DEPARTMENT OF HEALTH SOCIAL SERVICES AND PUBLIC SAFETY

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 4

NAZARETH LODGE AND NAZARETH HOUSE CHILDREN'S HOMES

BELFAST

I, Hilary R Harrison will say as follows:

This statement is provided on behalf of the Department of Health, Social Services and Public Safety in response to the Rule 9 Request dated 24 March 2015 which requires the Department to address questions posed by the HIAI regarding complaints made in relation to Nazareth Lodge children's home.

Introduction

1 The intention of this statement is to address issues raised by the HIAI in relation to complaints received by the Department during the period 1984 to 1995. The statement also provides to the HIAI, information that has recently come to light following further Departmental inquiry into the historical role of the former Ministry of Home Affairs (MoHA) and the former Department of Health and Social Services (DHSS) in relation to the inspection of children's homes. The Department believes that the latter will be of contextual significance to the HIAI in its consideration of the changing pattern of inspection within the period 1922-1995 with which it is concerned.

2 With regard to the current Module under consideration, other than fleeting references to the closure of Nazareth House in 1984 in the Nazareth Lodge Departmental files[1] and in its evidence to the Hughes Inquiry, visits to Nazareth House by a Social Work Advisor[2], the Department has been unable to locate any further Departmental information related to the Nazareth House home. The home closed in 1984 and it seems most likely that any files held on this home would have been destroyed in accordance with the Department's disposal of records schedules.

3 References have however been found in the documentation received from the HIAI to inspections by the Ministry of Home Affairs children's inspectors in 1953; 1964; 1965 and 1966[3], and in 1953[4], a visit by a party of ten 'Stormont' officials, which included a Children's Inspector. A letter sent to Nazareth House following the visit, expressed appreciation of the work carried out so unselfishly by the Sisters and commented on the "happy, healthy appearance of the children"

4 The Departmental files containing information and inspection reports on Nazareth Lodge home have been submitted to the HIAI. The documentation in these files broadly falls into the categories of monitoring and inspection functions and correspondence related to concerns about the welfare of specific children.

[1] Annexes A and B

[2] SNB Reference to be located

[3] SNB: 10308 (1953); 10327 (1964); 10335 (1965); 10344 (1966)

[4] 10309 (1953) ten visitors from Stormont came to visit the House. Mr Jackson, Miss McAleese, K Forrest and Miss Houston among them

5 From its establishment in 1897 until around 1950, Nazareth Lodge children's home was registered with MoHA as an industrial school. As such, it would have been inspected annually by the Industrial and Reformatory Schools branch of MoHA under the provisions of section 46 (3) of the Children Act 1908. The Department understands that the Department of Justice has agreed to accept responsibility for the provision of information to the HIAI in respect of the industrial and reformatory schools functions of the MoHA.

6 From 1951 onwards, Nazareth Lodge was registered with the MoHA as a children's home and inspected by MoHA children's inspectors in accordance with sections 102 and 136 of the Children and Young Person's Act (NI) 1950. According to the information received from the HIAI, it would appear that during the 1950s and 1960s the home was inspected and/or visited on average annually[5] by children's inspectors, at times accompanied by a medical officer from the former Department of Health and Local Communities. The Department has already provided evidence to the HIAI to the effect that the MoHA children's inspectors transferred to the Social Work Advisory Group (SWAG) in/around 1972 when the new DHSS was created[6].

7 During the period 1973-1983, which was considered by the Hughes Inquiry, the report of the Inquiry noted that the only SWAG report on Nazareth Lodge extant for this period related to an inspection carried out in October 1983. The report of this inspection and subsequent inspection reports for the years 1989, 1991, 1992, 1993, 1994 and 1995 have been submitted to the HIAI[7]. The Department is aware from its file documentation that inspections were carried out by SSI in 1986, 1987 and 1988 but we have been unable to locate the reports of these inspections.

8 Unless otherwise requested by the HIAI, the Department does not intend to make any further comment within this current statement regarding the content of inspections carried out during the above years, although the concluding section of the statement draws attention to the social policy context in which SWAG operated during the years immediately preceding the 1983 inspection.

9 The HIAI Rule 9 Request dated 24 March 2015 indicated that Module 4 of the Inquiry would, from the Department's perspective, deal with systems issues: *"... specifically how matters coming to the attention of the regulator were dealt with".* By way of background, this statement describes the

[5] Annex C List of Inspections/Visits to Nazareth Lodge during the 1950s and 1960s

[6] SND 15664 The Departmental statement to the Inquiry dated January 2014 paragraph 27

[7] 1983-SNB 50232; 1989-SNB 14334; 1991- SNB 14163; 1992-SNB 15236; 1993-SNB 15298; 1994-SNB 13865; 1995 SNB-14208;

development of the DHSS Circular "Provision of Information to and a Complaints Procedure for Children in Residential Care and their Parents" dated 30 April 1985[8] (the 1985 Circular) and considers the purpose of the Circular. The HIAI has also presented in the Rule 9 request, a series of questions to be addressed by the Department. These are set out below and are considered with specific reference to complaints about the treatment of children in Nazareth Lodge that were made known to the DHSS during the period March 1985 to March 1993. In its analysis of these issues, the Department also makes reference to the written submissions of the HSS Board's witness to the HIAI, [redacted] DL 518 and where appropriate, to the statements already provided to the Inquiry by former members of Department's Social Services Inspectorate's staff.

Development of a complaints system by the DHSS

10 Information about the development of the DHSS's 1985 circular was provided in fuller form to the HIAI in the Department's January 2014 statement[10]. By way of summary, key points that were made included:

- No formal complaints systems for children in care existed in Northern Ireland prior to the development of the DHSS's 1985 guidance. However, the former Northern Ireland Hospitals Authority had operated a system to deal with complaints from patients and following re-organisation of the health and social services in 1972, Boards had developed this system and extended it to all services and client groups.

- In 1982 the Sheridan report[11] recommended that the DHSS should *"introduce adequate arrangements for looking at complaints made by children and their parents about treatment in children's homes"* and suggested that the DHSS should take account of any such systems that had been developed elsewhere in the UK.

- At that time few systems existed in the UK exclusively for use by children.

