# HISTORICAL INSTITUTIONAL ABUSE INQUIRY

## WITNESS STATEMENT PREPARED BY NORMAN CHAMBERS

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**THE INQUIRY INTO HISTORICAL ABUSE 1922-1995**

**WITNESS STATEMENT OF NORMAN CHAMBERS**

## 1.0 Background

1.1 I qualified as a social worker in 1966 and until 2006 I was employed continuously in positions in both the statutory and voluntary sectors respectively in Northern Ireland.

Between 1974 and 1982, I was Director of Child Care for Barnardos, with management responsibility for the organisation's work in Northern Ireland and the Republic of Ireland.

Between 1982 and 1991, I was employed by the Social Work Advisory Group (later the Social Services Inspectorate), as a Social Work Advisor, and from 1991 till 1996 as Assistant Chief Inspector.

Between 1996 and 2006 I held positions in the Guardian ad Litem Agency, the Presbyterian Church in Ireland and the Registration and Quality Improvement Authority.

In 1985 I completed a Masters Degree in Social Policy, Planning and Administration at the University of Ulster.

1.2 Given the passage of time since I left the Social Services Inspectorate in 1996, the accuracy of my recall of specific events is inevitably flawed. I have not had access to Departmental files until recently, nevertheless I am pleased to assist the HIAI insofar as my memory and reflection permits. I have provided comment on the specific issues identified by the DHSSPS and the HIAI as being of relevance to Module 4 of the Inquiry. I have also, however, addressed wider issues that are, I believe, pertinent to the considerations of the HIAI and which reflect my understanding of the context in which Nazareth Lodge and other voluntary homes operated during the period in question.

1.3 In 1985 I prepared a dissertation as part of a Masters Degree in Social Policy, Planning and Administration at the University of Ulster. It may assist the HIAI if I draw on my analysis of factors which influenced the voluntary residential child care sector in Northern Ireland at that time, and which over the next decade contributed to its demise. My dissertation appears as Appendix 1 of this statement.

1.4 From 1950 voluntary organisations provided an increasing proportion of residential child care service in Northern Ireland and, for a period of up to thirty years, they were the major providers of these services. In 1978, 457 children were cared for by voluntary organisations, compared to 335 by statutory children's homes. By 1983, 277 children were in voluntary children's homes, compared to 381 in statutory

homes. During the same period, the proportion of children in State care being cared for in all children's homes had reduced from 39% to 22%. This reflected changes in the form of provision for cared for children, in favour of family placements, as well as a general decline in the use of the voluntary residential child care sector by HSS Boards.

1.5 Historically, voluntary homes were at a financial disadvantage relative to statutory providers of residential care services. During the 1970's there had been disproportionate increases in the funds made available to HSS Boards and voluntary homes respectively. While DHSS paid substantial capital grants of up to 100% to voluntary organisations of the cost of certain improvements to buildings, and also funded most of staff training costs, this was more than equalled by HSS Boards' ability to open new facilities. These new children's homes were more strategically placed than many of the older voluntary homes.

1.6 Comparison of the economic costs of voluntary and HSS Board homes respectively indicated that, in most cases, the former represented between one third and one half of those in the statutory sector. Departmental Circular HSS15(S) 1/74 had attempted to redress these disparities (SNB 9017). During the late 1970s the EHSSB initiated a review of the per capita payments made by Health and Social Services Boards (HSS) to voluntary children's homes in its area. In 1982, the Eastern Health and Social Services Board (EHSSB) made a deficit funding payment of £45,000 to Nazareth Lodge children's home; in 1983 the per capita payment was substantially increased. (SNB 14322)

1.7 Central to the debate about the role of voluntary organisations in the 1970/80s was concern about their ability to develop professional capacity. The principal criticism of them by HSS Boards was that, contrary to the expectation that they behave flexibly and adapt to changing demand, they were not perceived to have demonstrated that ability. As a result, HSS Boards found it necessary to achieve greater self-sufficiency by developing both residential and other child care services. The same general criticism applied to the inability of some voluntary organisations to contribute to planning and policy development.

1.8 The above criticisms of voluntary organisations had been identified as early as the 1950s and were the subject of informed comment by the NICWC. (See Dr Harrison's January 2013 statement to HIAI). By the 1970s HSS Boards had professional management structures within which responsibility for policy development, its implementation and management were assigned. The same structures also provided for professional support, consultation and staff development to take place. By comparison, most voluntary organisations were less well equipped, with heads of residential units reporting to lay committees, or in the case of some voluntary children's homes to religious orders based in London. Some were slow to avail of opportunities that existed for financial assistance in these areas.

1.9 Dr Harrison has covered in detail the development of inspection protocols in the 1980/1990s. This process was based on the definition of agreed standards in the management of residential child care services. These included, inter alia, a commitment to greater participation by children and their families and openness in the reporting of inspection findings. Children were provided with child friendly written summary reports; independent lay inspectors participated in some inspections. These arrangements could not guarantee the absolute safety of children accommodated in children's homes, but they did diminish opportunities for secrecy and the perpetuation of some institutional practices that had contributed to a climate of fear and various forms of abuse over several decades.

**2.0 Report of the Inspection of Nazareth Lodge, carried out by Victor McIlfatrick and myself on behalf of the Social Work Advisory Group (SWAG) in October 1983**

2.1 The SWAG report of the inspection of Nazareth Lodge in October 1983 is critical across a wide range of practice issues. (SNB 50513) Reference is made at paragraph 8.8 to sanctions used by the home when children misbehaved. The report notes that "the forms of discipline about which the inspectors were informed were not excessive...". The report does not refer to any form of complaint or expression of concern about the care of the children. A number of complaints made by staff regarding their conditions of service and poor communication within the home are described.

2.2 My hand written notes made during the inspection in October 1983 (Appendix 2) indicate that the use of sanctions in Nazareth Lodge was discussed with a number of staff, who reported that the following were used:

- Grounding, eg for bullying
- Deprivation of privileges eg attending the club
- Reduction of pocket money
- Delay in payment of pocket money
- Children were talked to about their behaviour

One staff member confirmed that smacking was not permitted.

2.3 In her response to the Department of Health and Social Services (DHSS) in December 1983 (SNB 14323) regarding the home's policy on corporal punishment, SR143 on behalf of the Order of the Poor Sisters of Nazareth stated that:

- Nazareth Lodge was generally a stable environment
- Discipline problems do not arise to any significant degree
- Reasoning/talking is used, but if this fails privileges may be withdrawn, time-out is used, or small tasks may be imposed.
- There is no occasion when corporal punishment may be used.

2.4 The report of the inspection portrays the home in very institutional terms.

- Staffing arrangements were very hierarchical in character, with minimal communication/consultation between Religious and lay staff.
- Staff had little time to spend with the children and were required to do routine cleaning in the home.
- There was no policy in place to promote the professional development of staff.
- Staff worked long hours even by the standards of the 1980s, and they were required to work split shifts, which meant they had a break of a few hours before going back on duty in any 24 hour period.
- Religious staff had responsibilities to the Order, which appeared to take precedence over their child care duties in the home.
- Staffing levels were unacceptably low.
- Staff complained about the standard of food served in the home.
- The number of children accommodated was high relative to numbers accommodated in most other homes.
- The physical condition of the premises required investment, but the Order was not in a position to carry out any upgrading without assistance by the DHSS or the EHSSB
- The level of maintenance payment by the EHSSB, the main user, was low relative to some other voluntary children's home, and substantially lower than comparable costs in statutory homes at that time.
- While the EHSSB offered staff training opportunities to the staff of voluntary children's homes, Nazareth Lodge did not appear to avail of these facilities.

2.5 The report of the 1983 inspection, paragraph 8.9 noted that, while care staff were present at meal times, they preferred not to eat with the children as they did not find the food appetising. The report also stated that the Sisters did not eat with the children. The draft report of the inspection ( SNB 14316) had stated that the children who were spoken to were content with the food provided by the home. *"Nevertheless, it was observed that some of them did not eat it and we were told by the staff that they had very limited scope to provide the children with anything different".*

2.6 Paragraph 8.9 continues, "*Although the menus record indicates that a balanced diet is provided, the way in which food is prepared and presented may need to be reviewed. It would be preferable if Sisters and staff on duty were to dine along with the children in order to create a more family like environment. This would enable staff to be more aware of the quality of the meals. It is recommended that management take steps to satisfy itself that the meals provided for the children are appetising".*

**Matters raised by the Committee of Inquiry into Homes and Hostels 1985**

2.7 The Committee of Inquiry into Homes and Hostels (1985) made reference to the SWAG visits to children's homes pre-1983 and the Committee's report casts doubt on the frequency and depth of visits of inspection up till 1983 and reporting arrangements at that time. I have no comment to make on these matters as I did not commence employment with SWAG until 1982.

