed to the more general assessment of how effectively each child's need were being met within that setting.

6.3 At no time did I have any responsibility for the management, inspection or regulation of either facility. My role was as professional lead seeking to afford these children the opportunity for their proper development. This subsequently has come to be described as seeking to ensure that the Corporate Parenting role is fulfilled.

7.0 **Observations on the case of** HIA 210

7.1 From the records shown to me, to date, I want to make the following comments:-

7.2 These matters were appropriately referred to me in writing by NL 191, Senior Social Worker on the 6th March 1985. See Exhibit 1. By that date she had already spoken to HIA 210 and his brother, Martin. As can be seen from [redacted] NL 191 report to me dated 11th April 1985, see Exhibit 2, there were considerable differences in HIA 210 and NL 204 recollection of their care experience and of specific incidents. In her letter NL 191 mentioned a number of children who HIA 210 apparently believed would be able to corroborate his allegations.

7.3 From the records, it would appear that I asked NL 191 to seek, if possible, to clarify some ambiguities in the original statement. The record suggests that she wrote to me again on the 11th April 1985 to set out the position, see Exhibit 2.

7.4 Nazareth Lodge, was a Regional facility taking children from Districts across a number of Boards. The names of all the children, on the list provided by [redacted] NL 191 were not familiar to me; therefore, I believed that a number of these young people would be in the care of other Boards or Districts within the Eastern Board. Consequently, if this matter were to be progressed, along the lines suggested by NL 191 in her letter of 6th March 1985 this would require a degree of central co-ordination at Board or possibly Departmental level.

7.5 I then wrote to DL 518, Assistant Director of Social Services, Family and Child Care on 30th April 1985. See Exhibit 3. I did so to:-

- Draw this issue to his attention, as I was required so to do;
- Alert him to the fact that children from other Units of Management or Boards might need to be involved, and to
- Seek his advice.

I believe that my letter to DL 518 reflected the fact that initial enquiries had produced little corroboration of the allegations.
It appeared that inadvertently I caused some confusion by giving the wrong Christian, name of a boy whom HIA 210 had mentioned as also being the victim of possible physical abuse.

7.6 In April 1985 when these allegations were shared they were historical in nature. HIA 210 was no longer a resident in the home. SR62 and NL60 NL60, against whom HIA 210 made his allegations, had both left the home. I had learnt that SR62 was no longer working with children.
Therefore, whilst it was clear that these matters needed to be investigated, there appeared no longer to be any obvious or present risk to any child.

7.7 Subsequently, and following correspondence between the Director of Social Services and the Chief Social Work Adviser, I was required by the Director of Social Services as set out in his letter to SR143, dated 13th June 1985 to investigate this matter. See Exhibit 4.

7.8 On the 21st June 1985 the record suggests that I and NL 191 met with Mr HIA 210. I wrote to SR143 on the 27th June 1985 setting out the allegations which HIA 210 had made. I concluded that NL 191 and I "believed that whilst there is a possibility that there might be some exaggeration, nevertheless [redacted] allegation must be taken seriously" See Exhibit 5.

7.9 On the advice of DL 518, I arranged to interview two members of staff, mentioned with some fondness by HIA 210. One of these was still a member of staff in the home but the other had left some time ago. The result of these interviews is set out in my letter of 8th July 1985 to DL 518, a copy of which was also given to SR143. See Exhibit 6. Despite neither member of staff corroborating his account I remained of the opinion that his account of events "should not be lightly dismissed", and set out the reasons why I had come to this conclusion.

Despite the fact that there was no corroboration, it was my opinion having conducted these interviews, that there was a need for a fuller investigation. I note from my letters that I was impressed by the manner in which HIA 210 told his story.

7.10 A related issue arose in relation to a child, NL145 who revealed to her Social Worker, NHB 136, that she had been abused in Nazareth. This was brought to my attention and therefore, I brought this to the attention of [redacted] DL 518 in a memo with an attached report on 26 November 1985. See Exhibit 7

HIA 210 also referred to another child NL 97 and further to my discussions with DL 518, I undertook to interview NL 97. I did so and this is detailed in a subsequent memo that I sent to DL 518 on 18 February 1986.