11 I refer to the witness statement dated 14 April 2015 made to the HIAI by Mrs Doreen Brown, a former DHSS Principal Officer with responsibility for implementing aspects of the Sheridan Report, including the development of a complaints procedure for children in residential care. Mrs Brown relates the

[8] SNB 19076 Circular HSS(CC)2/85
[9] SNB 6913 SNB 7323
[10] SND 15686-15688
[11] HIA 639

stages involved in the preparation of the 1985 Circular, which included:

- a consultation paper issued in October 1983;
- in the light of the responses received, draft guidance drawn up and circulated in August 1984;
- having regard to responses to the draft guidance, the revised final guidance was issued in May 1985.

12 In his oral evidence to the Hughes Inquiry, Mr George Buchanan, a former DHSS Assistant Secretary confirmed the breadth of the consultation involved in developing the 1985 circular which included consultation with the Northern Ireland Assembly[12]. The Hughes Committee appears to have received and commented on the Circular in its final form[13]. In her statement to the HIAI, Mrs Brown, however, explains that significant difficulties were encountered when the complaints procedures were being developed due to the withdrawal of co-operation by staff organisations because of concerns that staff would not be given adequate protection from unfounded allegations of mistreatment. Faced with this, she recalls that DHSS had two options: to defer the issue of guidance until staff co-operation had been achieved; or to issue it in the absence of co-operation. Although the position was not ideal, the DHSS's view was that proceeding to issue the guidance could be more helpful to those in the care system than countenancing a potentially open-ended delay.

13 In May 1985, the finalised complaints circular was issued to Boards and the managing committees of voluntary organisations. It described:

- the information to be provided to children and their parents
- the principles underlying the complaints procedure;
- grounds for complaint;
- channels of complaint (including provision of contact cards for children who did not wish to use the normal channels of complaint);
- recording, investigation and monitoring of complaints

14 The procedure provided for all children in residential care and their parents to be given an explanatory booklet explaining the complaints procedures. Booklets were to be prepared by Boards and voluntary organisations and provided to children and parents. Key factors to the successful implementation of the complaints procedure included the need to create a climate of non-victimisation of children who made complaints; regular visitation of children's social workers; children and parents to be familiar with and have easy access to monitoring officers/voluntary visitors; monitoring

[12] Annex D Mr George Buchanan Oral Evidence to the Hughes Inquiry Page 19 Day 5 - 6 July 1984
[13] HIA 656 Paragraph 13.89 of the Hughes Report

officers to have thorough knowledge of good practice and be skilled in communicating with children; and Boards and voluntary organisations to ensure staff receive clear explanation of the operation of the procedure.

15 All complaints were to be recorded in a complaints book and referred to the Assistant Director of the Board's relevant Unit of Management or the Chairperson for secondary recording. Boards and voluntary organisations were to include complaints within their monthly monitoring functions and voluntary organisations were to reflect this information in their monitoring returns to the Department. In the case of Boards, complaints were to be reviewed every 3 months by the DSS or his nominee. A 3-monthly review of complaints in respect of voluntary homes was to be undertaken by the DHSS.

16 The circular required Boards and voluntary bodies to establish *inter alia* procedures for the reception, recording and monitoring of complaints in the form detailed in the circular. The DHSS took the view that Boards and voluntary organisations should have scope to develop and operate differing procedures appropriate to their structures and circumstances. In her statement Mrs Brown has explained that this was in recognition of the fact that, not only did voluntary organisations differ structurally one from the other, but so too did the Boards. She states that Boards would, rightly, have resisted any attempt by DHSS to impose a uniform detailed scheme on them.

17 As further noted by Mrs Brown, the procedures were based on a premise that complaints would be properly investigated (paragraphs 17, 18, 29, and 40-44) and decisions taken about the most appropriate course of action. Boards were also directed to be prepared to assist voluntary organisations in the investigation of complaints (paragraph 28).

18 There was a clear interface in the procedures to be developed by Boards and voluntary organisations with other important processes, notably child protection and staff disciplinary procedures. Complaints alleging criminal activity by a child in a statutory home were to be referred directly to the Director of Social Services (DSS). In the case of a child in a voluntary home such complaints were to be referred to the Chairperson of the Management Committee (the Chair) who must then inform the DSS. The DSS or the Chair had to take a decision as to whether the matter should be referred to the police. In the case of complaints alleging criminal activity that were to be referred to the police, the DHSS was to be informed simultaneously.

19 With reference to investigations that might lead to staff disciplinary action, the circular noted that there was ongoing consideration by the General

Purposes Committee of the General Joint Council on the way in which initial investigations into complaints should be conducted in order to determine whether grounds existed for disciplinary action Boards were directed to incorporate into their procedures any guidance agreed as a result of this and voluntary organisations were advised to work within the spirit of any revised procedures operated by Boards.

20 For the purpose of this statement it is therefore important to note that the Department did not intend that the processes described in the circular should replace or supersede existing child protection or staff disciplinary procedures. Rather, the complaints arrangements, if properly implemented, were to link children, parents and their representatives into an accessible, early alert system that would enable those in authority to take appropriate and timely action. By inference, such action might well lead to the invoking of other necessary procedures.

Statements made by DL 518 in relation to the 1985 circular

21 DL 518 , [redacted] has in his statement dated 25 March 2015[14] claimed that a number of problems emanated from the 1985 circular:

(i) *"There were no procedures for investigation"*

As outlined above, Boards and voluntary organisations were to develop their own procedures for investigation of complaints. Furthermore, where abuse of a child was alleged, the complaints procedures did not prevent or inhibit the exercise of the Board's duty under Section 94 (2) of the Children and Young Persons Act (NI) 1968 (the 1968 Act) where, if a Board received information *"suggesting that any child or young person may be in need of care, protection or control"* it must *"cause inquiries to be made into the case unless satisfied that such inquiries are unnecessary".* The Boards' child protection guidance and procedures developed in accordance with the Department's 1975 and 1978[15] guidance on Non-Accidental Injury to Children and Child Abuse were established to inform such investigations.

(ii) The circular afforded *"Discretionary authority of the Director of Social Services or the Chair of Management Committees of Voluntary Organisations … to refer the complaint to the police*" and *"the Department had not included the specific procedures to be followed"*

[14] SNB 6913
[15] Annexes E and F

in relation to such referrals.