2.8 The Report of the Committee of Inquiry refers to the report of the SWAG inspection in October 1983 and, generally, makes favourable reference to the potential impact of its nineteen recommendations. (HIA 915)

**Monitoring arrangements by the Administering Authority**

2.9 The Committee of Inquiry sought to establish who was the administering authority for Nazareth Lodge. It seems clear that this was Mother General of the Order of the Poor Sisters of Nazareth based at Hammersmith, London. Responsibility for fulfilling the requirements of the Children's and Young Persons (Voluntary Homes) Regulations (NI) 1975, Section 4(2), was delegated to Mother Regional, who was based in Dublin.

2.10 The SWAG inspection report, paragraph 5.1 stated that Mother Regional "visits the home 3 or 4 times a year". (SNB 50242). The accuracy of this statement was not challenged by Nazareth Lodge when they received the draft inspection report for the purpose of a factual accuracy check, otherwise the draft report would have been amended.

2.11 The Committee of Inquiry Section 9.23 (HIA 914) stated that the accuracy of the SWAG report was stated in evidence to be incorrect and that "*Mother Regional visited the home at least once a month and a written report of these visits was forwarded to the Mother General in London*".

2.12 The report continues, "*We did, however, have access to the Visitor's Book and found that it had been signed only twice by the Mother General and three times by the Mother Regional from 1975 to 1983. Whatever is the factual position, the location of the statutory "visitor" in Dublin cannot have made compliance with the monthly visiting requirement any easier".....We consider , however , that to comply with the spirit of the 1975 requirement that the Mother Regional should have made a separate written report on her inspection of the home and that those should have been available to reassure the Department, through SWAG, that the Regulations were being fully observed."*

2.13 The SWAG inspection report, paragraph 5.1, while noting the frequency of Mother Regional's visits as 3-4 times a year, did not contain a recommendation aimed at informing the administering authority of its statutory obligation and requiring it to comply in spirit and in practice.

**Other monitoring arrangements (SNB-50028)**

2.14 Written evidence to the Committee of Inquiry, referred to the establishment in October 1984 of a monitoring team, comprising NL 123, Mr M Murphy and Mrs M Sim.

2.15 The status of this monitoring team was uncertain. Firstly, NL 123 was a Medical Officer for the home and as such could not be expected to monitor his own activities. Secondly, monitoring is a function of executive management and it is not clear whether the team's functions were advisory or managerial.

2.16 Written evidence to the Inquiry stated that "*The appropriate member of the team is shown any complaints or records of untoward events which may have arisen and signs the record to show that their attention has been drawn to the event. Equally the member is free to conduct such enquiries as they wish and to report to the Sister-in-Charge and the Mother Regional as they see fit. At six monthly intervals the Monitoring Team is asked to produce a report of their work and their observations..... and a copy (is) kept to be seen by the Department's inspection team.*"

**Comment**

2.17 In retrospect, the SWAG inspection might have included a recommendation aimed at clarifying the monthly visiting and reporting requirements of the 1975 regulations and indicating the need for improved monitoring by the administering authority.

2.18 The subsequent introduction of a "monitoring team" in 1984 was commendable as it brought a relatively independent perspective to the running of the home and a potentially helpful point of contact for both children and staff. It was not clear how this initiative fitted in with the statutory function of the administering authority as required by Section 4.2, or indeed the managerial functions of the Sisters-in-Charge.

**Vetting of visitors to the home**

2.19 Paragraph 8.6 of the SWAG inspection report 1983 refers to visits to the home by volunteers. The report commends this practice, "*There are benefits for the children and staff alike in such arrangements. It allows children access to male company in a home, which is run entirely by female staff*".

2.20 In the course of the inspection, inspectors were made aware that student priests visited Nazareth Lodge and took children out. We were informed that most of the children were glad to see them, apart from one exception. Whilst I cannot recall the reason why one of the students was not welcome in the home, I am satisfied that this did not involve child protection concerns otherwise these would have been addressed within the report. The draft report of the inspection stated, "*They take the children to the swimming pool, play games with them and in one group they provide assistance with homework. All of their contact with the children while they are in the home is supervised and they are not available in the evenings. It is assumed that the vetting process undertaken by their college is adequate for the purpose of ensuring their suitability to visit the home*".

2.21 Paragraph 8.6 of the final report of the inspection states, *"In the light of recent events at some other homes, it is considered that it would be prudent for the management of the home to satisfy itself regarding the background of anyone who is likely to have continuing contact with the children. It is recommended, therefore, that management should always make appropriate background enquiries regarding the credentials of persons offering to do voluntary work before linking them with the children"*. The draft report of the inspection noted that trainee priests were visiting in a voluntary capacity, however, we clearly took the view that the issue was broader than this and accordingly extended the recommendation that appeared in paragraph 8.6 (SNB 50252) of the final report, to volunteering in general.

2.22 Paragraph 9.7 of the Report of the Committee of Inquiry deals with Procedure for approving outings from children's homes. "*At the material times, there were no statutory procedures relating to members of the public visiting children's homes and taking children out socially. However, in a letter of July 1972 to Nazareth Lodge,* DL 518 *, then Children's Officer in Belfast, asked the home to ensure that the Welfare Department was notified and couples or families approved before children in care were allowed out of the home even for day visits*".

2.23 In her written evidence to the Committee of Inquiry, (50388) Mother General stated the home's policy on Release into Custody. "*Every request in the home to visit a child there, or for the temporary release of a child into the custody of a visitor, requires the prior approval of the named social worker of the Health and Social Services Board*".

2.24 In 1985, the Department had not issued guidance on the vetting of visitors to statutory children's homes. At that time, the Home Office was "*considering procedures which might be put in place in England and Wales to vet persons who were seeking "substantial access" to children. This means that England and Wales are considering adopting vetting arrangements similar to those introduced in Northern Ireland by*

*this Department in 1983, but extending to a wider range of persons than our current procedures."* (SNB-50394)

**Comment**

2.25 The recommendation made at paragraph 8.6 of the SWAG inspection report was correct in so far as it applied to volunteers visiting the home. It is inevitable, however, that volunteer visitors will form relationships with individual children, which may lead to them spending time alone with a child, either within the home and/or elsewhere.

2.26 I believe that management at Nazareth Lodge would have had no doubt as to the scope and significance of paragraph 8.6 of the inspection report, especially as the inspector had discussed with them the practice of student priests visiting the home.

2.27 Mother General had a clear understanding of the HSS Board requirement for the prior approval to every request for a child to be allowed out of the home, even for day visits.

**General Comments**

2.28 Nazareth Lodge appeared to be caught in a time-warp of institutional practice, while at the same time some other voluntary children's homes were actively promoting the professionalisation of residential child care, bringing it more into line with field social work standards of practice.

2.29 The inspectors did not, however, note evidence of complaint by children or their families, nor did the inspection report include any adverse comment or concern about the use of sanctions by the staff.

2.30 Subsequent reports of inspections by SSI a decade later portrayed a home that had been transformed by substantial investment in the fabric and layout of a still institutional style of building, and progress made in staffing arrangements and professional competence. The EHSSB, which had increased substantially the per capita payment, reported satisfaction with the standard of service being provided and both children and their families seemed content with the service.

**3.0 Complaints reported by NL 162 based on her observation of life in Nazareth Lodge children's home in 1984**

3.1 NL 162 had been on a short-term placement in Nazareth Lodge where she observed certain practices that caused her to make three complaints to EHSSB. (SNB 14679)

**Complaint 1**

3.2 The complaint was that a child, NL 157, had been harshly treated by a residential social worker, NL 163 who had told another child, NL 18 to put soap in his mouth in response to his swearing.

3.3 NL 162 stated that the soap broke into pieces in NL 157 mouth and that he wretched and was sick. She also alleged that SR 121 had said: "the only way to cure swearing was to put soap in a child's mouth."

3.4 SWAG and the EHSSB collaborated in approaching the investigation of this complaint. When interviewed by a Social Worker, NL 157 gave a coherent account of what had taken place and confirmed that this had happened only once to him. He said that two other children had been punished in the same way. He acknowledged that his behaviour had been wrong, but he felt that he had not been punished appropriately, given that the home had in place a range of sanctions that were acceptable to the children. He could not remember whether pieces of soap had been put in his mouth, or only one piece.

3.5 NL 157 said that he got on well with the offending member of staff. His reason for wishing to make a complaint, when given the opportunity of doing so, was that he did not wish other children to be treated similarly.

3.6 SR143 of Nazareth Lodge carried out an internal investigation, which included interviewing *inter alia* NL 163 and SR 121. NL 163 admitted that the incident had happened but alleged that it had been a 'playful' episode. She stated, however, that she had seen SR 121 rub shampoo across NL 157 mouth after he had been swearing. In her report of her interview with SR 121, SR143 stated: "SR 121 *confirmed that it took place. Sister stated that when* NL 163 *was washing* NL 157 *hair he resorted to swearing and using foul language and she took the opportunity to rub the shampoo across his mouth. Sister states that she did not injure* NL 157 *nor was he sick and her actions were entirely spontaneous, without much thought. Sister very much regrets the incident and has confirmed that this type of thing is not a practice in her Unit."*(SNB-19006)

3.7 SR 121 and NL 163 were reprimanded by SR143.

3.8 On 18 September 1984 DL 518, EHSSB, in reply to a letter of 4 September from Dr K McCoy (SWAG) stated "*It is proposed to take no further action in relation to the complaint concerning* NL 157.. NL 157 *is doing well in Nazareth Lodge and has a good relationship with his primary worker..* NL 157 *and his parents are satisfied*

*that the complaint has been properly dealt with and do not wish to pursue the matter further."* (SNB 14765)

3.9 The Departmental file does not indicate whether DL 518 obtained legal advice on this case. The EHSSB decided not to interview other children and were content not to take any further action.