See Exhibit 8. NL 97 confirmed to me that SR 62 beat him and HIA 210 regularly with a wooden spoon and a bamboo cane. He also confirmed that on one occasion SR 62 banged his head against a wash hand basin causing him to bleed. He indicated that SR 62 picked upon him and HIA 210 to excess.

This information re NL 97 is referred to in the Director of Social Services letter of 30 April 1986 to the Chief Social Work Adviser. See Exhibit 9. DL 518 states that this corroborates the allegations made by HIA 210 and NL145 , with regard to the behaviour of SR 62 . In this same letter he goes on "there can no longer be any question that the information, we now have available, from three former residents amounts to alleged general malpractice and in some instances physical assault by SR 62 .

7.11 I am aware that SR143 conducted her investigation of the allegations made by these three young people. I note that this occurred sometime in 1986. I cannot recall whether I saw this report in 1986 but I have not seen it as part of this process. However, I note that the Director of Social Services expressed his dissatisfaction with this investigation and as a consequence required that all three children should be approached, made aware of the outcome of this investigation and offered the assistance of social work staff, if they wished to make a complaint to the Police.

7.12 I note that in his letter of 19th February 1987 in relation to the allegations of ill treatment, DL 518 informs SR 62 , that all three young people were contacted and informed of their right to make a complaint to the Police, if they so wished See Exhibit 10.
In the case of HIA 210 , it appears that he did not wish to do this.

7.13 I have been asked to comment specifically on why I did not refer this matter to the police.
I would firstly cite the accounts provided to me by NL 191 , of her interview with NL145 dated 21st February 1985 and with his brother NL 204 dated

03rd April 1985, there were obvious and significant differences in their respective recall of events. At that time I had not interviewed HIA 210 and was therefore unsure of what was fact, distorted memory, or fiction. Perhaps in 1985, I may also have found it difficult to reconcile my stereotypical view of a nun, with the harsh treatment and behaviour HIA 210 was describing.

7.14 When I spoke to HIA 210, allowing for some element of distortion or exaggeration, I believed him. Therefore I took what he had to say very seriously. This is reflected in the letters I sent to both SR143 and DL 518 albeit that there was no corroboration from the 2 members of staff (one a former member) whom I interviewed. I believed that an investigation was needed to establish the facts.

7.15 After this, the issue of how such an investigation should be handled, appears to have been the focus of a debate between senior Departmental and Board officials. In that context I was awaiting instructions. Being the sole Principal Social Worker (Fieldwork) in [redacted] I had more than enough current and day to day challenges. In the context of 1985, practice and organisational culture, I did not believe that notifying the police was my decision; a belief which I think is supported by sections 32 and 33 of the Guidance issued in May 1985 in relation to a Complaints Procedure for Children in Residential Care.

7.16 In relation to the decision, to give the right to these three older adolescents, to decide whether they wished to make a complaint to the RUC, I had no problem in arranging for this decision to be implemented. I believe it was appropriate to afford these young people, and in HIA 210 case he was then 17 years old, with the opportunity to have a say in making this decision. I believe that social work practice was moving in that direction at that time as partly illustrated by the introduction of complaints procedures across the United Kingdom. I also believe that the legal ruling in relation to the Gillick Principle in 1986, gave further weight to this position, so for older adolescents such as these, I did not see any principled problem.

7.17 In relation to the debate between the Board and the Department as to how any investigation should be conducted, I did not believe that I had the authority to conduct a full and thorough investigation, I had no power to interview staff, access Nazareth House records or for that matter interview children from other Boards or Districts. These were my views then and they are my views now.

7.18 However, I believe it important to try and put this incident into its historical context. I want to state that the Complaints Procedure for children in Residential Care issued on 30th April 1985, did not come into operation as expected. There followed protracted discussions, primarily with Management and Staff Side of the General Joint Council to seek safeguards for Residential Care staff. Pending resolution of this problem NIPSA instructed its members not to co-operate with the implementation of these procedures. This was referred to in the Hughes Report see Exhibit 11 paragraph 13.97.