DL 518 has noted that the Hughes Committee, whilst voicing concern that the question of whether a criminal offence had occurred was a matter for investigation by the police, sided with the DHSS in that it was of the view that all allegations of criminal activity must be referred to the police except those that are "patently false". The circular did not permit the Chairs of voluntary organisations' management committees to have sole discretion regarding the reporting to the police of complaints alleging criminal activity. As already noted, the circular required Chairs to report all such cases to the DSS. Either the Chair or the DSS could then decide when and whether to refer to the police, regardless of whether the other party dissented from such a referral.

With reference to the considerations to be made in deciding to refer to the police, the Boards' complaints procedures should have been capable of setting out the procedures to be followed in these cases and how the circumstances in which the DSS must make such a referral might be determined.

(iii) The circular did not contain *"procedures for the investigation of general malpractice in voluntary children's homes and no procedures for joint investigation of complaints in voluntary homes and by Boards and Management Committees."* DL 518 also makes reference to the procedures not being '*fit for purpose"* in this respect.

This assertion appears to emanate from DL 518 experience of the DHSS's refusal to participate with the Board in a *"co-operative approach to investigation … with the Department as the Registering Authority and Inspectorate taking the lead role"* in the investigation of certain complaints which had been made by or on behalf of children in Nazareth Lodge and which allegedly had implications for the care of other children in the home. The specific complaints with which he was concerned are considered below. However, whilst the 1985 circular provided that Boards could assist voluntary organisations in the investigation of complaints, it did not seek to address issues such as general malpractice in a children's home which were plainly beyond the scope of a procedure that aimed to establish processes by which individual children and their parents might voice concerns and have those concerns investigated. Actions following initial investigations under complaints procedures that might lead, for example, to further inquiry under child protection procedures or referral of the home to a

regulatory body did not fall with the remit or purpose of the circular.

(iv) There was *"Nothing in relation to the role of the Department apart from approving the Boards' investigatory procedures."*

It would be most unusual in procedural guidance such as that contained in the 1985 circular to refer to the inspectorial or regulatory role of the Department. To take an analogy, the detailed Children (NI) Order 1995 guidance on representation and complaints procedures for children's services, which includes residential services, makes no reference to the role of regulatory bodies.

The HIAI Rule 9 request dated 24 March 2015

22 The above request requires the Department to address the following:

a) The actions the Department took when it was made aware of complaints from a number of individuals in a home about how a member of staff was behaving;

b) How the complaints were viewed by the DHSS and its inspectors at that time;

c) Whether what the DHSS did was satisfactory or if deficient whether it was indicative of a more general systems failure in the governance or regulatory arrangements for a children's home; and

d) What options were available to SSI when concerns over the behaviour of a member of staff in a related voluntary home were brought to SSI's attention and whether those options and the steps taken were sufficient.

23 The documentation available to the Department, which includes information within its own files and that received from the HIAI, indicates that during the period March 1984 to 1995, the DHSS received complaints which were reported to SWAG/SSI in relation to five named young people who were residents or former residents of Nazareth Lodge. The Board's reports on these named were set in the context of allegations about the care regime and treatment of other unnamed children in the home. During this period, SSI also received one complaint from a former member of staff about general standards of professional within the home. The detail of the following complaints and the Department's actions are set out in Dr McCoy's minute to the CSWA dated 6 June 1986.

- The NL 157 complaint reported to the Department in March 1984[16]
- The HIA 210 complaint reported to the Department in May 1985[17]
- The NL 145 complaint reported to the Department in December 1985[18]
- The NL 97 complaint reported to the Department in April 1986[19]
- The NL 269 complaints reported to the Department in January 1993[20]; and
- The Sam Nicholl complaint reported to the Department in 1995[21].

The NL 157 complaint reported to the Department in March 1984

24 This complaint and the SWAG handling it has been considered in detail by Mr Chambers in his statement dated 15 April 2015. The complaint had involved allegations of soap or shampoo being placed in the child's mouth to deal with swearing. Assertions were also made about the use of an unsuitable room for children who were given 'time out' and consumption by the children of donated food that was past its sell-by date. Whilst there were some differences in the respective understanding of the agreements made between the Board and SWAG in the handling of this, two Social Work Advisors (SWAs), Mr Chambers and Mr Walker liaised with the Board and the home in the investigation of the concerns. The ultimate consequence was that a member of Nazareth Lodge's staff was reprimanded and the child and his family appeared to be content with the outcome and that their concerns had been addressed.

25 The NL 157 complaints had plainly been viewed to be of a sufficiently serious nature for the DHSS to conclude that such liaison was necessary and the Department is content that SWAG acted in a satisfactory manner. The investigation of the complaints did not indicate any systemic failures on the part of the DHSS in respect of its regulatory responsibility for the home or on the part of Nazareth Lodge in relation to governance issues. In view of the fact that appropriate action was taken by the Officer in Charge to discipline a staff member, no further action by SWAG and the DHSS would have been necessary in relation to this matter.

The HIA 210, NL 145 and NL 97 complaints reported to the Department between May and December 1985

[16] SNB 18980-19011
[17] SNB 19013-19068
[18] SNB 19030-19068
[19] SNB 19042-19068
[20] SNB 19070
[21]

26 The HIA 210, NL 145 and NL 97 complaints amounted to allegations of serious physical assault. Each of the young people alleged that other children in the home had also been physically abused.

27 The HIA 210 incident was notified by the DSS to the Chief Social Work Advisor (CSWA) in May 1985 seeking advice on "the appropriate action that should be taken in the matter." The CSWA advised that the complaint should be investigated under the procedures laid down in the 1985 Circular. The EHSS made an initial investigation and although staff denied the allegations, the Board's view expressed by letter in December 1985 to the CSWA was that there was some substance to John's complaints. The December 1985 correspondence also notified the CSWA of the NL 145 complaint. The EHSSB outlined the action taken and listed 4 issues related to the need to interview staff and former staff in the home and suggested that the DHSS "was in the best position to follow up these issues with the appropriate officials".

28 The CSWA replied in January 1986 to the Board stating that the complaints should be "investigated and dealt with in the first instance by the Board and the administering authority". The outcome was to be reported to the DHSS to enable consideration of the "relevance and importance of issues involved to the current and former operation of the home".

29 The EHSSB responded to the CSWA in January 1986 stating that the two young people who had made the allegations had alleged that other children in the home were subjected to the same treatment, therefore the issues had moved from *'the particular'* to *'the general'.* The CSWA replied in February 1986 that there was *"no new information"* that would lead SWAG to alter its views. The Board was again referred to paragraphs 28 and 29 of the 1985 circular.