**Comment**

3.10 This episode was handled properly by SWAG, the EHSSB and Nazareth Lodge. The complainant was vindicated, the child's right to make a complaint and to be listened to, was upheld, and Nazareth Lodge accepted responsibility.

The EHSSB did not consider it necessary to have other children accommodated in Nazareth Lodge interviewed regarding their experience of life there, or the use of sanctions.

**Complaint 2**

3.11 NL 162 **alleged that children who misbehaved were on occasions placed in a cloakroom as a means of punishment. She claimed that the cloakroom so used was infested and frightening for children.**

3.12 The Head of the home admitted that on occasions children were placed in a cloakroom because of their misbehaviour, but stated that this was for the purpose of "time out`' and generally for not more that 10 minutes. The cloakroom was adjacent to a television room on the ground floor, it was well ventilated and subject to supervision by care staff. She said that a number of rooms on the ground floor had been treated for infestation.

The cloakroom was examined by Mr C Walker (SWAG) who reported, *"it proved to be a light and airy room on the opposite side of the corridor from the children's living room, which makes supervision of any child placed there easy. It is rather bleak having a tiled floor and walls and lacking furniture except for a chair. It was, however, clean and there were no signs of cockroaches……I told* SR143 *that in my opinion the boot room was not unsuitable but since there is a small, fully furnished sitting room which is used for homework next to it, it might be better to use that for "time out", when it is not otherwise occupied.* SR143 *accepted the suggestion."* (*SNB-19003*)

**Comment**

3.13 I agree with Mr Walker's suggestion that the sitting room was a more suitable place to send a child for the purpose of "time out". The apparent bleakness of the other room could suggest punitive intent,

rather than opportunity for the child to calm down, or reflect on his/her behaviour.

**Complaint 3**

**3.14 A major retailer donated foods not sold at the end of the day to Nazareth Lodge and this was given to the children.**

3.15 The Head of the home defended the practice of the limited use of food donated to Nazareth Lodge by a major retailer at the end of trading on certain days. She stated that the home was scrupulous in ensuring that the food was not past its sell-by date. This food was not part of the children's normal diet but was in addition to their meals and they were not required to eat it.

3.16 The retailer confirmed that some items of unsold food were made available free to Nazareth Lodge. It was not out of date and was entirely safe if eaten within 24 hours of delivery.

**Comment**

3.17 It may have been expedient for Nazareth Lodge to make limited use of certain foods, which did not comply with the sales policy of the retailer. There was no reason to doubt the assurances of the Head of the home that these items were used responsibly and that food that became out of date was discarded. There is no record in any inspection report examined that children suffered from food poisoning as a result of food provided by the home. Indeed the high quality food items in question may have amounted to treats for the children whose meals were criticised by some staff as being dull and unappetising.

**4.0 Complaints received from a former member of staff in January 1993**

4.1 The Social Work Advisory Group was renamed the Social Services Inspectorate (SSI) in 1986. In January 1993, Miss M Reynolds, an SSI Inspector received information by telephone from NL 269 who had been employed at Nazareth Lodge between September and November 1992. He alleged that because of the response of his Team Leader and Sister Superior, when he expressed a number of concerns regarding staffing and other matters, which he believed had a bearing on the wellbeing of the children, he had no alternative but to resign.

4.2 The inspector recorded NL 269 comments and read back to him her notes to assure their accuracy.(SNB 19070)

4.3 She informed him that some of the points raised by him had been covered in the draft inspection report, which had already been written;

other points would be raised by her in discussion of inspection findings with the Head of the home. She declined to let him have sight of the inspection report.

4.4 The concerns raised by NL 269 included:

4.4.1 When he reported to his Team Leader that a child had overtly demonstrated sexualized behaviour, she had not responded appropriately;

4.4.2 At times the "sleep-in" arrangements were not satisfactory as only one staff member was on duty, and that could be a male staff member, who could be the subject of a complaint;

4.4.3 NL 269 had been censored by a Sister on account of his having exceeded his professional remit;

4.4.4 Allegedly, a Field Social Worker had inferred to him that Nazareth Lodge staff had not told them "the whole story" regarding the behaviour of one resident who was known to be abusing drugs.

4.4.5 He said that residential staff were not permitted to contact Field Social Workers without the permission of their Team Leader, and that there was a lack of confidence between Field Social Workers and residential staff;

4.4.6 A former resident, who according to another member of staff had previously abused a child while in care, was a frequent visitor to the home, and had full run of the house.

4.4.7 Two boys, according to another member of staff, in another group, were permitted by the Team Leader to have access to their mother's cohabitee who had abused them, without the authority of a "child in care review".

4.4.8 He believed that there was not a role at Nazareth Lodge for qualified staff;

4.4.9 He believed that the staff rostering arrangements at Nazareth Lodge were unsatisfactory.

**Comment**

4.5 Examination of the report of the 1993 inspection indicates that Miss Reynolds had indeed covered in considerable detail most of the concerns raised by NL 269 .(SNB 15298).

**Sexualised behaviour at Nazareth Lodge**

4.6 At paragraph 8.3, the report states, "*No complaints have been recorded in the home's complaints register since the last inspection. From a review of individual logs, however, the Inspector identified 3 occasions where reference was made to a complaint. The records suggest that these matters were investigated either within the home or referred to social services for investigation.*"

4.7 NL 269 did not name the child who had demonstrated overtly sexualized behaviour. Paragraph 9.1 of the report of the inspection states that,
"*In total 80 untoward events were recorded since the last inspection. More than 25% of these involved physical interaction between children in the form of fighting, with another 7% involving behavior of a sexualised nature…….The risks* (arising from peer abuse) *carried are recognized by the Team Leaders who are conscious of the supervisory requirements in relation to the children in their care.*"

**Staffing**

4.8 Paragraphs 2.5 and 2.7 deal with the adequacy of staffing arrangements at the home and specifically refer to the high incidence of sexually abused children in Unit 2 and the implications for new admissions to that Unit.

**Sleeping in Arrangements**

4.9 Paragraphs 9.4 and 9.6 address the matter of Sleeping-in arrangements, "*This level of cover is unacceptable as it does not provide adequate supervision and protection for the children…….For a unit caring for a high number of children, who have been sexually abused, to have only one staff on duty during the night is of concern.*"

**Relationship with the EHSSB**

4.10 Paragraph 2.9 states, "*The Administering Authority has arranged satisfactory funding with the Board and reports excellent working relationship with the Board and its officers*".

**Freedom for a known offender to roam**

4.11 NL 269 alleges that he was told by another member of staff, who he did not identify, that child[redacted], who had previously sexually abused a child while in care" *now frequently had the run of the home*". The report of the inspection does not address this specific allegation. I am not aware if the Inspector subsequently discussed this matter with the Head of the home.

**Regime of Fear at Nazareth Lodge**

4.12 NL 269 alleged that there was a regime of fear at Nazareth Lodge. While the report of the inspection acknowledges that there were tensions arising from staff shortages at times and that arrangements varied between Units in the way staff were used, there was no indication of a regime of fear. NL 269 statement is not specific.

**Contact by a known abuser with two children in the home**

4.13 NL 269 stated that he was told by an unnamed colleague in another Unit that 2 boys, who had been abused by the cohabitee of their mother, were permitted by the Team Leader to have access to the perpetrator, without a child in care review. The report of the inspection does not refer to this matter. I am not aware if this allegation was subsequently discussed with the Head of the home by the Inspector.

**Status of Qualified Staff**

4.14 NL 269 expressed dissatisfaction regarding his perception of the status of qualified social workers, the boundaries of their responsibility and their accountability to Team Leaders. Paragraphs 4.4 – 4.7 of the report of the inspection deal with the concept of Keyworker and acknowledges that there were variations in the way this was exercised at Nazareth Lodge. "*Some staff felt curtailed in their key worker role……..The home's policy is designed to promote and encourage the keyworker system".*

4.15 Paragraph 7.4 refers to the practice of house meetings. "*This system of regular house meetings and the sharing of information in an open manner is commended. Wider use of these processes should be given consideration".* Clearly there were differences between Units and development of the role of residential social workers was a work in progress.

**Request by SSI for a written statement**

4.16 On the question of whether NL 269 should have been asked to make a written statement of complaint, I am in no doubt that he should. It is not possible to thoroughly investigate ill-defined complaints from whatever source. Some of the complaints had disciplinary implications and should have been addressed to the Administering Authority in the first instance. Others might have been dealt with under grievance procedure. NL 269 did not indicate whether he had pursued either course of action. I think it probable that I would have taken the view that a former member of staff of the home, who was professionally

qualified, and who wished to make a formal complaint, should have done so in writing.

