
HISTORICAL INSTITUTIONAL ABUSE INQUIRY

being heard before:

SIR ANTHONY HART (Chairman)

MR DAVID LANE

MS GERALDINE DOHERTY

held at

Banbridge Court House

Banbridge

on Friday, 8th May 2015

commencing at 10.00 am

(Day 118)

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

Friday, 8th May 2015

1

2 (10.00 am)

3

(Proceedings delayed)

4 (12.20 pm)

5

DR HILARY HARRISON (called)

6

CHAIRMAN: Good morning, ladies and gentlemen. As always,

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please ensure that your mobile phones have been either

8

switched off or placed on "Silent"/"Vibrate", and I also

9

have to remind you that no photography or recording is

10

permitted either in the Inquiry chamber or indeed

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anywhere on the Inquiry premises.

12

Good afternoon, Mr Aiken.

13

Questions from COUNSEL TO THE INQUIRY

14

MR AIKEN: Chairman, can I first apologise for the delay in

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us getting started? I am afraid when we get to the

16

detailed witnesses such as Dr Harrison, sometimes it can

17

take a little longer than we might hope. So I apologise

18

for that.

19

Dr Harrison the Inquiry has heard from twice before

20

--

21

A. Yes.

22

Q. -- perhaps three times -- twice before. This is her

23

third time giving evidence, and she has previously given

24

her affirmation, Chairman.

25

I am going to bring up on the screen just for you to

1 adopt, Hilary -- (Pause.)

2 CHAIRMAN: Yes.

3 MR AIKEN: I am going to bring up on the screen your witness
4 statement for this module of 24th April 2015. If we can
5 bring up, please, 9549, does that resemble the first
6 page of your statement?

7 **A. It does.**

8 Q. And then if we move through to 9571, please, and can you
9 confirm you have signed your witness statement?

10 **A. I have signed it, yes.**

11 Q. And you want to adopt the contents as your evidence on
12 behalf of the Department --

13 **A. I do.**

14 Q. -- to the Inquiry. This statement came, not unusually,
15 Hilary, with significant exhibits to it. Those exhibits
16 run from 9572 to 9862, so in total the documents about
17 300 pages. I think from our discussion there may be
18 some further work that we will allude to as we go --

19 **A. Yes.**

20 Q. -- that the Department is going to continue to do to
21 assist the Inquiry.

22 Given the detail that's available -- and the Panel
23 have had the opportunity to read your statement and have
24 had a lot of evidence around the types of issues that we
25 are going deal with -- I am going to try, as I have said

1 to previous witnesses, to cut right to the chase to
2 reduce the amount of time that you have to sit where
3 you're at. Whenever I am finished the Panel may want to
4 ask you some specific questions as well. I am going to
5 cover some broad categories, but I am going to cut right
6 down to the detail. So you can take it as read that the
7 Panel have already considered the background that's in
8 the material.

9 The first issue I want to talk to you about, Hilary,
10 is about the departmental inspections that were being
11 carried out. I know you were very anxious to clarify
12 something that was said yesterday by my colleague about
13 how the homes had not been inspected between 1950 and
14 1983. In fairness, you have done a lot of work to try
15 and be able to assist the Inquiry with when the
16 inspections happened, but the dilemma that you have
17 faced, which is the same as unfortunately the Inquiry
18 has faced, is that the files that are likely to have
19 existed and contained the type of Miss Forrest,
20 Ms~Wright, Dr Simpson, page and a half type, annual,
21 close type record of how they found the home to be
22 getting on and might have talked about grants issues and
23 those types of -- the files that relate to Nazareth
24 Lodge and Nazareth House have not been found by the
25 Department.

1 **A. Yes. Well, no files relating to Nazareth House have**
2 **been found by the Department. We have been reliant on**
3 **information coming from the evidence submitted to us**
4 **from the Inquiry --**

5 Q. Yes.

6 **A. -- in relation to inspections and so on that took place**
7 **that we were able to gather information about from the**
8 **books held by the Nazareth House Sisters.**

9 Q. Yes. If I put that in context for you --

10 **A. Yes.**

11 Q. -- like we did in Termonbacca, you have gone to the
12 council books and the foundation books for each of the
13 homes.