30 In April 1986, the EHSSB reported to the DHSS that NL 97, who had been named as a witness by HIA 210 had confirmed the physical abuse by Nazareth Lodge staff of himself, HIA 210 and other children. The Board stated that it did not consider it had the authority to interview senior staff in the home as *"they were neither employers of the staff nor the registering authority".* The Board also made further reference to general allegations of malpractice and assault.

31 It should be noted that SR 143 had been the Officer-in-Charge of the Nazareth Lodge home until October 1985 when she was elevated to Regional Superior in Ireland. It would appear that at some stage after her move she was asked by the CSWA to carry out an investigation into the allegations. Her report, in which she confirmed that she had spoken to all

Sisters and members of staff employed in Nazareth Lodge during the relevant period, was completed in July 1986. All had denied the allegations. This was forwarded to the Board for comment. The Board responded that the SR 143 investigation did not lead them to conclude that the allegations of brutality were not substantiated. It proposed that the police should be involved and children and parents should be given the opportunity to make complaints with the assistance of staff. A meeting took place between SWAG and the DHSS on 20 October 1986 to discuss the way forward. There are no notes of this meeting on file. In a letter dated 23 October 1986 to SR 143 , SWAG advised her that the Board did not share her views that the allegations of brutality were not substantiated and that they intended to inform the children of their rights to have these incidents referred to the police. A copy of the letter was sent to the EHSSB. Departmental information in relation to the HIA 210 , NL 145 and NL 97 complaints concludes with a letter from DL 518 dated 5 March 1987 in which he stated that two of the young people, NL 97 and NL 145 wished to make a complaint directly to the police and "*We are assisting them in doing so".*

Comment on the handling by SWAG of the HIA 210 , NL 145 and NL 97 complaints

32 During the period of the correspondence between the EHSS and SWAG it should be noted that there were numerous contacts between SWAG and the child care policy branch and the home. Nazareth Lodge had been inspected in October 1983. In November 1983 a meeting was held between the Department and the home, to consider amalgamation of Nazareth House and Nazareth Lodge due to closure of the former. It would appear that there was ongoing discussion between the home and SWAG, as a decision on a grant aid application by Nazareth Lodge had to be postponed until matters raised by the inspection had been considered by the Sisters.

33 A monitoring statement that was returned to the Department by Nazareth Lodge in December 1983 indicated that there had been joint considerations in relation to the number of children's places offered by the home. The Billy Mullaney allegations brought further contacts between SWAG and the home throughout 1984. In November 1984, SR 143 sought SWAG support for in-house training of staff.

34 In the Spring of 1985, Mr Walker, SWA visited to consider with the Nazareth Lodge staff the implementation of the 1983 inspection recommendations. In July 1985 SR 143 wrote to the DHSS confirming that procedures for the receipt and monitoring of complaints had been established in Nazareth Lodge. She also returned monitoring information to the Department. In September 1985, the Department requested further information to be

provided by the home in respect of the care regime and treatment methods used; hygiene standards; maintenance of statutory records and procedures for approving volunteers. Mother Mary took up her post as the new Officer in Charge in October 1985. Nazareth Lodge returned the further monitoring information required in December 1985.

35 Following the NL 145 complaint which had been received in December 1985, a SWAG inspection was carried out in January 1996[22]. Unfortunately the Department no longer holds the report but there is a letter on file from SR 143 dated July 1986 which details the progress of the home in implementing the nine recommendations of the January 1986 SWAG report. These included action on staffing increase; staff salaries; establishment of a management committee; appointment of Deputy Head; establishing mixed groups; regularising the role of the visiting social worker in accordance with the regulations; meeting with DHSS re monitoring arrangements; staff attending in-service training courses and seconding staff to professional training. An SWA met with the home in August 1986 to discuss the January 1986 inspection and a monitoring meeting took place in which the Department undertook to provide Nazareth Lodge with guidance on forming a management committee (a recommendation of the SWAG report) and provide them with a procedural guide on Community Homes Design and handbook on staffing. An issue was also raised about the potential for EHSS to establish a social worker liaison arrangement with the home.

36 There is ample evidence therefore to suggest that SWAG and the Child Care Policy Branch of the DHSS had close contact with the home during the period that the above complaints occurred and were maintaining a significant degree of familiarity with the situation in Nazareth Lodge. The guidance in the complaints procedures stated that complaints should be referred to the management committee of the home. At that time Nazareth Lodge had not established a management committee and SWAG requested SR 143, the then Regional Superior and regional representative of the Sisters of Nazareth Order, to carry out an investigation of the allegations. SR 143 had, of course, recently been the Officer in Charge of Nazareth Lodge although it is not certain whether she was in charge of the home during the period to which the allegations referred. With hindsight it might have been better for SWAG to have asked the administering authority to appoint a more independent and professionally qualified person to carry out the investigation and for that person to have been more distant from the operational management of the home.

[22] This should read '1986'.

37 Having reviewed the correspondence between the Board and SWAG in relation to the complaints, the Department is in no doubt that responsibility for the investigation of such matters rested solely with the Board and the Boards responsible for the care of the other children/ former residents of Nazareth Lodge. Indeed, the allegations made by the three latter young people were about serious physical abuse. They also alleged that other children had experienced similar treatment. If this had turned out to be the case, following the Board's investigations, SWAG had expressed the willingness of the DHSS to consider the implications of the findings for the current and former operation of the home. It is also significant that immediately following the NL 145 complaint, reported to SWAG in December 1985, an inspection of the home was carried out in January 1986. The DHSS was clearly keeping the situation under review. In a summary of events dated 6 June 1986, and prepared by Dr McCoy for the CSWA[23], he observed that the 1983 and 1986 inspections had *"made no adverse comments about the harshness of the regime"* and acknowledged that the home was "*receiving an increasing number of difficult and disturbed children".* Dr McCoy also noted that Policy Branch had agreed that there were "*insufficient grounds for the Department to become involved in the home over and above our annual inspections and scrutiny of their monitoring arrangements."* Nevertheless once it had been established that the allegations were about physical abuse, it might have been more helpful if SWAG had reminded the Board of its duties and powers under the 1968 Act in respect of child protection and considered with them whether the investigation might be more usefully progressed under child protection procedures, in addition to referring the Board to the complaints circular.