7.19 This, I believe, reflects the significant change in practice which was associated with the introduction of a Complaints Procedure, which indirectly changed the relationship of the Social Worker, the child and the institution. The fact that this debate was taking place at the same time as the Hughes Inquiry was gathering evidence is also not co-incidental.

7.20 However, irrespective of this, matters such as this always both need time to "bed in" and more importantly practice time for these systems to be tested, reviewed and revised. The issues here were complex, today they would be handled much more straightforwardly because practice is stronger and better informed by experience.

Statement of Truth

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

Signed [redacted] NL 223

Dated 12 February 2015

**HIA REF: [ ]**

**NAME:** NL 223

**DATE: [22 April 2015]**

**THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995**

**Supplemental Witness Statement of** NL 223

**I,** NL 223 **will say as follows: -**

1. **Further to my initial statement dated 12th February 2015, I now make this supplemental statement.**

2. **At paragraphs 7.13-7.16 of my initial statement, I address the issue in relation to why steps were not taken to notify the police. This supplemental statement is intended to address this issue further.**

3. **The initial reports from Senior Social Worker indicated a number of inconsistencies.** HIA 210 **was predominately complaining of being locked in a bathroom/cupboard and being beaten by Staff with a range of implements. The most serious allegation of someone being pushed against a wash basin was experienced by others and there was initial doubt about who it was,** NL 204 **or** NL 97 **.** NL 204 **denied it was he.**

4. **These incidents would have most probably occurred in the 1970s (** HIA 210 **left Nazareth in 1981). Even in 1984/5 Corporal punishment was still permissible in schools and residential settings.**

5. **I believe the allegations made by** HIA 210 **lay somewhere on a continuum of corporal punishment, inappropriate child care, physical abuse through to criminal assault.**

6. I did not believe, in the context of 1985 society, that there was sufficient evidence to present to the RUC, which would have resulted in a criminal investigation. My sense was that this matter needed further investigation by Social Services and personnel from the Home, although I note the disquiet in the Hughes Report when addressing this type of issue.

7. The May 1985 Guidance in relation to Complaints at sections 32 and 33 clarified that the decision maker, in relation to referral to the Police of matters of a criminal nature, was the Director of Social Services and or the Chairman of the Management Committee of the Voluntary Body. At this time, I had no previous experience of an issue such as this.

8. There were obvious issues for me about conducting such an investigation, there were no guidelines as to how such an investigation should be conducted; there was no training in place with regard to carrying out such investigations and to my knowledge no research had been undertaken as to what constituted best practice, given the fact that the introduction of similar complaints procedures across the UK, was so recent

9. Further to what I have stated in my initial statement at paragraph 7.15, instinctively I believed that I had neither the power nor the time to conduct such an investigation. In relation to the power. I had no authority to access records of the Home, nor to interview SR 62 or for that matter the previous Mother Superior. Nor did I have the power to interview children in the care of other Districts within the Eastern Board or other Boards. Intuitively I believed this was the responsibility of others, namely the Department and the Sisters of Nazareth. I would re-refer to Exhibit 8 of my initial statement which I understand is now identified at SNB 7032-7033 and to the last paragraph of this document.

10. I would also point out that the decision to ask me to undertake this investigation, was not consistent with Section 28 of the Complaints Procedure Guidance which stated that "Boards should be prepared to assist voluntary bodies in the investigation of the complaint". I appreciate that this Guidance could not be introduced in 1985 and was therefore operationally non-extant.

11. In relation to the issue of time. I from the summer of 1984, was the sole Principal Social Worker fieldwork, within the District. I was working very long hours in a pressurised environment and did so for the rest of my time in [redacted]. I was presented weekly, with very significant professional decisions involving immediate risk or danger to children. Keeping children safe was my operational priority. I did not at that time view the case of [redacted] HIA 210 in this way.

12. From all of these perspectives, plus the fact that as the investigation broadened, it become apparent that this was more than an individual young persons' complaint. I believed that this matter should have been investigated by others.