4.17 Departmental Circular HSS(CC) 2/85 (SNB 19076) deals with procedures for dealing with complaints in children's homes. The Circular is primarily to do with arrangements aimed at enabling children in residential home to articulate complaints and for such complaints to be investigated by the respective authorities. At Paragraph 28.0, it is explicit that complaints should be reported appropriately to ensure that they are acted upon. "*Boards should be prepared to assist voluntary bodies in the investigation of the complaint*".
While the Circular does not state that complaints should be made in writing, that is implicit. This is the requirement in all statutory authorities from the Police to the Commissioner of Complaints, to trade unions.

4.18 Nevertheless, it would not have been prudent for SSI not to have taken account of information and concerns that had been passed to us verbally.

**Adequacy at that time and Scope of the Inspection -1993**

4.19 I am satisfied that the report of the inspection was thorough in documenting evidence across a range of standards. In doing so, Miss Reynolds had addressed most of the concerns raised by [redacted] NL 269, which had a bearing on professional practice in Nazareth Lodge.

4.20 Whilst I am unable to recall whether I personally raised NL 269 concerns with the management committee, I have no reason to think that Miss Reynolds would not have pursued with equal rigor the findings of the inspection and any matters of concern articulated by NL 269 when she met the Head of Nazareth Lodge. This view is based on my knowledge of Miss Reynolds' work as an inspector over a number of years.

**Access to the Report of the Inspection**

4.21 NL 269 had no entitlement to see the report of the inspection, which was confidential to the Administering Authority.

**5.0 Investigation of complaints made to Miss J Chaddock regarding SR 18 in November 1995**

5.1 In November 1995 Miss Chaddock inspected Nazareth Lodge children's home. Overall, the report of the inspection was positive. (SNB-14219)

5.2 Paragraph 6.4 states, "*In discussion with the children and from questionnaires returned by them to the Inspector, additional matters of concern were identified. The inspector has drawn these complaints to*

*the attention of management at Nazareth Lodge and the HSS Trusts responsible for the children involved. These matters are now subject to investigation*".

5.3 In December 1995 Miss Chaddock wrote to Mother Regional (SNB-17967) informing her of the complaints that had been made to her and asked her to investigate the matters further and that a report be sent to her in due course. Miss Chaddock's letter was copied to the Nazareth Lodge Management Committee and the relevant HSS Trusts.

**Was action taken by SWAG on receipt of complaints from children resident in the home correct?**

5.4 The inspector's action complied with the requirement and guidance contained in Departmental Circular HSS (CC) 2/85, which deals with procedures to be followed when a complaint is received in statutory and voluntary children's homes respectively. The Head of the home, the Management Committee responsible for the home and the relevant HSS Trusts were notified of the complaints with requests that the complaints be investigated.

**How the complaints were viewed by the Inspector**

5.5 In her letter to Mother Regional, the Inspector listed six complaints, requested that they be investigated and that a report by made to her in due course. By such action Miss Chaddock indicated that she viewed the complaints as serious and therefore requiring formal investigation. In my view, the action taken by Miss Chaddock on behalf of the Department was correct.

**Options available to the SSI when concerns over the behavior of a member of staff in a regulated home were brought to its attention, and were those options sufficient.**

**Options in respect of the Administering Authority**

5.6 In 1995 the options available to the SSI were as follows:

- Refer the complaint to the relevant authorities with a request that the complaints be investigated, and a report of the investigation made to SSI;
- Subject to the outcome of investigations, SSI would have entered into discussion and negotiation with the Administering Authority with a view to effecting necessary changes;
- In the event of the Administering Authority failing to co-operate in implementing any recommendations made by SSI, the only further option open to the Department would have been the threat of deregistration;

- In the event of the Administering Authority's non-co-operation, the Department could have deregistered the home, in which case the Administering Authority should have closed the home.
- Failure to close the home following deregistration might have led to the Department taking legal action against the Administering Authority.

5.7 Regulations at that time did not specify procedures to be followed or criteria to be met when considering the question of the continuing registration of a voluntary home. It is not clear, for example, whether failure by an Administering Authority to close a home following its deregistration by the Department would have been a criminal offence. Nevertheless, the above actions could have been followed had circumstances arisen, which required the Department to act against an Administering Authority.

5.8 Where investigation by an Administering Authority led to disciplinary action against a member of its staff, the Administering Authority was required under Departmental Policy, which established the Pre-employment Consultancy Service in 1983, to notify the Department of details of any person who had either been dismissed or who had resigned in circumstances that suggested that children might be placed at risk if that person were again appointed to a position involving responsibility for children's welfare.

**Options in respect of a child in the residential home**

5.9 Where an Inspector had reason to believe that a child was at risk because of the behaviour of a member of the home's staff, SSI would have been expected to notify both the HSS Trust responsible for the child, and also the Administering Authority. In accordance with its child protection responsibilities under Section 94 of the Children and Young Persons (NI) Act 1968, the responsible HSS Trust would have been required to investigate and, where necessary, take action to protect the child. If criminal behavior was suspected, the police would also have been notified by the responsible HSS Trust.

5.10 The Departmental guidance document, Co-operating to Protect Children (DHSS, 1989 - Appendix 3) and subsequent child protection policy and procedures implemented by HSS Boards in 1991 under Area Child Protection arrangements, provided for child abuse allegations to be investigated under joint protocol arrangements between the Police and Social Services. (HIA 7746)

**6.0 Overview of inspections of Nazareth Lodge in 1993, 1994 and 1995**

6.1 In my capacity as Assistant Chief Inspector I would have read and signed off each of these inspection reports. Reading them again some 20 years later I remain satisfied that these reports reflected progress in the conduct of inspections at that time. They adhered to the use of agreed professional standards, the requirement for reports to be

evidenced-based, and that the recommendations contained in them should lead to action in specific areas of activity.

6.2 None of these reports alluded to any significant concern regarding the form of sanctions being used in Nazareth Lodge, nor was any complaint by a child, a parent or staff member noted, the exception being a reference at paragraph 6.4 of the 1995 inspection report, that certain matters had been brought to the attention of the inspector. (SNB- 14219) These were the subject of subsequent correspondence between Miss Chaddock and Mother Regional. (SNB-17967)

6.3 I have no recollection of subsequent consideration of the matters alluded to at paragraph 6.4 of the 1995 inspection report. I left the employment of SSI in March 1996.

6.4 It may be noted that, overall, Nazareth Lodge had made significant strides in promoting and developing residential social work practice during a period when the behaviour of many children and young people was becoming increasingly challenging. In 1983 [redacted] reported in the Annual Monitoring Statement on Nazareth Lodge that, generally there was a stable environment in the home, and that "*discipline problems do not arise to any significant degree*". (SNB 14323)

6.5 The Annual Monitoring Statement for 1994-1995, Appendix 5 (SNB 14255) listed Untoward Events in Unit 1, including:

- A 15 year old girl stayed out overnight without permission, on one occasion;
- A 14 year old girl stayed out overnight without permission;
- A boy hit another for calling him names;
- A boy stole £30;
- A 14 year old boy hit and grazed another boy, with a knife;
- A 15 year old boy absconded from school on 16 occasions, climbed on the roof of the home on 3 occasions, returned home at 2.00am; cut his arm with a blade, swallowed 5 Amoxcillan tablets at the same time; absconded from the unit on 2 occasions, taking an 11 year old with him;
- Sniffing of Tippex;
- An 11 year old boy absconded on 12 occasions; broke 12 windows, head-butted a member of staff, stole £5 from a taxi, climbed on the roof of the home on 3 occasions and remained there until 3.00am, set off the fire extinguisher and broke into the nursery school on one occasion.

6.6 The relationship between Nazareth Lodge and the principal user, the EHSSB, had improved both in terms of funding and between Nazareth Lodge staff and field social workers, who generally reported positively on the services being provided.

6.7 The responses inspectors received from the parents of children were also positive.

## 7.0 Medical input to SSI inspections of children's homes

7.1 From the 1980s research in GB had indicated that the health care needs of children cared for had not been well served. I do not recall what specific action, if any, SSI incorporated into the inspection process to address this issue. Inspectors examined children's files and ensured that the health care needs of the children were always covered in statutory reviews and that children in residential homes had ready access to a General Practitioner, who was frequently their own doctor prior to their entering residential care.

The Medical Officer for Nazareth Lodge visited the home weekly.

## 8.0 The accommodation of two retired priests on the Nazareth Lodge site in flats adjacent to the children's home

8.1 In a letter of 23 June 1995, DL 518 informed me of the presence of two retired priests in accommodation at the rear of Nazareth Lodge Children's Home. (SNB 16660). He felt that this practice was unacceptable and that the matter should be considered in relation to the registration of the home by DHSS.