38 With reference, in particular, to the Board's concerns about not having the authority to interview senior or former staff, as noted above, in situations where a child might be in need of care, protection or control, the Board had the power under the provisions of the 1968 Act to *"cause inquiries to be made into the case unless satisfied that such inquiries are unnecessary".* Interviews of senior and former residential care staff would not have been precluded by this provision.

39 Finally, it is noted that SWAG met with the Board to discuss the issue of the Nazareth Lodge allegations in October 1986, some 17 months after the more serious allegations had been notified to the DHSS. This was also a significant period of time after the tensions regarding the respective roles of the Board and the Department in these cases had begun to emerge. Despite SWAG's referral of the Board to the section of the complaints guidance, which stated that the Board could assist a voluntary home in its investigation

[23] SNB 19050

of complaints, the Department does not have any information to indicate whether the Board offered such assistance. It is possible that if SWAG had assisted the process by convening a meeting at an earlier stage and, if necessary, mediating between the Board and the administering authority to encourage the establishment of a joint approach this might have assisted earlier agreement on the way forward. This would not have been incongruent with the support, advisory and consultative role of SWAG, considered below. Most importantly, it is possible, although obviously not certain, that this might have resulted in a more timely response and resolution for the young people who had complained and those who were alleged to be at continuing risk of abuse. The model adopted by the management committee and Boards in respect of the investigation of the 1995 complaint (see below) is an example of how a joint voluntary and statutory approach was plainly a more robust process that was capable of delivering more acceptable outcomes.

40 Whilst having pointed up some of the possible shortcomings in the approach of SWAG to these matters, the Department is of the view that in relation to the handling of the above complaints there was no evidence of systemic failure on its part nor was there failure in respect of its governance or regulatory responsibilities in relation to Nazareth Lodge children's home.

41 With reference to the final question of the HIAI regarding the options open to the Department if concerns about the behaviour of staff were brought to its attention, the Department was not the employing body and, if the issue required staff training, supervision or disciplinary action, could only encourage an appropriate response on the part of the voluntary body. However if, for example, the Board's investigation in the above cases had found the staff problems to be serious and endemic, the ultimate sanction that the Department would have had at its disposal at the time would have been to de-register the home. The Department no longer holds registration responsibilities for voluntary homes. The Regulation and Quality Improvement Authority which is the body currently responsible for the registration and inspection of voluntary and statutory children's homes has a range of regulatory sanctions which may be imposed prior to the decision to de-register a home.

DL 518 comments in his statements dated 25 March 2015 and 3 April 2015 regarding the HIA 210, NL 145 and NL 97 allegations.

42 The allegations of NL 97 were significant and the child had named ten other children who were in Nazareth Lodge with him and whom he alleged may also have been abused. The Department takes issue with [redacted] DL 518 assertion at paragraph 2.2 of his statement in which he claims that

"*the complaint not only contained allegations of physical and emotional abuse of HIA 210 [HIA 210] and 10 other residents but also indicated general malpractice in the home".* The Department received no indication at any stage that the ten other residents had been interviewed and supported HIA 210 allegations by alleging that they had been subjected to similar experiences.

43 Having received the complaint from NL 145, who alleged that two brothers and a black boy had received worse abuse, DL 518 states in paragraph 2.8 of his statement *"by this stage we now had 2 complainants and a minimum of 14 children identified as possibly having been abused."* In paragraph 2.20 DL 518 asserts that by virtue of the Board having received a further allegation of physical assault, two further children were mentioned as possible complainants, "*which now brought the minimum number to 16 not forgetting the group of children who were beaten with a stick, some of who may have been included in the 16. Also there were two named alleged perpetrators and one unknown all working in the same unit at the time".*

44 In the absence of each of the children having been interviewed, it is difficult to comprehend how DL 518 came to such firm conclusions, nor does the Department understand if it were indeed the case that so many children were alleging abuse, why the Boards concerned did not immediately jointly instigate child protection investigations.

The 1993 NL 269 complaint

45 This issue has been considered in detail in the statements of Dr McCoy, Mr Chambers and Miss Reynolds. There is no need to rehearse the facts here other than to confirm that there was and is no policy that requires child protection concerns to be submitted to the Department in writing before they can be actioned. As Dr McCoy has stated, the concerns expressed by Mr Gilmore should have been conveyed to the administering authority of the home and the outcome recorded. SSI may ultimately have taken this course of action but in view of the limited information that has been preserved in DHSS files, the Department is unable to determine with certainty that this did or did not occur. In view of the thoroughness with which the 1993 inspection was conducted and the follow-up arrangements, the Department does not, however believe that any shortcomings in this matter signified systemic failure on its part or failure to discharge its regulatory responsibilities.

The 1995 NL 164 complaint

46 A series of complaints regarding the care of NL 164 l and care practice in general on the part of one member of staff was notified to the SSI inspector during her 1995 inspection of Nazareth Lodge. The inspector immediately

referred the matter to the administering authority of the home, the Eastern Board and its Trusts who had children placed in Nazareth Lodge and asked that a report be provided to her when the investigation was complete. As a result, a panel which included a member of staff from the Board and a member of the Nazareth lodge management committee was established to investigate the complaints.

47 The Inspector had acted with timeliness and communicated the complaint appropriately to each of the responsible bodies. These in turn, in accordance with the Board's statutory and the voluntary agency's regulatory responsibilities, took the complaint forward in an appropriate manner. The investigation concluded with the resignation and removal of a Sister from the home. In view of the limited information retained on the Departmental files, the Department is not aware if, in accordance with the Inspector's request, SSI received a full report of the investigation.

Any other information of relevance to the HIAI

Inspection of children's homes functions within MoHA, SWAG and SSI during the 1922-1995 period

48 In its written and oral evidence to the HIAI, the Department has conceded the findings of the Hughes Inquiry in relation to the inadequate nature of its predecessors' programmes of inspection until the early 1980s. The conclusion reached by Hughes in relation to inspections of Nazareth Lodge reflected the Committee's general findings of an unsatisfactory record of SWAG in this area. The Department did not challenge the Hughes finding and had, as previously testified to the HIAI, by the time of the publication of the Hughes report in 1986, instituted a radically revised programme of inspection of both statutory and voluntary homes. This approach continued to develop in terms of refining and improving inspection methodology and expectations of professional standards of practice in residential care until responsibility for inspections of children's homes passed in 1996 to HSS Boards.