13. Another issue which I would wish to address in this supplemental statement is how as a Principal Social Worker in the [redacted] District, I knew so little about the investigation in the early 1980s into abuse at Rubane.

14. My early career in [redacted] meant that I had no contact whatsoever with Kircubbin.

15. When I arrived in [redacted] part in the criminal investigation was already complete. DL 515 who was originally a Senior Social Worker in the [redacted], and was charged with facilitating the RUC by sitting in on interviews and acting as a liaison with the RUC, had been promoted and taken up a new role in the [redacted] before my arrival.

16. I have been told that there was an instruction from the Director of Social Services to the DSSO that this matter was to be very tightly managed. This instruction was I believe also issued by the DSSO to the [redacted] staff identified to liaise with the RUC.

17. I have contacted Joan McCrea, who was my colleague Principal Social Worker (Fieldwork services) managing the other half of the District until her retirement in the Summer of 1984, and also John Compton, to verify my understanding. I have been told by Joan McCrea that she believes this matter was managed personally by the DSSO and that any information she was told

about this was on a "need to know" basis. I was told by John Compton that he was instructed to produce a hand written report, rather than a typed report, to prevent any gossip about this issue.

18. I understand this investigation was discussed at the Social Services Senior Team meeting at the Board, attended by the Director of Social Services and all of the Assistant Directors.

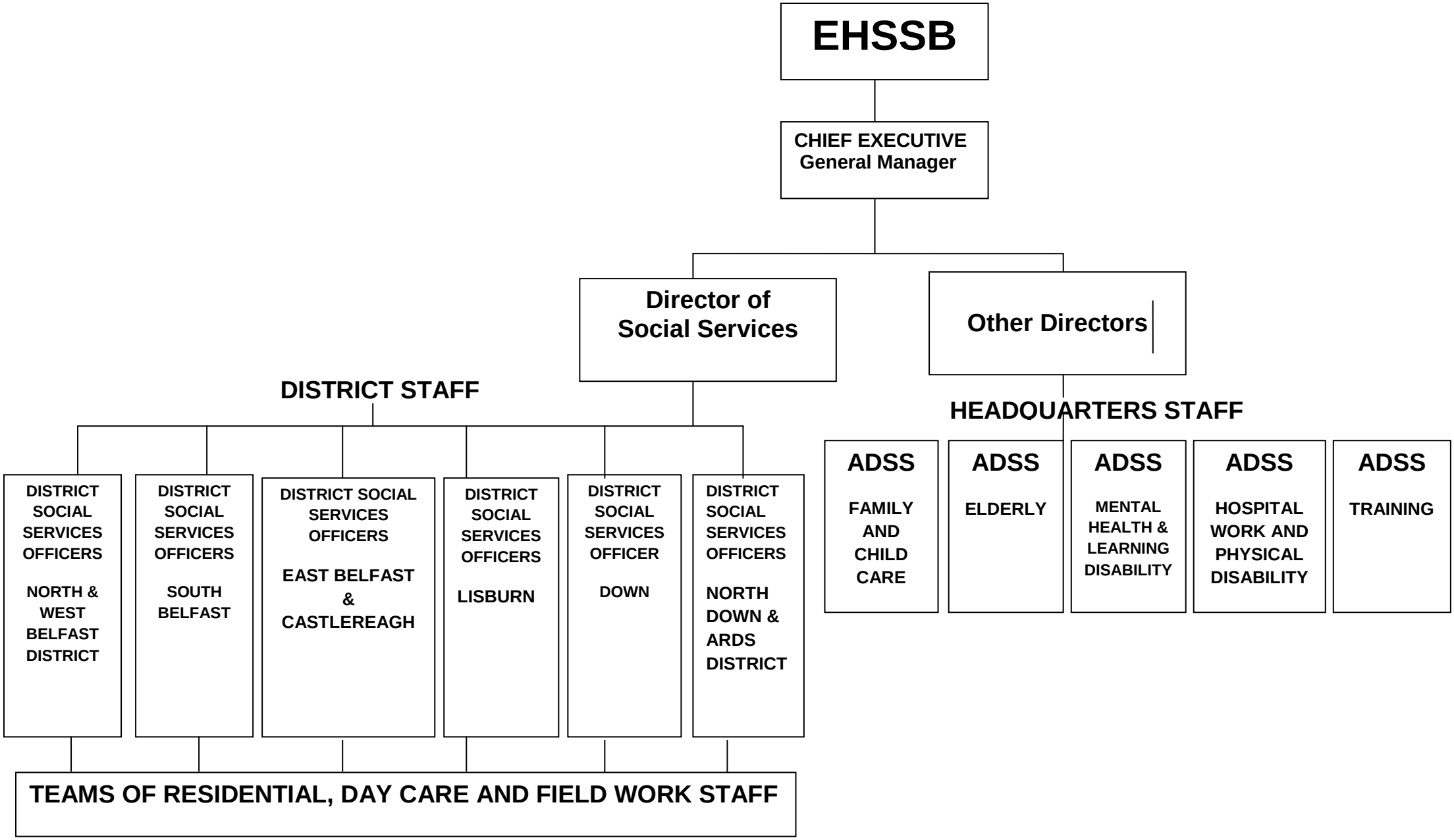
19. I have no recollection of any detailed discussion at the DSSO's meeting on this issue. No report was produced or circulated as would be case today to create a learning document, similar to a Case Management Review, which would be used to analyse the sequence of events or make recommendations about how practice can be improved.