14 **A. Yes, and visitors' books, where they existed, yes.**

15 Q. And the visitors' books.

16 **A. Yes.**

17 Q. You have identified the lines such as "Miss Forrest
18 called today" or "The people from Stormont were down
19 today" --

20 **A. Yes.**

21 Q. -- that type of record.

22 **A. Yes.**

23 Q. What you are in a position to say, if we look at
24 paragraph 2 and 3 of your statement at 9550, please, is
25 that from the material outwith the inspection file and

1 the inspection reports itself you have been able to see
2 that the Ministry of Home Affairs visited Nazareth House
3 in 1953 twice; visit again in 1964, '65 and '66. In
4 respect of Nazareth House you are going to look in
5 detail at the council books and foundation books to see
6 the further occasions that are listed that would,
7 therefore, give rise to the indication that
8 an inspection took place, and if one had the file, we
9 would have a report of a page and a half a couple of
10 days or a week or two later.

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

12 CHAIRMAN: Sorry. The document on the screen is not the one
13 we have. Our Bates number copies are 9375.

14 MR AIKEN: What -- I wonder if --

15 CHAIRMAN: Now the content appears to be the same.

16 MR AIKEN: Yes, but the references won't be there.

17 CHAIRMAN: And paragraphing is different and pagination is
18 different.

19 MR AIKEN: I wonder if we could rise for a short time just
20 to fix that for you, because the version I am working
21 from is the one that contains all the references added.
22 That will make life very much easier for the Panel.

23 CHAIRMAN: Very well. We will just rise for a few minutes
24 to have hard copies of that run off for us.

25 (12.20 pm)

1 (Short break)

2 (12.30 pm)

3 MR AIKEN: Apologies, Members of the Panel, for that false
4 start. What has happened -- I am going to work from the
5 up-to-date version of the statement, which can be found
6 at 9549 to 9571. When I say up-to-date, what
7 Dr Harrison has done, which was to be for everyone's
8 ease, was add into the already filed statement the
9 references in the evidence bundle, so that one wasn't
10 finding a reference to a document but then not knowing
11 where to find it, given the volume of exhibits that
12 there are.

13 What appears to have happened with the updated
14 version, a return character has been hit at an early
15 point in the statement which drives it one paragraph
16 further on than the original version, which is also at
17 an earlier point in the bundle, which the version that
18 you have. So between us we will get to the right
19 passage, because, as I understand it, Hilary, the text
20 hasn't changed.

21 **A. It hasn't.**

22 Q. It is just the formation of the footnotes, because
23 a number of them have been taken out and put in --

24 **A. And amplified.**

25 Q. -- as part of an appendix to the report.

1 **A. Yes.**

2 Q. Then we have that one return at paragraph 3 that creates
3 the difficulty. So we will work with that, and if we
4 get into difficulty, we will find a way through it.

5 So what I was talking to you about first was the
6 inspections that were taking place in the Ministry of
7 Home Affairs, and really the material that has been
8 available to the Inquiry is the inspection report from
9 1983, and prior to that there are no reports available
10 other than Miss Forrest's generic note that covered
11 a series of homes in 1953, which involved the same -- we
12 have looked at it in earlier modules, her assessment of
13 the various homes. Then from '83 onwards we have got
14 various SWAG reports, but not a complete set.

15 **A. That's correct, yes.**

16 Q. As far as the inspections that took place prior to 1983
17 in respect of Nazareth Lodge you have been able to do
18 a full assessment of the materials available, looking at
19 the Nazareth Lodge council books, foundation books,
20 visitor books. If we can bring up Annexe C to your
21 statement, please, which is at 9576. You cover this in
22 paragraph 6 of the body of your statement, but if we can
23 bring up 9576, please, what you have prepared for the
24 Panel from the material that's in the Inquiry evidence
25 bundle that has been gathered by the Inquiry is a list

1 of all those occasions whenever reference is made to
2 visitations or inspections by the Ministry personnel in
3 Nazareth Lodge from 1950 onwards.

4 **A. Yes. That's right, and there are significantly more**
5 **inspections and visits than actually reported in Annexe**
6 **C.**

7 Q. So there are more --

8 **A. There are more to come, yes. That's right.**

9 Q. So this is a work in progress based on working your way
10 through the evidence bundle?

11 **A. Exactly.**

12 Q. But what you're in the position to show to the Panel at
13 this stage is that inspections were taking place roughly
14 annually?