The inspection functions of the DHSS from 1972 to the early 1980s

49 Continuing scrutiny of the historical information received from the HIAI together with the need to revisit Hughes Inquiry documentation led the Department to question why a significant shift occurred in its exercise of children's homes inspection functions during the above period. From the evidence received so far, it would appear that whilst lacking in thoroughness of methodology, inspections of voluntary children's homes were carried out by MoHA inspectors on an annual basis. This pattern may have been continued for a few years by former MoHA personnel on their transfer to the Social Work Advisory Group in 1972. However, it will have been apparent to

the HIAI from the testimony of Mr Denis O'Brien that former child care Social Work Advisors had advisory functions and liaison responsibilities with voluntary and statutory providers across the whole range of children's social care services. This included, but was by no means confined to residential care services. In his oral evidence to the Hughes Inquiry, Mr Pat Armstrong, the then Chief Social Services Advisor stated:

"*.... Social Work Advisors on the child care side have a range of duties as well as inspections. Inspections are only part of their duties and they have got to allocate their time as appropriate, depending on the demands of other parts of the service, like policy and planning, like membership of working groups on various aspects of child care; a whole range of functions."*[24]

50 Mr John O'Kane, a former Social Work Advisor whom the Department understands may have undertaken at least four visits to Nazareth Lodge during the 1972-1983 period and at least two visits to Nazareth House , testified to the Hughes Inquiry with reference to his immediate responsibilities on appointment to SWAG:

"I was given certain tasks. The one that I remember best was to look at the provision for day care of children under five in the Eastern Health and Social Services Board. That entailed visiting facilities throughout the Board's area."[25]

"I think it was a prelude to the issuing by the Department of a document on day care provisions and education for under-five-year-olds." [26]

51 During the 1973-1983 period, the work of SWAG, in comparison with that of the children's inspectorate within MoHA was therefore characterised by wider childcare consultation and advisory responsibilities and periodic visits to, but fewer inspections of children's homes. The Department was unable to find explanation for this obvious but evidently quite deliberate change of policy either in its archived material or from former SWAG employees. Being aware of the former existence of a Social Services Inspectorate within the former Department of Health in England (SSI, England) the Department sought clarification of the position there prior to the establishment of the SSI and was referred to Mr Arran Poyser a former Inspector with SSI, England. Mr Poyser was helpfully able to inform us that the predecessor to SSI in England was the Social Work Service, established by the Westminster Government as part of its response to the 1968 Report of the Committee on

[24] Annex G - Pat Armstrong's Oral Evidence to the Hughes Inquiry Day 8 - 6 September 1984 page 13
[25] Annex H - John O'Kane's Oral Evidence to the Hughes Inquiry Day 9 - 7 September 1984 page 5
[26] As above footnote 24

Local Authority and Allied Personal Social Services, chaired by Frederic Seebohm (the Seebohm Report)[27]. The Seebohm Committee was appointed

"to review the organisation and responsibilities of local authority personal social services in England and Wales and to consider what changes are desirable to secure an effective family service"[28].

52 As a consequence of the Committee's recommendations, social care services for children and families, the elderly, disabled people and those with mental health needs which had formerly been administered by separate local authority departments in England and Wales were brought together into newly created social services departments with the aim of enabling *"the greatest number of individuals to act reciprocally, giving and receiving services for the well-being of the whole community"*[29].

53 The Seebohm Committee considered the implications for central government of such new structures and recommended that one central government department should be "*responsible both for the relationship between central government and the social services departments which we have proposed and to provide the overall national planning of social services, social intelligence and social research."*[30] The Department believes that the following further conclusions of the Seebohm Committee may be of significance to the considerations of the HIAI in terms of its consideration of the role of SWAG during the above critical years:

"In order to carry out its functions effectively, the central government department concerned must have a strong, accessible and well-respected inspectorate to advise local authorities, to promote the achievement of aims and maintenance of standards and to act as two way channels for information and consultation between central and local government"[31].

and

"It does not necessarily follow that the new inspectorate would adopt the methods of any one of the present government departments concerned. We see the role of the inspectorate not so much as regulatory as promotional, educative and consultative ..... Its help would be particularly valuable in the early stages of the development of the new service and for that reason it is

[27] Report of the Committee on Local Authority and Allied Personal Social Services HMSO London 1968 'The Seebohm Report'.
[28] Seebohm Report page 11 paragraph 1
[29] Seebohm Report page 11 paragraph 2
[30] Seebohm Report page 194 paragraph 637
[31] Seebohm Report page 197 paragraph 647(c)

vital that the Government should take early action in setting up a new body of inspectors .... We would hope to see some of them with experience both in field work and in administration and free movement between the central government inspectorate and local authority services encouraged".[32]

54 To assist our further understanding about the role of former MoHA children's inspectors and SWAG in relation to the situation that pertained in England at the time regarding children's homes, the Department was helpfully referred by Mr Poyser to Sir William Utting, the Chief Officer and Director of the Social Work Service in the Department of Health and Social Security 1976-1985 and a former Chief Inspector, SSI England 1985-1991. By letter dated 4 February 2015[33], I wrote to Sir William and set out the Department's premise about the possible influence of Seebohm and sought additional information about the profile of children's homes inspections in England which were of interest to the Department. Sir William responded by letter dated 6 February 2015[34]. He stated that he believed Seebohm directly influenced DHSS[35] thinking about the role of the new combined Social Work Service:

" *... the advice about this role being 'not so much regulatory as promotional educative and consultative' appears to have been particularly significant. My later understanding of DHSS thinking in 1971 was that the big new social services departments should not need close government oversight. This was reinforced by the prevailing professional dislike of the concept of inspection".*

55 Sir William's responses to the Department's additional questions may also be of interest to the HIAI[36].

56 The major reorganisation of health and social care services in Northern Ireland in 1972, which led to significant changes to the structure and administration of regional social care services was plainly directly influenced by the Seebohm report. Having received Sir William Utting's reply, the Department believes it is most likely that the contemporaneous changes in Northern Ireland were an endorsement by the DHSS of the recommendations of Seebohm. Children's social care services transferred from MoHA to the newly created Department of Health and Social Services which was to be responsible for strategic planning of all the social services, supported by a new inspectorate with a revised focus on advisory,

[32] Seebohm Report page 197 paragraph 647(c)
[33] Annex I
[34] Annex J
[35] The Department of Health and Social Security, England
[36] See Annexes I and J

consultation and support functions. Like England which adopted the name 'Social Work Service', Northern Ireland rejected the term 'Inspectorate' suggested by Seebohm and established the 'SWAG' as a professional grouping within the newly created Department.