Statement of Truth

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

Signed NL 223 [redacted]

Dated 22/4/15


EHSSB
CHIEF EXECUTIVE
General Manager
Director of
Social Services
Other Directors
DISTRICT STAFF
HEADQUARTERS STAFF
DISTRICT SOCIAL SERVICES OFFICERS
NORTH & WEST BELFAST DISTRICT
DISTRICT SOCIAL SERVICES OFFICERS
SOUTH BELFAST
DISTRICT SOCIAL SERVICES OFFICERS
EAST BELFAST & CASTLEREAGH
DISTRICT SOCIAL SERVICES OFFICERS
LISBURN
DISTRICT SOCIAL SERVICES OFFICER
DOWN
DISTRICT SOCIAL SERVICES OFFICERS
NORTH DOWN & ARDS DISTRICT
ADSS
FAMILY AND CHILD CARE
ADSS
ELDERLY
ADSS
MENTAL HEALTH & LEARNING DISABILITY
ADSS
HOSPITAL WORK AND PHYSICAL DISABILITY
ADSS
TRAINING
TEAMS OF RESIDENTIAL, DAY CARE AND FIELD WORK STAFF

should be made to foster the relationship between staff and children in this respect. However, there will be occasions when children will feel the need to complain. The explanatory booklets should, therefore, inform children, and parents, how they may do so.

24.0 Children and parents should be encouraged to raise their complaints with staff in the home in the first instance. However, it should be made clear that, should they not wish to make a complaint within the home, or should they already have done so but are dissatisfied with the outcome, they can raise the matter with other persons, namely:-

- the child's social worker;

- in statutory homes, the visiting social worker designated under paragraph 3(3) of the Conduct of Children's Homes Direction (NI) 1975 or, in voluntary homes, the voluntary visitor authorised by the administering authority under paragraph 4(2) of the Children and Young Persons (Voluntary Homes) Regulations (NI) 1975.

The child's social worker should be informed of any complaint made by a child in a voluntary home.

25.0 It should be explained to children and to parents that the complaints system does not take away their right to express any legitimate concern which they might have through other channels available to them, for example, directly to members of the Board or Management Committee during the course of visits to homes or otherwise, or to Members of Parliament or Members of the Northern Ireland Assembly.

CONTACT CARDS

26.0 A further arrangement is needed for those children or parents who do not wish to use any of the channels of complaint set out above or who, having used them, are not satisfied that their complaints have been dealt with fairly. This will require the introduction of a system of pre-paid contact cards.