8.2 On 14 July 1995 I confirmed to DL 518 that the Department had not been aware that adults had been accommodated at the Nazareth Lodge site.(SNB 16659)

8.3 On 3 August 1995 I visited Nazareth Lodge and spoke with SR 121. She confirmed that two flats at the rear of the main building were used from time to time to accommodate two retired or convalescing priests.

8.4 The flats were self-contained, had a separated entrance, which was adjacent to the front of the main building; and this area was out-of-bounds to the children. There was a connecting corridor between the flats and the main building. This part of the main building was used only for administrative and conferencing purposes, but was "not generally used by the children".

8.5 There was a connecting staircase between the flats and the chapel, but this was not used by the children.

8.6 Children, care staff and adult residents of the flats would have attended mass at the same time. Children were always accompanied and supervised by care staff.

8.7 Prospective adult residents were police checked and the Bishop vouched as to their suitability.

8.8 In September 1995 I wrote to DL 518 clarifying the Department's view of the matter (SNB 16652) :

- I described the configuration of the site and functional relationship of the two flats and the children's home. The flats had a separate entrance and were self-contained. There was a connecting corridor between the flats and the part of the building used for administration and conferences, but "children did not generally use this corridor".
- The Down Lisburn Trust was considering with the Sisters of Nazareth how the home might be re-instated at an alternative location in the community.
- There was no evidence that the arrangement for accommodating adults adjacent to Nazareth Lodge had had an adverse impact on the children.
- Criminal records checks had been carried out on adult residents.
- DHSS had not issued specific guidance regarding the presence of adults in the same building as children, though the Department would generally deprecate this.
- The Department could not prescribe what activities may take place in premises adjacent to or adjoining a children's home.
- Where any activities are deemed prejudicial to the welfare of children, the administering authority would be expected to seek a remedy.
- Generally, even temporary arrangements for non-staff to reside in a children's home should be discouraged, and where this happens, the administering authority should ensure that such arrangements are regulated and monitored.

**Other charitable activities at Nazareth Lodge**

8.9 The note of my meeting with SR 148 on 3 August 1995 (SNB 16661) concludes with a reference to the practice of religious staff offering charity to homeless men who called at the home on a regular basis (possibly weekly). Men came to the side of the administrative building where they received food parcels. This was a longstanding practice, which the Sisters saw as an important part of their charitable service to the community.

8.10 Generally, the children would have been at school when this took place, though this might not have been the case during school holidays. I do not recall offering any particular guidance on this matter.

**Comment**

8.11 The Sisters of Nazareth had provided a wide range of charitable services to the community over many years. The sites at Ravenhill Road and Ormeau Road were home to at least the following:

- Residential care of boys and girls respectively, some of whom had been rescued from unsatisfactory home situations by religious staff and

who were not necessarily in state care. Other children were placed at both homes by statutory authorities who contributed toward their maintenance;

- A residential nursery, St Joseph's on the Nazareth Lodge site, accommodated babies, many of whom were placed for adoption;
- Education was provided for both primary and secondary aged children;
- Charitable services were offered to homeless men and possibly others who were destitute;
- Accommodation was offered to retired or convalescent priests;
- A worshipping community used the chapel on the Nazareth Lodge site.

8.12 While it is conceivable that there might have been a conflict of interests at different levels, DHSS was not aware of any episode of the welfare of children having been compromised as a direct result of a range of activities having taken place on the site over many years.

8.13 Even by the standards of the 1970's Nazareth Lodge was a very institutional complex and the large building that had been used to accommodate over 100 children was no longer considered suitable as a children's home. The Down Lisburn Trust had begun discussions with the Sisters of Nazareth with a view to re-locating the home.

8.14 The historical practice of accommodating retired priests in flats adjacent to the children's home, with an inter-connecting corridor, was not satisfactory and was open to potential misuse.

**9.0 Wider Comments Regarding the Relationships between Voluntary Organisations and the Department of Health and Social Services and HSS Boards**

**9.1 Changing pattern of need for the residential care and per capita funding**

9.2 Paragraph 11.1 of the report of the SWAG inspection 1983 concluded as follows: "*....., half of the children in the home have been there for 2 years or more and a quarter of them for 5 years or more. Few of the children present serious behavioural problems for staff. It is considered that more could be done to prepare residents for independence and it is recommended that management give consideration to ways in which this can be achieved.*

*9.3 11.2 The future demands for residential child care are likely to be different. It is expected that increasingly the demand will be for residential placements for adolescents who present difficult patterns of behaviour and require residential care for shorter periods. It is considered that the home is not at present adequately prepared to meet such a demand and that changes will be needed if it is to retain its viability in the longer term. It is recommended that management discuss with the Eastern Health and Social Services Board what sort of service is likely to be needed in future and make its plans accordingly."*

9.4 Paragraph 6.1 of the inspection report described staffing arrangements and noted that, apart from one of the Sisters having the CQSW qualification, *"there are no other staff with professional qualifications."*

9.5 Paragraph 6.2 reads, *"The staffing levels in the home are low by comparison with those in other homes of comparable size.....The Castle Priory Report guidelines would suggest that a home of this size accommodating children between 3 and 16 years requires at least 18 care staff as well as management staff. It is understood that agreement has been reached recently in discussion with the Eastern Health and Social Services Board to have the per capita payment increased."*

9.6 In 1982 the Eastern Board had made a deficit payment of £45,000 to Nazareth Lodge. This significant additional payment was based on the running costs of the home, which was considered by SWAG to have been substantially under-staffed, and by staff who were mostly untrained.

9.7 Clearly Nazareth Lodge management, even if they had wanted to, could not have contemplated professional development, given the level of funding afforded to them. Up until 1983 they were reliant on deficit funding to cover their relatively modest running costs.

9.8 In response to a question by Mr Kennedy at the Committee of Inquiry about the inadequacy of staffing at Nazareth Lodge, (SNB 50112) [redacted] stated *"at the time (of the SWAG inspection) we could not afford the staff, but we now have been given extra money by the Department; by the Eastern Board I think. They have upgraded the per capita."*

Q *Was the administration of the home restricted by the constraints of finance?*
A *Very much so, yes.*

Q *That was the reason why the staff was low?*
A *That was the reason the staff was low, yes.*

Questioned by Mr Cahill (SNB 50128)

Q *So far as staff were concerned, in relation to the amount of money that you had available, would it really be unfair to put it that you were always chasing the devil by the tail to try and get enough money to run the thing, in any sort of adequate way?*
A [redacted] *Yes, because when I came there we were quite a big sum of money in the red, but eventually the Board were very considerate and they gave us grants and helped us out that first year to get out of this debt that we had.*

9.9 It should be noted that from the early 1980's the EHSSB had begun a process of reviewing per capita payments to a number of voluntary children's homes and that, in time, this resulted in significant increases. Furthermore, the recommendations of the Committee of Inquiry 1985 also led to a programme of investment in staff training and professional development in both the voluntary and statutory sectors.

**10.0 DHSS contribution to consideration of the future of voluntary residential child care organisations**

10.1 From the early 1970s there had been debate and consideration about the future contribution of voluntary child care organisation and the nature of the relationships between them and HSS Boards.

10.2 In 1982 and 1983, the Department consulted both sectors about the way ahead. Broadly speaking, both welcomed the opportunity to state their perceptions of relationships and the reasons why certain difficulties existed. HSS Boards thought that their treatment of and relationship with voluntary bodies was favourable, but most of the voluntary child care organisations held that the contrary was the case. Boards emphasised the need for voluntary organisations to provide services that were relevant in terms of their objectives and they were agreed that voluntary organisations should fulfil an innovatory as well as a service providing role. Voluntary organisations described why they felt excluded from planning and decision making processes and emphasised their precarious financial position and their inability to plan with certainty.

10.3 In 1985 the Department issued a discussion paper, which identified matters for consideration (HIA 4048). These included:

- The impact of the changing nature of child care on residential child care services;
- The extent of the likely residential child care services over the next five years;
- The practicable arrangements which can be devised to ensure voluntary sector participation in planning;
- The arrangements to be made to ensure that voluntary homes receive adequate per capita payments from Boards in respect of children in the care of homes;

10.4 Departmental circular of 1985 (Appendix 4) envisaged that the National Council of Voluntary Child Care Organisations would assist the smaller voluntary organisations in making their case. The Department decided not to take an active part in this particular confrontation, preferring, if need be, to enter the negotiation at a later stage. In so deciding, the Department was undoubtedly aware that, even if some resolutions did emerge, this would not be without casualties.

**Comment**

10.5 It would be difficult to escape the conclusion that a significant part of the reason for the failure of Nazareth Lodge to invest in the professional development of the service, pre 1983, was under-funding.

10.6 Up until 1983, the home relied on the uncertain benevolence of end of year deficit funding to balance the books, let alone think of investment in service development. This was during a period of relatively unrestrained development by statutory bodies, some of which appeared to aspire to independence of the voluntary residential child care sector.