57 It is evident that SWAG attempted to combine the functions of advice and inspection although, as was the situation for the SWS in England, these tasks were not evenly divided. Whilst inspections of children's services remained a function of the SWS it is not known how frequently this was exercised:

"The Social Work service established its own style combining periodic use of the Secretary of State's inspection powers with the development of a strong advisory and developmental culture. The latter was unquestionably dominant, reflecting the nature of its founding. Inspections were generally reserved for programmes inherited from the Home Office, linked to the Secretary of State's regulatory responsibilities for children's services (particularly in the voluntary sector) and for the joint inspection of community Homes with Education on the premises conducted jointly with her Majesty's Inspectorate for Schools".[37]

58 The Department has examined the written submissions and oral evidence given to the Hughes Inquiry by former members of SWAG and former senior civil servants in the then DHSS. Whilst there are references to the impact of Seebohm on the social services here, there is no reference in the evidence given to the Hughes Inquiry to the Seebohm report in relation to the role of SWAG.

59 As stated above, SWAG was found by the Hughes Inquiry to have had an unsatisfactory record in terms of the rigour of children's homes inspections and particularly during the 1972-1983 period, the infrequency of inspection activity. The DHSS's explanations for the latter tended to focus on Departmental resourcing issues[38]. It would appear, however, that the implications of the Seebohm report for the intended role of SWAG were either not known or not communicated by personnel who provided evidence to the Inquiry.

60 The Department believes that this was an important factor, which had it been made known to the Hughes Inquiry might have provided a more cogent explanation for the lack of inspection activity than was provided and might have led to the placing of more value by the Inquiry on the nature of the visits to children's homes by SWAG which took place during this period. Rather

[37] Annex K The Social Services Inspectorate: A History (Page 8) Department of Health 2004
[38] Annex L Mr Armstrong's evidence to the Hughes Inquiry (Page 13 Day 7)

than the infrequency of inspection being a resourcing issue, SWAG, by focusing on supportive and advisory relationships with both voluntary and statutory providers of child care services and by assisting the department in the social work aspects of its functions was implementing a Departmental policy which had also been promoted by the UK government.

61 It is noteworthy that in her evidence to the Hughes Inquiry, SR 143, the then Officer-in-Charge of the Nazareth Loge confirmed that Mr O'Kane (SWAG) and Miss Forrest (formerly MoHA, then SWAG) had been frequent visitors to the home[39]. She also stated that shortly after she arrived in 1982, she had received a visit from Mr Walker (SWAG), accompanied by an officer from the Child Care Branch and they "*discussed the changing practice of child care ... and how much had changed in that it was now more difficult for children coming into care and that kind of thing and how important it was to consider staff training and that.*"[40] SR 143 also confirmed that pre-1982 'people from the Department' also *"made recommendations in writing from time to time".*[41] The Department believes that such relationships were characteristic of the policy at the time, that these were perhaps of more value to providers than the previous models of inspection activity and served, as Seebohm had envisaged, to "*promote the achievement of aims and maintenance of standards and to act as two way channels for information and consultation between central and local government.*"

62 The role of SWS, England was already evolving and whilst there was to be no change to its traditional role, as described above, the Director of the Social Work Service signalled to Local Authorities in 1979 that in future the work programme would included certain activities based on inspectorial powers. In 1982, the Social Services Committee of the House of Commons "favoured the idea of an inspectorate based on the present SWS"[42]. In April 1983 the then Secretary of State responsible for personal social services issued a consultation document proposing the development of the SWS into an inspectorate for the local authority social services. The SSI in England came into being in February 1985. In Northern Ireland, following the Kincora scandal and the revelations that children from other homes had been abused, the SWAG had already effectively become an inspectorate in practice, if not in name, with particular reference to children's homes and children's social care services. In the latter part of 1986, SWAG was renamed the Social Services Inspectorate for Northern Ireland.

[39] SNB 50779
[40] SNB 50779
[41] SNB 50780
[42] Annex K page 8

Signed: 

Dr Hilary R Harrison

Date: **24 April 2015**

16/7.

D-r Clk & Cog

To discuss on your return

SR

10 JUL 86

NAZARETH HOUSE,
CHURCH HILL,
SLIGO.

3rd July, 1986.

gja 10/7

Mr. P. Armstrong,
Chief Social Work Adviser,
Department of Health and Social Services,
Dundonald House,
Upper Newtownards Road,
BELFAST. BT4 3SF

Dear Mr. Armstrong,

I wrote to you on 22nd May, 1986, in respect of the previous correspondence about alleged incidents having taken place in Nazareth Lodge some time ago. I have conducted exhaustive enquiries about this matter and I have interviewed the following people -

NL 66 [redacted] - interviewed 25.6.86 - worked in Nazareth Lodge 1973-76, and in 1979.

NL 32 [redacted] - interviewed 24.6.86 - worked in Nazareth Lodge 1979-82.

NL 146 [redacted] - interviewed 24.5.86 - worked in Nazareth Lodge 1978-81.

NL 147 [redacted] - interviewed 23.5.86 - worked in Nazareth Lodge in child care - still employed.

[redacted] - interviewed 23.6.86 - Principal, Bethelem Nursery School, and also worked in Nazareth Lodge.

SR 29 [redacted] - interviewed 26.6.86 - worked in Nazareth Lodge for a period of years until August 1984.

SR 62 [redacted] - interviewed 8.6.86 - now retired - worked in Nazareth Lodge in the late 70's and early 80's.

I saw each person individually and I conducted the interview informally so as to set the interviewees at ease. I also conducted the interviews in a format to take account of the complaints raised specifically in your letter of 27th May, 1986, numbered 1 to 8, and of the additional allegations appearing in the several reports made available to you by the Director of Social Services of the Eastern Health and Social Services Board.

i) In respect of the allegations that SR 62 had punched HIA 210 on the nose, none of the persons interviewed could substantiate this statement and equally none of the persons interviewed had ever seen any evidence or incident which suggested that this had taken place. The point was made to me that HIA 210 had been subject to frequent nose bleeds sometimes at night and sometimes during the day but as he grew older these nose bleeds stopped.

ii) None of the persons interviewed could throw any light on the allegation that NL 97 was struck by SR 62 and as a consequence banged his head off a wash hand basin. SR 62 expressly denies that this ever happened. NL 147 however said that she had heard that there had been an accident in the bathroom on an occasion but she did not know what it was. Let me reiterate however that no-one recollected the outcome of any such accident.