27.0 In the case of both statutory and voluntary children's homes the contact card should be addressed to the Director of Social Services of the Board in whose care the child has been placed. Boards should make a supply of contact cards available to voluntary homes.

28.0 On receipt of a contact card, the Director of Social Services should take immediate action to ascertain, through a social worker not immediately involved in the care of the child, the nature and substance of the complaint being made. On receipt of this information the Director should, where the child is in a statutory home, put in train whatever investigatory action he deems appropriate. Where the child is in a voluntary home, the Director should inform the Chairman of the Management Committee of the home, or his equivalent, of the nature of the complaint and should agree the follow-up action required. Boards should be prepared to assist voluntary bodies in the investigation of the complaint.

29.0 In each case where a contact card is used, the Director of Social Services should keep himself informed of the progress of the investigation and

EASTERN HEALTH AND SOCIAL SERVICES BOARD

NORTH AND WEST BELFAST DISTRICT

EASTERN HEALTH & SOCIAL SERVICES BOARD
DIRECTOR OF SOCIAL SERVICES
FORWARD TO ...
SEEN BY...
HOLD ☐ FILE ☐
21 FEB 1986
COPY TO ...
FOR ACTION/COMMENT/INFORMATION

MEMORANDUM

From NL 223 - P.S.W.

Ref. HC/mg

To R Bunting - A.D.S.S.
cc: R G Black - A.D.S.S.
NL 281 - S.S.W. Cliftonpark

Ref.

18 February 1986

re: [redacted]/Nazareth House Complaint

When last we spoke on this matter I undertook to interview [redacted] at the earliest opportunity. This I did in the presence of his mother who wished to be present on [redacted]. Prior to seeing [redacted], NL 281 - Senior Social Worker, [redacted] - who was known to the family, had made contact and explained the background.

[redacted] is physically a very small boy for his age and was also quite immature. He was quite embarrassed initially, giggling frequently, but as the discussion wore on he played a more responsible part. I think it would be difficult to give great credence to his views other than on one matter, namely, the fact that he was frequently physically abused by SR 180.

He confirms that SR 180 beat him and HIA 210, in particular, regularly with a wooden spoon or a bamboo cane. He confirms that on one occasion SR 180 banged his head against a wash-hand basin causing him to bleed. There was no swelling to his face and no black eyes as reported by HIA 210. He does however recall an incident involving HIA 210 when the two boys were playing, ran into each other and he ended up with two black eyes and a swollen face. He is quite specific in his complaint that SR 180 picked upon him and HIA 210 to excess although he again was in a position to name other children, particularly [redacted] and [redacted] whom he thought had also been beaten by SR 180.

Like HIA 210, he was ambivalent towards SR 180, on the one hand expressing very strong feelings that she had beaten him unnecessarily and yet, on the other hand, expressing considerable affection for her. He denies that any other member of staff beat him and he also denies that he was ever locked in a cupboard or had his food withheld as a punishment. He does however recollect that HIA 210 was sometimes locked in a cupboard although he thought this was upstairs rather than downstairs as HIA 210's story would indicate. He reports that he was regularly put into a cold bath although it would appear that this was more to do with the temperature of the water being insufficient rather than any desire to punish him, unlike HIA 210 who says that he was given cold baths as a punishment.

During this part of the interview Mrs [redacted] sat quietly. When encouraged to speak she substantiated what [redacted] had said in that she reported a particular incident towards the end of [redacted] when [redacted] had returned from Nazareth with his thigh bruised as a result of having been beaten with a wooden spoon. Mrs [redacted] said that [redacted]'s version that SR 180 had beaten him was confirmed by her elder daughter who was also in the unit. She challenged SR 180 who denied the incident. Mrs [redacted] said that she was not prepared to accept the denial. She also recalls telling one of the other nuns (I think she said SR 29) who was in charge of one of the other units and finally she said she told NL 110 who was then the social worker. NL 110, left our employ approximately two years ago and is working in a third world country. I have had the files checked for that period and there is no mention of this incident.

Contd...

EXHIBIT 6.