10.7 Funding, however, was only one of the critical elements that would determine longer term relationships between the two sectors. The nature of service demand was changing in favour of residential care for older children with more difficult behaviours, who would need more specialised forms of provision. Increasingly, children whose behaviour and lifestyles would be heavily sexualized would need to live in smaller groups. Alternatives to residential care would be needed, including specialised family placements. At the level of primary service provision greater investment would be needed in support for the families of very young children, while at tertiary level greater diversification was called for.

10.8 Viable child care provision, is predicated by on-going investment in staff training and development, the guarantee of reliable professional support for front-line workers, the evaluation of all forms of professional intervention in the lives of families, and a range of genuine partnerships between and across both statutory and voluntary bodies. In the context of changing and more challenging demands and expectations, most voluntary bodies perceived themselves to be minor players, and unlikely partners.

10.9 It would become increasingly necessary for voluntary bodies to offer a range of services options. Few of the organisations that operated children's homes in the 1970/1980s would succeed in achieving the level of professional competence needed to do this.

10.10 It was therefore not conceivable that homes such as Nazareth Lodge would survive, let alone be significant providers of residential child care for a client population of predominantly adolescents with complex and demanding behaviours.

**Statement of Truth**

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

Signed N. J. Chamberlain Date 15/4/15

**Historical Institutional Abuse Inquiry 1922-1995**

**Supplementary Witness Statement by Norman Chambers with reference to the witness statement provided by DL 518 dated *3 April 2015* –**

***SNB 7323 to 7354***

***Responsibility for the investigation of complaints***

1. *In his statement* DL 518 *makes a number of key points relating to the investigation of alleged abuse of* NL 157 *, who resided at Nazareth Lodge Children's Home in 1984, and matters raised in the report of the inspection* of the home by SSI in October 1983.
    - The Board and the Department had dealt co-operatively with the complaints.
    - The Department, through SWAG, was prepared to accept responsibility for the subsequent investigation, if it transpired that general malpractice was indicated.
    - Subsequent events, DL 518 suggests, cast doubt on the Department's willingness to carry through that understanding.

2. DL 518 identifies some differences in his record and that of mine of a meeting held on 4 April 1984 when he and I met the Senior Social Worker who had interviewed NL 162, who had made three allegations about NL 157 mistreatment at Nazareth Lodge.

3. According to DL 518 record of the meeting, Mr C Walker (my Social Work Adviser colleague and I would "*discuss the complaints with* SR143 *, ascertain her reaction and decide how the care arrangements in* SR 121 *unit will be investigated by the Department".* Furthermore that I would, " *indicate to* SR143 *that it is likely that Board Social Workers will have to discuss with individual children the care they are receiving and whether they have any complaints to make".*

4. My record of the meeting stated, "*in the light of the homes response* DL 518 *will brief supervising social workers to interview all children in the care of the Eastern Health and Social Services Board regarding their experience of discipline in the home".*

5. In his statement (SNB-7325-paragraph 2) DL 518 states, "*This made it clear that it was the Department who were to take the lead in investigating this, however this in practice did not happen."*

6. It was the case that, while Mr Walker and I did not meet with SR143 to ascertain her reaction to the complaints, Mr. PJ Armstrong, CSWA, wrote to SR143 requesting her response.

7. Mr. Armstrong also wrote to the Director of Social Services on 9 April 1984 suggesting, "*in the first instance, the allegation relating to* NL 157

NL 157 *be investigated and when the outcome of that is known a decision be made regarding other children in the Board's care. Perhaps you will arrange for the supervising social worker to interview the child as soon as possible".*

8. Two points of significance are made by DL 518 regarding the handling of this complaint. One, that the Department was to take the lead in the investigation. I do not recall the matter of lead responsibility being discussed at the meeting on 4 April 1984, though it is clear that the Board and SWAG agreed to co-operate in the investigation. In the event, Mr Armstrong CSWA initiated action by writing to SR143 and to Mr Gilland (DSS). In writing to SR143 it is not clear whether Mr Armstrong was effectively taking the lead on behalf of the Department, or whether he was simply seeking a preliminary response from SR143 in order to establish what action should follow, by either the Department and/or the Board. I do not recall my having discussed the matter of lead responsibility with Mr Armstrong.

9. SR143 reacted by speaking to her staff, presumably to enable her to respond to Mr Armstrong's letter. In doing so she pre-empted any alternative action the Board and SWAG might have proposed. I doubt if this variation to what had been discussed on 4 April materially affected the eventual outcome.

10. DL 518 also notes, SNB-7325 paragraph 6, that my record of the meeting on 4 April stated, "*that the Department will notify the Southern and Northern Boards, again evidencing the regional and co-operative nature of the agreed investigation".* I think that is a reasonable inference, though I do not recall the principle of lead responsibility, as such, being discussed.

11. I share DL 518 view that roles and responsibilities should be defined and assigned at the commencement of an investigation into alleged child abuse. However, the scope of an investigation, and respective responsibilities can be determined only after preliminary fact finding. Where, for example, preliminary fact finding had indicated that the investigation would be limited in scope, it might have been sufficient to agree who should co-ordinate defined responsibilities and prepare the report. Had a number of interests and authorities been involved in the investigation, it would have been necessary to have identified a lead been agency. In particular circumstances , for example, where there was evidence of systemic failings or a pattern of general malpractice, the Department might have established an independent inquiry.

12. In the NL 157 case, it transpired, after preliminary fact finding, that the scope of the investigation was confined to allegations relating to one child, and that the Board did not consider it necessary to interview other children in the home. The actions that followed were to be handled by

social workers at local level. Hence, the need for Departmental involvement did not arise.

**EHSSB contribution to the development of voluntary children's homes since 1970**

*13.* At paragraph 2.17 DL 518 states, "*It appears that they* (SWAG Inspectors*) were unaware of this (*the Board's efforts over several years to promote the development of voluntary children's homes in its area*) and the progress which had been made in improving standards, when they undertook their inspection*.( in 1983*) Also that they were not aware of the responsibility of the Department for the Registration and Inspection of voluntary homes, which are directly related to the concerns they identified…"*

14. I would have been well aware that the EHSSB was favourably disposed towards voluntary children's homes in its area, particularly as the Board had relied on voluntary bodies to provide services for children in its care. I would also have been aware that the Board and the Department had invested substantially in residential child care services over many years. . I believe that this knowledge would have been shared by Social Work Advisers on the child care side, senior officers within SWAG and the Child Care Policy branch.

*15.* It was also the responsibility of Inspectors to contribute to the development of services by making informed suggestions about development, as well as fulfilling their regulatory functions, pointing up weaknesses in the service and making recommendations where action was considered to be necessary. Inspectors routinely consulted the Boards, which placed children in voluntary homes. With reference to the 1983 inspection of Nazareth Lodge conducted by Mr McElfatrick and myself, it would appear that DL 518, when preparing his evidence, may not have been aware that the completed report of the inspection was contained within the HIAI evidence bundle at SNB 50232 to SNB 50266. At Para 2.17 of his statement DL 518 states that *"one would have expected to see recommendations at the end of the report to address the concerns".* The inspection report contained 19 recommendations.

16. When making recommendations, Inspectors would have been aware of the cost implications of their recommendations, whether those fell to the administering authority, the Boards and/or the Department. Reports of inspections were passed to the Child Care Branch of the Department by SSI in final form; the Child Care Branch respected the professional independence of inspectors.

**Police involvement in the NL 157 case**

17. Paragraph 2.13 (SNB-7330) of DL 518 statement explains the reasons why the complaint made by NL 162, was not referred to the Police. Board officials seem to have concluded that NL 157 "punishment" did not constitute criminal assault, and thi emed to have been shared by Mr Armstrong, CSWA. In retrospect, I think that balanced judgment was in NL 157 best interests and was consistent with his mother's wishes.

Norman Chambers
16 April 2015

Mr P J Armstrong

NAZARETH LODGE CHILDREN'S HOME

1. In March 1984 the Eastern Board referred a report to us setting out a number of complaints in relation to the running of this Home. These were:

- putting soap into children's mouths as punishment for swearing;

- using a room infested with cockroaches as a isolation room for disruptive children; and

- the use of surplus food from Marks and Spencers.

These complaints were investigated by Mr Walker and Mr Chambers and no further action was taken by the Department or the Board in relation to the child named in respect of the use of soap.

2. On 15 May 1985 Mr Moore wrote to you with reports from North and West Belfast Unit of Management which contained allegations of physical abuse by a boy, HIA 210, who had lived in the Home from [redacted] 1973 to [redacted] 1981. These allegations were made when the child, who was placed with foster parents, was having nightmares and was interviewed about his experiences in the Home.

3. HIA 210 alleges that:

- he regularly received beatings from SR 180 who used whatever implement would be at hand;

- he was placed in a bath of cold water as punishment for informing his social worker about the beatings;

- he was locked in a bathroom overnight without lights; and

- he was placed in a locked cupboard.

4. The North and West Belfast Unit of Management staff investigated these allegations by interviewing the boy on 2 occasions, his brother on one occasion and a social worker who had responsibility for him during his time in the Home. The interviews with his brother and social worker did not corroborate his allegations and the Unit of Management report concluded "as a child he is not adverse to making allegations although we have no personal experience of him being dishonest in this nature although his interpretation of what has happened, as always the case, may be called into question".