15 **A. Yes. That's right.**

16 Q. Through the years through the '50s and '60s and up to
17 1972?

18 **A. That's right.**

19 Q. If we scroll down -- just if we scroll down the page,
20 please, so the Panel can see the references, and the
21 difficulty we have, Hilary, is that there would -- if
22 matters followed a similar pattern to other homes that
23 we've looked at, there would have been a report that
24 matched the years that we are seeing references made to
25 inspection by Ms Hill or Dr Simpson or by Miss Forrest,

1 but when we scroll on to the next page, please, the
2 references that you can find stop in 1972.

3 **A. That's right.**

4 Q. What you have explained -- and I am not going to go into
5 the detail of it today -- but what you have explained to
6 the Panel towards the end of your statement is why it
7 might be the case that inspections were not happening in
8 the same way from SWAG was introduced in 1973 or '72/'73
9 with the reorganisation. That was to do with the
10 Seebohm report and the idea of setting up an advisory
11 group within social work within the Department looking
12 after Social Services. That was not -- in the initial
13 working out of Seebohm that was seen to be it shouldn't
14 be seen as an inspectorate; it should be seen as
15 an advisory body there to assist with a wide range of
16 matters --

17 **A. Exactly.**

18 Q. -- not just inspecting children's homes. Now if that
19 analysis is right, of course, that doesn't negate the
20 obligation that was on the Ministry and then the
21 Department to ensure the home was being run in the best
22 interests of children and to exercise as they saw fit
23 the statutory power to inspect. So if it is the case
24 that they dropped away because of this idea of SWAG
25 being more an advisory, that's obviously something

1 that's not ideal.

2 A. Yes. It's not, but I think we've got to remember that
3 the inspection functions and what was seen as
4 a regulatory role was replaced by the supportive,
5 consultative, advisory role and, in fact, if we look at
6 those years '72 to '81/'82, we find that there was
7 a very close -- appeared to be a very close working
8 relationship between SWAG advisers and children's homes,
9 children's residential homes, voluntary homes in
10 particular, and that there were visits and there were
11 several contacts, for example.

12 They may not have been seen to have been inspection
13 visits, and I do fully accept that there should have
14 been some ensuring during those years that homes were
15 adhering to their regulatory responsibilities, but
16 I think the purpose of those visits was to try and
17 encourage and develop practice, develop good practice.
18 Residential care during those years was changing
19 dramatically, and the role of the advisers -- as it
20 would have been incidentally with statutory homes and
21 all social services delivered by statutory agencies --
22 the social work advisers weren't employed solely by any
23 means to advise and consult residential providers. They
24 had a host of responsibilities over the whole range of
25 social services.

1 Q. Yes.

2 **A. So it was a different role. It was not an inspection**
3 **role and it's certainly true that the regulatory**
4 **requirements on voluntary homes were not addressed as**
5 **they ought to have been during that period.**

6 Q. If we take an example, the failure -- the systems
7 failure you have accepted regularly before the Inquiry
8 of the regulator not identifying to voluntary homes the
9 fact they weren't complying with the regulation 4(2)
10 duty is unlikely --

11 **A. That's an example.**

12 Q. -- to have improved during the '70s --

13 **A. Yes.**

14 Q. -- when that advisory liaison was going on --

15 **A. Yes.**

16 Q. -- because we see it actually still deficient --

17 **A. Absolutely, yes.**

18 Q. -- after SWAG commences in 1982, which we'll come to,
19 but the point you are making about this is, as
20 I understand, is that you have got a certain way through
21 demonstrating what you can find from the evidence, and
22 I appreciate quite often it is reading handwritten
23 material, so it is an intensive task. You have found
24 considerable evidence about the annual visits that
25 appear to be taking place to Nazareth Lodge and you

1 anticipate finding the same pattern for Nazareth House.

2 **A. I would hope so, if the same archive material exists.**

3 Q. Yes.

4 **A. Yes.**

5 Q. I think it probably does and is in the evidence
6 bundle now. So it may be it can be taken forward in
7 that way.

8 So breaking it into three parts, there's that part
9 prior to SWAG and the inspections are likely to have
10 taken a similar form and pattern and content --

11 **A. Yes.**

12 Q. -- potentially with the deficiencies you've previously
13 identified in the Rubane module when you had inspections
14 of that type.