NL 146 recalled that HIA 210 and NL 97 had a head-on collision which resulted in HIA 210 getting black eyes.

iii) None of those interviewed had any knowledge of beatings as described. All acknowledged that a child might get a smack on the back of the hand and NL 66 said that on one occasion she saw SR 62 give HIA 210 a slap on the hand with a wooden spoon. SR 62 herself acknowledged that she did use a wooden spoon on the hand on a few occasions. The particular incident recalled by NL 66 occurred in the kitchen where SR 62 was working and at the time HIA 210 was misbehaving. NL 147 also said that she saw SR 62 give HIA 210 a "box on the ear" once because he gave cheek and answered back.

iv) None of those interviewed had ever witnessed a child being locked or placed in a cupboard. It was confirmed by most of those interviewed that the form of discipline was that a child might be made to stand for a short period either in the corridor or in the study room or that certain privileges or treats would be withheld. NL 147 did however say that HIA 210 may have been made to stand inside a store room for 5-10 minutes with the door ajar and she said that the light switch is inside the door. She herself did not see this incident.

v) None of those interviewed could substantiate the allegation that HIA 210 was made to sleep in the bathroom as a punishment overnight. All said that they did not believe that such an incident could take place.

vi) None of those interviewed could substantiate the statement in respect of the cold baths used as a punishment and once again all stated that they did not believe that it would take place.

vii) None of those interviewed had ever witnessed or been aware of any child being deprived of food and expressed the view that this did not happen.

viii) No-one was aware of the alleged incident in respect of serving and eating of liver. SR 62 expressly denies that this event ever took place.

I also put as a general question to all those interviewed had they ever witnessed any beatings, brutality or abuse of the children in the Home. They all responded that they had not. Several mentioned that a child could be smacked usually on the hand for misbehaving but that such an event was very rare. Mention was also made of SR 62 having on one occasion hit with a wooden spoon when she was in the kitchen and SR 62 herself acknowledges that this took place and that on a few other occasions a similar thing happened. The reaction of those I interviewed was frankly one of disbelief that such allegations were being made but they understood the need for thorough investigation of such matters and co-operated with me during the course of the interviews.

In respect of the mention made by NL 145 the persons interviewed expressed surprise at the allegation. Most stated that NL 145 had been a quiet girl and did not require correction. No-one could substantiate the allegation that she had been required to lie on a bed and there was no recollection of the allegation made by NL 145 that boy was beaten.

Having completed what I regard as a very thorough investigation of the alleged incidents and recognising the difficulty of dealing with such matters after a lapse of time, I took the view that the allegations of brutality are not substantiated and did not take place. For example there was a suggestion that NL 97 had been beaten by SR 62 and had bruised his thigh. It has been established that SR 62 herself brought in the Social Worker at that time to enquire into the allegation and after enquiry it was admitted by NL 97 that he had not been beaten and that the bruising had occurred as a result of an injury.

The relationship with SR 62 seems to have been very close with a number of the children. She exhibited maternal instincts of care but did on a few occasions smack or beat the children on the hand with a wooden spoon. She should not have acted in this way but in my judgement these events were not regular and most certainly did not warrant any suggestion of brutality.

SR 62 herself is astounded at the allegations and deeply worried that such statements should be made. In a letter to me she reiterates her concern about the welfare and well-being of the children in her care and the comment of all those whom I interviewed substantiate this care and consideration.

Could I say once again that the policy of the Order does not permit any physical abuse of children and that this policy is rigorously adhered to in Nazareth Lodge.

It is my hope that in the light of the exhaustive enquiries made and in the light of the information I have given you it will be possible to satisfy you and the Director of Social Services in the Eastern Health and Social Services Board about the alleged incidents in the correspondence to which this letter refers.

Yours sincerely,

SR 143

Mother Paul
Mother Regional
Nazareth House
Church Street
SLIGO

14 May 1986

Dear

NAZARETH LODGE, BELFAST

On 21 January I wrote to you enclosing copies of correspondence with Mr R Moore, Director of Social Services, Eastern Health and Social Services Board, about the complaints made by 2 residents and asked you to liaise with him about the investigation of these complaints and let me have a report on the outcome.

Mr Moore wrote to me again on this subject on 24 January and I sent copies to you of this letter and my reply to him on 7 February.

Mr Moore has now written to me again and has submitted a report from a social worker on his interview with [redacted] who also alleges ill-treatment during his stay in Nazareth Lodge. A copy of both the letter and report are enclosed for your information.

It would be most helpful in deciding the next steps if you could let me have some indication of the progress of your investigation of these matters.

If you think a discussion would be helpful I would be happy to arrange this.

Yours sincerely

P J ARMSTRONG
Chief Social Work Adviser

23 MAY 86

Tel. 641356

J. M. J. †

Nazareth Lodge,
516, Ravenhill Road,
Belfast BT6 0BX.

22nd May, 1986.

Mr. P. Armstrong,
Chief Social Work Adviser,
Department of Health and Social Services,
Dundonald House,
Upper Newtownards Road,
BELFAST. BT4 3SF

Dear Mr. Armstrong,

I have received your letter of 14th May, 1986, in reference to the enquiries being made about alleged incidents having taken place in Nazareth Lodge some time ago.

I have already spoken to Sisters and members of staff who were employed in Nazareth Lodge during the period and so far I have been unable to obtain any information which supports the allegations. I have also written to SR 180 and received a letter from her completely rejecting the allegations.

What I propose to do now is to speak once again to the members of staff who were employed during the period and put to them the latest information which Mr. Moore has given to you. I intend to document statements made by Sisters and members of staff and I will let you have this information as quickly as I can.

I am sure you will appreciate that it is difficult after the lapse of time to get explicit answers but I can assure you that the Order, and this Home, will make every effort to establish the facts whatever they be. I can also assure you that the policy of the Order, which does not permit any physical abuse of children, is rigorously adhered to in Nazareth Lodge.

I will write to you again as soon as I can.

Yours sincerely,

[redacted]

MOTHER REGIONAL

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 September 1992. 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 ( ) came in high on drugs. NL 269 claims that at the very least 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 . 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.