In his letter of 15 May Mr Moore stated "as these allegations described unacceptable child care practices rather than complaints relating to one child, I would be grateful for your

voluntary organisation a per capita charge is payable. A comparison of the economic costs of statutory and voluntary homes indicates that, in most cases the latter represents between one third and one half of the weekly unit cost in statutory homes. Only one voluntary organisation incurs costs which are comparable to those of most statutory homes and, in this case, the full cost is not recouped by the organisation. It therefore appears that voluntary organisations are disadvantaged both in terms of their ability to finance the development of their services and, that even the level of recoupment of their direct costs from Boards is insufficient.
Departmental circular HSS15(S)1/74 states that "Boards will normally meet the whole cost of any services provided under such arrangements. A prime example is the provision of places in voluntary homes on a contractual basis." It is therefore disconcerting to find such disparity between the costs incurred in the two sectors and that some organisations are still unable to recoup the total cost of the service they are providing.

ACCOUNTABILITY

Associated with this issue of funding is the question of whether voluntary organisations should fund part of their services from voluntary resources. The issue of fund raising by voluntary organisations will be referred to later in the paper, but it is sufficient at this point to acknowledge the need for voluntary organisations to achieve some degree of financial independence. It is argued by some that they should do so in order to be seen to be

which ceased to be needed five - ten years ago. The direct admission of children to the care of voluntary organisations, who acted as substitute parents to them has long since ceased and the concept of "permanent rescue" has been replaced by a commitment to support natural family contacts in the pursuit of rehabilitation if at all possible. Residential care is no longer considered to be a last resort service where children reluctantly, but inevitably, remain until they leave care. On the contrary, it is increasingly used only when considered to be the better alternative and, in most cases as a means to an end, rather than an end in itself. Recent years have seen steady improvement in the salaries and conditions of service of staff and the staffing complement in most chidren's homes has now increased to take account of the particular needs and demands made by residents. Improved staffing levels are reflected in higher running costs. The weekly charges made by voluntary children's homes in 1983 varied between £42.00 and £198.00 per week, while the average weekly cost in three health and social services boards was £250.00 per week. The average cost of maintaining a child in homes in the Eastern Area was £185.00.

During the four year period 1979-1983 the number of children in care who were returned home on trial under Section 145 of the Children and Young Persons Act (NI) 1968 increased from 413 (19%) to 623 (24%). During the same period the number of children boarded out under Section 114 increased from 663 (50%) to 1,224 (63%). The percentage of the total number of children in residential care of either voluntary or statutory organisations during the same period fell from 36% to 26%.

CONFIDENTIAL

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NAZARETH LODGE CHILDREN'S HOME

The Home was inspected by Mr Chambers and Mr McElfatrick on 10-12 October 1983. All Child Care staff who were available were interviewed. A sample of case files was examined and all statutory records were examined. Those parts of the building used by the children were inspected. SR 143 (Mother Superior) has responsibility for all aspects of the home and for the Sisters of Nazareth who live there. In addition to the sisters who work in Nazareth Lodge there are some others who work in the local schools and a few retired nuns. SR 143 is accountable to Mother Regional who is based in Dublin. The latter visits the home approximately 3 times a year. The Headquarters of the Order of Nazareth is in Hammersmith and Mother General visits the Home every 3 years. There is no committee of management and full responsibility for the staff and children is vested in SR 143. Mother Regional appoints 2 "councillors" who meet with her monthly to discuss the affairs of the home. These are 2 sisters one employed in the Home (SR 46) and another who works in the nursery school (SR 29). Their meeting is referred to as the Council for the Community but its function appears to be more advisory and consultative than executive.

The Home is divided into 3 functionally autonomous living units with approximately 12-14 children in each. Responsibility for day to day affairs is delegated by SR 143 to the 3 Sisters who run the groups. It is possible for the Sisters to be self determining in a wide range of issues and we found that the regime in the 3 groups differed markedly. Only one of the Sisters is social work trained and this was evident in her approach to the residential task. It is fair to say that SR 121 had only recently been appointed to the home and, while she is not social work trained she has considerable experience in working with adolescents in [redacted] and she may in time contribute to raising professional standards.

The management style in the home is rigidly hierarchical. The Sisters do not consult the staff on matters of policy and practice and an atmosphere of [their] authoritarianism prevails. In only one of the groups has staff had access to children's records though in another the Sister has recently told the staff that they may have access to the children's files. In only one group do staff attend case reviews; they have all limited, if any, contact with social workers. Just as the Sisters do not consult with the staff nor involve them in decision-making, so the lay staff do not acknowledge the Sisters as being members of the caring staff. They perceive them as authoritarian background figures who absent themselves from the group, particularly during periods when their help is needed. The

Sisters do not socialise with the staff, they eat separately and have their own living quarters. The need for the Sisters to attend to religious duties throughout the day is considered to be intrusive, and while it is understood that they may occasionally be late for Offices, their religious duties are considered to be paramount.

RESIDENTIAL TASK

The residential task undertaken by child care staff is described by them as being primarily the physical care of the children and a range of domestic duties. The latter includes clearing up after meals, sweeping and hoovering the floor, keeping bedrooms tidy and attending to all of the younger children's laundry. In one group the emphasis on cleaniness and routine domestic duties appear to be excessive if not obsessional, but all child care staff complained about the amount of time spent on domestic work.

The staffing complement in the Home is such that staff have little time to spend with the children beyond ensuring their physical care. No group activities are undertaken, other than escorting children to the swimming pool and no individual work is undertaken with them. In only one group did any activities resemble residential social work. This included weekly meetings to discuss the children. However, this group was short staff during the inspection and it has not been possible to roster all of the staff to ensure full attendance. In the same group a system of primary workers has been started and one staff will be responsible for groups of children from the same family. The range of discretion which the staff have is such that a system of primary workers could be developed to only a limited extent.

Children are encouraged to participate in outside activities and one formed the impression that the children had rather more freedom than the staff.

We were told that parents are encouraged to visit their children in the Home, but that very few avail of the opportunity. However, a considerable number of the children go home at weekends and this type of family contact is encouraged. Child care staff have no contact with parents, who speak to the Sisters if and when they visit the Home. Arrangements for parents to spend time with their children in Nazareth Lodge is very unsatisfactory. When they arrive they must speak to one of the Sisters and they are then permitted to spend time with their children in a small sitting room. A cup of tea will be provided for them. One of the Sisters encourages parents to assist the children with their homework as she feels they

have received contracts of employment. Staff complained that they could not understand differentials between their salaries and from the figures quoted to us the amounts paid to them appear to be low. SR 143 said that the scales were based on a National Joint Council scale but she was unable to explain the basis of remuneration.

Staff work split shifts and they appear to work between 56 and 70 hours per week. All staff, with the exception of one temporary member is resident. They have very little freedom to socialise during off-duty periods and complained that they have neither a staff sitting room nor a staff kitchen. We were told that a staff sitting room had been prepared but that as yet it had not been used. They complained that they had little privacy in their rooms and that the Sisters frequently complain that they are noisy. The home does not provide a television for them though they may go to the group sitting rooms to watch television.

As a staff group they appear to get along well and they seem to enjoy working with the children. However their relationship with the nuns is very poor and none of the staff is content. Their principal grievances are to do with salary levels, split shifts and living conditions. While these are important considerations we would be equally concerned about their professional development which is virtually non-existent.

VOLUNTEERS

The only volunteers who come to the home are student priests. They appear to make a valuable contribution and most of the children are glad to see them. We were advised of one exception. They take the children to the swimming pool, play games with them and in one group they provide assistance with homework. All of their contact with the children while they are in the home is supervised and they are not available in the evenings. It is assumed that the vetting process undertaken by their college is adequate for the purpose of ensuring their suitability to visit the home.

FUNDING

The Eastern Board has recently increased the weekly payment from £80 to with effect from 1 April 1983. We did not see any documentation on this matter but were advised that a condition of the increased payment was that 2 additional staff would be employed in each group. By making this a condition the Board is effectively imposing a staffing level on the home and their action in this matter needs to be clarified. Prior to this decision being made the home was incurring

H1A1(62)C-TAD1 T

**NOTES OF TELEPHONE CONVERSATION WITH NL 269 (SOCIAL WORKER, GRANSHA HOSPITAL)**

**Date: 26 January 1993**

NL 269 'phoned stating that he had heard that I was undertaking the Inspection at Nazareth Lodge and wanted to pass on a number of concerns he had regarding the Home. The following details his comments:

1. He was employed by Nazareth Lodge Children's Home and commenced work in [redacted]. By November he felt he had no option but to resign.