15 **A. Of course, yes.**

16 Q. Then you have the second phase, which is when SWAG
17 commences that more advisory function, but again for
18 different reasons won't necessarily have been
19 identifying -- there is no record of it identifying the
20 type of deficiencies in the context of the likes of
21 regulation 4(2).

22 **A. That's right.**

23 Q. Then we get into the post-Kincora phase, when you have
24 inspections reintroduced in a formal way to SWAG to
25 carry out, and they do a system of inspecting all homes

1 between '83 and 86, and then an annual inspection of
2 homes thereafter.

3 **A. That's correct.**

4 Q. The difficulty we have is we have the '83 report. There
5 was it seems according to the work you have done and I'm
6 still -- there's a document, as you know -- you refer to
7 it -- that I don't have, which is about nine
8 recommendations that were made in 1986, which suggests,
9 therefore, there was a report.

10 **A. Yes.**

11 Q. We don't have the report, but we do then have some
12 reports from '89 onwards.

13 **A. We do.**

14 Q. The -- what I want to ask you about briefly, you have
15 heard Mr Chambers and Mr McElpatrick gave evidence about
16 the 1983 inspection and you have had the opportunity to
17 see what I will call the first document of the '83
18 inspection and then the second document, the final
19 version.

20 Cutting to the chase, one can see on one view
21 a watering down, a removal of the strong language of
22 criticism between document one and -- I think you used
23 the word "softening" --

24 **A. Yes.**

25 Q. -- a softening of language. Looking -- looking at that,

1 is that a satisfactory way to have approached regulating
2 a children's home, that you aren't telling them exactly
3 as you find it, but instead sugar -- whatever word you
4 want to use to try and condense down a big subject --

5 **A. Yes, yes.**

6 Q. -- you are sugar coating the bad news and limiting the
7 extent of the recommendations to sort of encourage them
8 along without being too critical or over-critical or as
9 critical --

10 **A. Yes.**

11 Q. -- as you might have found or wanted to be.

12 **A. I have listened to the testimony of both my former
13 colleagues and I suppose I would find it very difficult
14 to add further to what they have said.**

15 I think one of the things that didn't come out in
16 their evidence was that all inspection reports are --
17 where there is one or more inspector involved, they are
18 done in a collaborative way, and often inspectors coming
19 to the same situation, who have had opportunities to
20 experience perhaps different things in the -- during the
21 inspection and different perspectives, may actually feel
22 that what a colleague has said is being over-critical or
23 indeed not sufficiently critical.

24 I would imagine, although it didn't come out in this
25 process, but I have checked afterwards, that this report

1 would have been discussed by both -- both of the
2 inspectors and that there would have been some kind of
3 mediation about what was appropriate language.

4 Now it -- and indeed I have -- I can speak from
5 personal experience on that in that I have done
6 inspections with colleagues, up to five colleagues, for
7 example, in a multi-disciplinary inspection, and each
8 will have a different perspective to bring and some may
9 not have experienced the situation as others experienced
10 it. So I think there's that element that perhaps wasn't
11 discussed yesterday.

12 Having said that, it is unusual for there to be such
13 a wide -- you know, such a change in the content of the
14 report and the way the major issues of concern are
15 explained, but again I think we've got to look at the
16 context of this inspection. It was probably among the
17 first of this type of inspection that had not been done
18 before. There were no standards to inform the
19 inspection process. These weren't developed until 1986,
20 and I had testified earlier that we couldn't find those
21 standards. We have now amazingly been able to find
22 them. Those were the first set of standards that
23 provided a framework for inspectors and also provided
24 a framework for voluntary homes to know exactly what
25 they should be doing and what they should -- what would

1 be expected of them.

2 So you have a series of inspections started off in
3 response to a very tragic situation in one particular
4 home, an ongoing Inquiry, the Hughes investigation
5 ongoing at the time, and I expect that inspectors were
6 kind of feeling their way and trying to tease out what
7 was an appropriate approach, and they were coming from
8 a very -- a very -- as someone has described it, a very
9 kind of light touch approach to a much more rigorous
10 system. You know, I have no doubt that there were
11 discussions along the way about how that might be
12 developed and at the same time bring voluntary and
13 statutory homes along with that process and Boards and
14 administering authorities. I would find it difficult to
15 add any more than -- you know, to what my colleagues
16 have said.