EASTERN HEALTH AND SOCIAL SERVICES BOARD

NORTH AND WEST BELFAST DISTRICT

COMMUNITY UNIT OF MANAGEMENT

MEMORANDUM

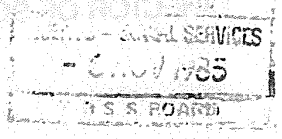
From ..... NL 223 PSW

Ref. HC/DP

To ..... Mr R Punting ADSS

Ref. cc SR 143, Nazareth Lodge

8 July 1985



Re Nazareth Lodge and the Complaint of HIA 210

As you requested I interviewed NL 147 and NL 146, the two staff members mentioned by HIA 210 whose whereabouts are known and who are currently available. SR 143 kindly organised these interviews as NL 147 continues to work within Nazareth and NL 146 (although no longer employed) lives close by.

Both state that they have no previous knowledge of the complaints HIA 210 is making. They deny any knowledge of practices of children -

1) being locked in the domestic cupboard,

2) being allowed to sleep on the bathroom floor,

3) having their mouths washed out with soap and

4) having meals withheld from them.

They acknowledge that there was some element of physical punishment of the children but both put this very much at the minor end of the continuum using words such as 'smacked' or 'tipped'. They are unaware of the incidents that HIA 210 cites with regard to himself and [redacted]. They further said that they have no knowledge of implements, sticks or canes, being used to beat the children.

NL 147 worked in the Unit from [redacted]. She was the member of staff who replaced [redacted]. NL 146 worked in the Unit from [redacted] through to [redacted]. They both said that the atmosphere in the Unit was good at that time, the children were a happy, contented bunch. They know of no reason why HIA 210 should be making these allegations as they say he was very much the favourite of SR 180 and she quite frequently made excuses for him.

In conclusion, there was nothing stated at that meeting to confirm any of the allegation which HIA 210 has made. However, as I have relayed to SR 143, I feel that even allowing for the fact that HIA 210 is undoubtedly a child who has suffered quite a disturbed early experience and is of limited intelligence, I believe that there is some substance to the allegations that he has made. These, I have no doubt, may well be exaggerated or, indeed, distorted by his perception of relationships but the way in which he told his story, the fact that he was very specific about incidents and was anxious to be believed and to tell his story to anyone including staff in Nazareth, plus the fact that he was discriminating in terms of the members of staff whom he mentioned, leads me to believe that his story should not be lightly dismissed.

NL 223

PRINCIPAL SOCIAL WORKER

which the competent authorities have decided not to proceed (eg paragraph 7.76). All of these decisions, however, are separate and distinct from a decision as to whether a criminal offence has occurred.

Preliminary investigations and liaison with the police

13.104 This leaves the question of what, in practical terms, Social Services staff should do on receipt of an allegation of criminal activity implicating a member of staff. It is not our intention that staff should go to the police at the first hint of a complaint of a criminal nature. Some form of structured preliminary investigation is necessary. We endorse the "points of principle" set out in the April 1985 circular (see paragraph 13.91) and would summarise our recommended procedure for a preliminary investigation as follows:-

a. the member of staff receiving the complaint should contact the child's Primary or Key Worker, his Social Worker, and the home's line management;

b. the child should be interviewed by his Social Worker (Primary or Key Worker if the Social Worker is not available) in the presence of another officer and his complaint recorded;

c. the recorded complaint should be referred to the appropriate member of the home's management eg R&DC manager;

d. the R&DC manager, in the presence of another officer, should advise the accused member of staff of the allegation, give him an opportunity to involve his union, staff association or legal representative and record any explanation or evidence which he wishes to provide;

e. the R&DC manager should interview, in the presence of another officer, any parties who are suggested by the child or the accused as capable of providing corroboration or relevant evidence and make a written record of the interviews;

f. the R&DC manager should refer the product of this preliminary investigation through his Assistant Director (Unit of Management) to the Director for consideration in the context of the Complaints Procedure and the recommendations which we have made above;

g. if in any doubt as to whether a criminal offence is implied, the R&DC manager, Assistant Director or Director should seek advice from their legal staff or the RUC.