2. He claims he raised concerns about policy and procedure with the Team Leader who made him out to be a trouble-maker. The following instances were cited:

   i. One of the children had demonstrated overtly sexualised behaviour. He reported this to the Team Leader who passed it off and did not report the matter to the field social worker. He queried this approach with the Team Leader who said that as he was newly qualified and a new member of staff she was unsure whether or not she could trust his judgement;

   ii. sleep-in arrangements. In the absence of Sister one residential worker is used to cover the sleep-in. He claims he expressed concerns about a male member of staff undertaking this duty on a single-handed basis feeling it exposed the individual to possible complaint. Sister rejected this view. He states he then checked with BASW who supported his view. He was, however, required to undertake these duties.

   iii. While on sleep-in one 17 year old ([redacted]) came in high on drugs. NL 269 claims that at the very least [redacted] is handling drugs and would admit to this fact. Surgical gloves have been found in his room with the fingers removed. It is felt these are used for carrying drugs. According to NL 269 the Team Leader is aware of this situation. As a sanction for returning home high on drugs NL 269 imposed a 2 day grounding on [redacted]. On the Team Leader's return she apparently censured him for:

   - imposing a sanction without permission;
   - liaising with the field social worker without permission;
   - taking action prior to her return to duty.

   NL 269 claims that the field social worker had told him that she did not feel she was "told the whole story" by residential staff. NL 269 stated it would have been general practice in his unit, not to contact field social workers without the Team Leader's consent;

iv. One of the ex-residents, NL 165, according to another member of staff, had previously sexually abused a child while in care. He now frequently visited the Home and had full run of the house;

v. NL 269 claims that staff in the Unit in which he worked are frightened to act or do anything as they are unqualified and have no way out. He states they are an excellent staff team who work under a regime of fear;

vi. NL 269 states a colleague from one of the other Units had told him that 2 boys who were sexually abused by their mother's cohabite were permitted by the Team Leader to have access to the perpetrator without a child in care review.

vi. NL 269 claims there is no role for qualified workers in the Home.

vii. He further states that he took his concerns to the Sister Superior who advised him that his Team Leader felt he was unsuited to residential work.

ix. he queried the rota as he had a disproportionate number of late shifts given that he was covering for 2 staff on CSS. His Team Leader apparently told him if he was a trouble-maker he could look for another job, which he did.

3. I have told NL 269 that I would prefer it if he placed his views on record by writing to me. Although I read back my notes to check that he was in agreement with the record of our telephone conversation. NL 269 queried what would happen to his comments. I advised him that the draft report was written and would be with the Home in the near future and some points raised had already been covered in that format. His comments would, however, be followed up in discussion. He asked to receive a copy of the report. I advised him to write in requesting a copy of the summary report as at this time the main report was the property of the Administering Authority.

MARION REYNOLDS

Mrs. Reynolds.

While NL 269 expression of concern confirms your own findings. I don't think it can be used, unless he makes specific complaints in writing.

NL 269 is not entitled to access to the inspection report or to the summary. Should he request in writing, please decline, and advise him that his comments have been noted.

N. J. Chamberlain
2-2-93.

SCOPE OF THE PROCEDURE

50.0 It is not intended at this stage to extend the complaints procedure beyond the residential child care field. The Department will, however, review the procedure after a suitable period and, in the light of initial experience of the arrangements outlined in this Circular, will consider the extension of the procedures to children in care in non- residential settings.

CONCLUSION

51.0 Boards and voluntary bodies involved in the provision of residential child care are now asked to:

- establish, by 1 May 1985, procedures for the reception, recording and monitoring of complaints in the form detailed in this Circular;

- produce, by 1 May 1985, booklets for children in residential care and their parents, to include the standard listings of grounds for complaint (in Appendix 1(a) and (b)) and an explanation of the complaints procedure which will operate. A copy of each booklet should be sent to the Department for information;

- ensure that all children in residential care and their parents receive copies of the booklets, and an oral explanation of the contents, by 13 July 1985;

- submit to the Department, by 13 July 1985, a statement of the procedures which operate for the investigation of complaints made by children in residential care and their parents;

- as from the date of this Circular, notify the Department of any complaints alleging criminal misconduct against children in residential care which are referred to the Police for investigation.

52.0 Enquiries relating to the arrangements set out in this Circular should be directed to Mrs D Brown (Child Care Branch - Tel No Belfast 650111 Ext 355).

Yours faithfully

G BUCHANAN

13 January 1984

KL/JR

[redacted]
Department of Health and Social Services
Bow House
Bow Street
LISBURN

Dear Terry

Further to my conversation with your Office on the 13 inst, this is to authorise your Department to pay the Supplementary Benefit of HIA 31 [redacted] to Mr Kieran Drayne.

Claimant :- HIA 31, [redacted], [redacted].

This is to certify that I wish my Supplementary Benefit paid to Kieran Drayne, Social Worker of Lisburn Health Centre, Linenhall Street, Lisburn.

Signed : HIA 31

Yours sincerely

K Drayne
Social Worker

Cancelled on Billy.

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Social Services Inspectorate, 11th
Dundonald House Upper Newtownards Road Belfast BT4 3SF

Telephone (Belfast) (01232) 524431

Your reference

Regional Superior
The Poor Sisters of Nazareth
Nazareth House
Malahide Road
Dublin 3

Our reference JAC/SSI

Date 11 December 1995

CONFIDENTIAL

Dear Mother Regional

Re: Nazareth Lodge Ravenhill Road Belfast

I am writing to you about certain allegations regarding SR 18 which were brought to my attention during the recent inspection of Nazareth Lodge. These are referred to in the attached report which was prepared by a staff member who has now left. You will see what matters referred to include the following:-

1. forcing a young person to eat food retrieved from the waste bin in front of other children

2. striking a young person in the course of a violent argument, then dropping him off in the countryside in Co Donegal at night leaving him to make his own way back to the holiday home

3. undermining of staff who had voiced concerns about the effects of such behaviour on the young people

4. refusing to speak to a young person for almost two months before the inspection

5. treating him unfairly in relation to her treatment of other children within the group

6. was reluctant to give him his clothing allowance

I ask that you investigate these matters further and that a report is sent to me in due course. I am copying this letter to the Management Committee for information, SR 148, Operational Manager and have notified the Trust's responsible.

Yours sincerely

J A Chaddock.

J A Chaddock
Inspector - Social Services Inspectorate

5.5 Staff duties are organised on a rota basis. The Sisters are available in the home at all times. The rota arrangements for the assistant houseparents vary from one unit to another but work is organised on the basis of a 40 hour week. It is arranged on a 3 week cycle with 7 days on/2 days off/8 days on/4 days off. In one unit there is generally only one member of staff on duty in the morning along with the Sister whilst in the other 2 units there are frequently 2 on duty with the Sister. In all units there are usually 2 members of staff on duty with the Sister in the afternoon and evening shift. In SR 121 's group, where most of the children go home for week-ends there is only one member of staff on duty with her for most of the time over the week-end. Most of the staff are required to work split shifts occasionally. Since all but one of the staff are resident in the home this arrangement appears to work fairly well, although it can be restricting for the staff. An example of the rota arrangements is provided at appendix B.

the children have access to a range of indoor games and most of them spend part of their leisure time watching television. Staff accompany groups of children to the pool and there are a number of volunteers who visit the home and take the children out.

8.6 For the past few years the residents have had visits from volunteers. This arrangement was established prior to the arrival of SR 143 at Nazareth Lodge but she has been content to allow the visits to continue. There are benefits for children and staff alike in such an arrangement. It allows children access to adult male company in a home which is run entirely by female staff. In the light of recent events at some other homes it is considered that it would be prudent for the management of the home to satisfy itself regarding the background of anyone who is likely to have continuing contact with the children. It is recommended, therefore, that management should always make appropriate background enquiries regarding the credentials of persons offering to do voluntary work before linking them with the children.

8.7 The home has its own minibus. Staff, however, said that it is used infrequently. It can be driven only by the Sisters and appears to be used mainly in connection with special occasions and holidays. Staff and children have on occasion to walk quite long distances, for example, to the city centre, because money is not available for transport. It is unfortunate that an asset such as this is used so little when it could make a real contribution to widening the

children's experiences. It is hoped greater use can be made of the minibus in future.

8.8 As can be expected in any children's home the staff are confronted by incidents of misbehaviour by the children from time to time. These are dealt with in a variety of ways including the withdrawal of privileges. A young person may be refused permission to go to the youth club or watch television or he may find that his pocket money is reduced. Staff will sometimes remove an errant child from the group to talk to him about his behaviour. Where a child is isolated from the group it is normally only for a short period. If bad behaviour persists the situation would be discussed by the Sister with the child's fieldworker. The forms of discipline about which the advisers were informed were not excessive but the practice of reducing pocket money for misdemeanours is regarded as unsatisfactory.

8.9 The Sisters do not have their meals along with the children. Some of the care staff, although present at meal times, prefer not to eat the food provided as they do not find it appetising. It was noted that a small number of children did not finish their meals on the occasion when the advisers dined with them. Although the menus' record indicates that a balanced diet is provided the way in which the food is prepared and presented may need to be reviewed. It would be preferable if the Sisters and staff on duty were to dine along with the children in order to create a more family like environment. This would enable staff to be more aware of the quality of the meals. It is recommended that management take steps to satisfy itself that the meals provided for the children are appetising.