17 Q. That all being said, Hilary, obviously is it not
18 a disservice to the home that you are investigating if
19 you don't tell them plainly what you actually find,
20 bearing in mind all the caveats you have just explained?

21 A. Yes. I think -- I think if we were looking at the
22 situation today, the answer to that is yes. What my
23 colleagues were suggesting yesterday was that the
24 messages were got across in a softer way, that there
25 would have been discussion with the person in charge of

1 the home about the general findings and that issues such
2 as the difficulty that they saw with one particular
3 member of staff, I would be very surprised if that
4 hadn't been discussed. We know that that member of
5 staff actually I think left shortly after the inspection
6 was done to my -- to the best of my knowledge.

7 Q. No, she didn't.

8 A. Oh, sorry.

9 Q. No. SR46 continued in 1984, the inspection having been
10 conducted in 1983. She continued in 1985 and may have
11 stopped in 1986. So that's exactly -- the Inquiry was
12 told, "Oh, well, it would have been the case that ..."
13 There is no record of this serious problem about the
14 head of a unit, who is clearly considered, if the first
15 version is accurate, as not suitable to be the head of
16 a children's unit, ever being tackled with the home
17 or -- and, in fact, this lady appears to have continued
18 to be in that role for at least another three years.

19 A. Uh-huh.

20 Q. The question -- in terms of you want to -- all the
21 caveats you have explained about bringing people along,
22 encouraging them and not wanting to be over-critical,
23 this is someone who is looking after as her job all day,
24 every day a group of children, and the regulator
25 considers that that person is not an appropriate person

1 to be doing that.

2 **A. Yes.**

3 Q. If they didn't tell --

4 **A. Uh-huh.**

5 Q. -- the home that --

6 **A. Uh-huh.**

7 Q. -- is that not a disservice to them?

8 **A. Well, I just wonder. I mean, I have explained that**
9 **inspection was a collaborative process. I -- you were**
10 **-- the 1983 whatever it was that has been described as**
11 **a draft report, an aide-memoire, etc, I'm not sure of**
12 **the extent to which that would have been agreed by the**
13 **other colleague who was -- who was also present during**
14 **the inspection. So to that extent I'm not sure what**
15 **discussions took place after that, whether it was agreed**
16 **that perhaps someone didn't experience the lack of**
17 **competence as one inspector saw it in exactly the same**
18 **way.**

19 Q. Is that not so serious a thing that would you expect to
20 find it on the file if it happened? If a discussion
21 took place between them about the fact that one thought
22 the lead member of staff in one unit was incompetent,
23 and the other disagreed about that, and that, therefore,
24 they weren't going to do something about it -- and
25 I~have to say Mr Chambers was not demurring at all from

1 that was his finding, that was his belief, and there was
2 no suggestion that that had ameliorated in any way.

3 **A. Yes.**

4 Q. He explained it was not in the report because they
5 didn't name a particular member of staff directly in a
6 report.

7 **A. Yes, and that would be true --**

8 Q. You are saying the practice would have been to engage --

9 **A. That would --**

10 Q. -- and all I'm saying is there is no record of any
11 engagement and the person keeps working.

12 **A. Yes.**

13 Q. Maybe they got trained.

14 **A. Yes.**

15 Q. I don't know.

16 **A. Yes. Uh-huh. There is --**

17 Q. Would you not expect there to be some --

18 **A. Well, our records are very deficient. I think it would**
19 **have been appropriate obviously if there had been a very**
20 **great divergence of opinion for that to be recorded and**
21 **also some record of the follow-up or the discussions**
22 **with the person in charge of the home. I agree that**
23 **that would have been appropriate to make those kind of**
24 **records.**

25 Q. The other main issue that comes out of -- because I am

1 not going to go through the detail of that with you in
2 terms of the findings and how they weren't necessarily
3 mirrored then in the final version -- but what's absent
4 from the report, and it was accepted by every Department
5 who has given evidence, about the fact there was no
6 reference at all to the regulation 4 duty to have
7 a visitor appointed for a specific purpose, which was to
8 ensure the home was being run in the best interests of
9 children. A report is compiled every month, given to
10 the administering authority and therefore should
11 an available to be seen by the inspector when they come.
12 That's just not there at all.

13 The question that I wanted to ask you, which we were
14 discussing earlier, was: can you give any assistance to
15 the Panel as to why the regulator wouldn't have
16 considered it necessary to ensure that the mandatory
17 statutory duties were being met?

18 **A. I think in my very first evidence to the Panel I said**
19 **that I found this quite incredible that an inspection**
20 **would be carried out without reference to the most**
21 **fundamental regulations that existed. So that would**
22 **have been a fundamental part of the inspection process.**
23 **I do see from the very early inspection reports, for**
24 **example, that inspectors inspected statutory books. So**
25 **they were actual checking that these books existed --**

1 Q. Yes.

2 A. -- but in terms of the other requirements in the
3 regulations, there is no indication that they in any way
4 sought to identify where they hadn't been being -- they
5 weren't being met and sought to ask the voluntary
6 organisation or sought to enforce them in any way.

7 We did note that the -- in Nazareth Lodge's evidence
8 to the Hughes Inquiry, which was given in 1984, that
9 SWAG had provided the home with a copy of the
10 regulations.

11 Q. Yes.

12 A. Now I don't think that that would have simply been sent
13 to them. I think that that -- I would have been very
14 surprised if that had not been handed in person and
15 discussed with them, and whether as part of that
16 discussion the administering authority issue came up.
17 It certainly wasn't in the inspection report and that
18 was a defect in the inspection report. It may have been
19 discussed later. We have some indication that in 1986
20 in the next inspection that was done that this issue may
21 have come up. We don't have the report, but we have the
22 officer in charge's response to the recommendations made
23 in the report, and certainly one of those -- and I am
24 sorry -- I don't have the exact detail here -- but one
25 of those refers to the regulatory -- the role of the

1 visiting social worker and -- I can't remember the exact
2 wording -- but something about the regulatory
3 responsibilities of that social worker. I think that
4 this may refer to the monthly visiting requirement, but
5 I would need to double check that to be sure.

6 Q. You are going find that document. It may be a document
7 we already have.

8 A. Yes.

9 Q. It may not.

10 A. Yes.

11 Q. We will get hold of it --

12 A. Yes.

13 Q. -- and make it available to the Panel.

14 A. Yes.

15 Q. There was certainly a social worker from the Down &
16 Connor diocese who became attached to the home. I'm not
17 sure that is --

18 A. Yes. Well, in fact, she could -- that social worker may
19 well have been asked by the administering authority to
20 carry out the functions of the independent -- of that
21 person.

22 Q. She may have been, but there is no evidence that she was
23 unfortunately --

24 A. Yes.

25 Q. -- and there is no reports to suggest that she did that

1 --

2 **A. Yes.**

3 Q. -- in terms of -- but in any event the 1986 inspection
4 that you talk about, it comes after the circular has
5 come into existence, the 1985 complaint circular.

6 **A. Yes.**

7 Q. I am not going to go through the detail of that with you
8 either today, because, as you know, this is a -- with
9 the Department and with the Board an ongoing process --

10 **A. Yes.**

11 Q. -- because there's a long debate takes place in
12 correspondence that the Panel have read and heard about
13 and will no doubt read and hear about as further modules
14 take place, but the -- what the circular did do, and the
15 point you make in paragraph 20 of your statement, if we
16 can bring up, please, 9555, paragraph 20, you say:

17 "For the purposes of this statement it is therefore
18 important to note that the Department did not intend
19 that the processes described in the circular should
20 replace or supersede existing child protection or staff
21 disciplinary procedures."

22 Presumably one could add into that "for the
23 regulatory function of the Department".

24 **A. That's right.**

25 Q. "Rather, the complaints arrangements, if properly

1 implemented, were to link children, parents and their
2 representatives into an accessible early alert system
3 that would enable those in authority to take appropriate
4 and timely action. By inference, such action might well
5 lead to the invoking of other necessary procedures."

6 So what you are saying is this was not a replacement
7 for anything else. It was an addition to the
8 obligations that already existed on everybody under the
9 1968 Act --

10 **A. Absolutely, yes.**

11 Q. -- and the 1975 regulations.

12 **A. Uh-huh.**

13 Q. One of the -- if we go back to paragraph 15, please, at
14 9554 -- we will not go to the document itself -- but you
15 draw attention to the fact that the way the mechanism
16 was set up -- and obviously it was drafted by the
17 Department ultimately, although there was a lot of
18 consultation about it and then some unhappiness about it
19 being issued, and the decision, as you point out, was
20 taken to issue it in any event. Better to have it than
21 not have it. The mechanism that seems to be put in
22 place for reviewing is that as far as voluntary homes
23 were concerned -- and you make this point in the last
24 sentence -- the complaints in respect of voluntary
25 homes, the review of them was to be undertaken by the

1 Department.

2 So the mechanism, if you strip it down, that's set
3 up is when there's a problem in a voluntary home, the
4 Management Committee and the relevant Board should
5 liaise and the Board should assist the management to
6 investigate --

7 **A. Yes.**

8 Q. -- the complaint, but the Department expected to receive
9 the three-monthly records of what complaints there had
10 been in respect of the voluntary homes.

11 **A. Yes.**

12 Q. The mechanism was different for the statutory homes.
13 They went to the head of -- the Director of the Social
14 Services of the relevant Board where the home is
15 located.

16 **A. Yes.**

17 Q. So some oversight was being kept by the Department over
18 the complaints regime that came on foot of the '85
19 circular as far as voluntary homes were concerned --

20 **A. Yes.**

21 Q. -- but then the onus of investigating, the Department
22 was saying, "That's not for us to do. It is for the
23 voluntary home with cooperation and assistance from the
24 relevant Board whose child is placed in the home."

25 **A. Yes, that's right.**

1 Q. Is that in simple terms what's a long document stripped
2 down?

3 **A. Yes.**

4 Q. The basis for that process, the document also explains,
5 as Doreen Brown explained in her statement, that the --
6 each -- the Department took the view that it would be
7 inappropriate for it to lay down procedures for each and
8 every home or each and every Board, that everybody was
9 different and therefore they should all design their
10 own.

11 **A. Yes. That's right, and that wasn't just -- that sort of**
12 **principle wasn't just confined to the complaints**
13 **procedure. I think if you look at all departmental**
14 **guidance, there is an element in every part of**
15 **departmental guidance that allows or that requires**
16 **statutory and other relevant authorities to set up their**
17 **own procedures as to how they will work within the**
18 **framework of this guidance. Guidance is usually**
19 **a framework. The Department would rarely get into**
20 **detailing specific procedures to be followed for the**
21 **very reason that you have explained.**

22 Q. That is essentially where the nub comes in the '84 to
23 '86 correspondence that ensues. The Eastern Board
24 clearly wants something to be done by the Department --

25 **A. Yes.**

1 Q. -- and the Department don't want to do and don't
2 consider they have a basis for doing what the Eastern
3 Board wants them to do.

4 **A. Yes.**

5 Q. We will no doubt return to this issue. So I am not
6 going to cover it in any great deal today --

7 **A. Sure. Uh-huh.**

8 Q. -- other than that to make the point that you say in
9 paragraph 37, if we look, please, at 9562 -- you say:

10 "Having reviewed the correspondence between the
11 Board and SWAG ... the Department is in no doubt that
12 responsibility for the investigation of such matters
13 rested solely with the Board and the Boards responsible
14 for the care of the other children/former residents of
15 Nazareth Lodge."

16 That remains the Department's position, that they
17 considered these matters should be investigated by the
18 Boards. The question, as you know, I was asking you
19 earlier -- and having heard -- and you heard me talk to
20 Kevin McCoy about this -- what would have been required
21 before the regulator asked itself the question,
22 "I wonder is this home being run in the best interests
23 of children beyond just the standard inspections and we
24 will get on the front foot and go and investigate".

25 **A. Uh-huh.**

1 Q. Would that ever on what you have heard and read --

2 A. Yes.

3 Q. -- been something that was going to happen?

4 A. I think if you look at the complaints that we got and
5 the actions that the Department took, the nature of
6 those complaints, the Department was involved in
7 investigating the first one, the **NL 157**
8 complaint, where there was a complaint about a child,
9 soap being put in a child's mouth.

10 Q. That was '84.

11 A. That was '84. The Board investigated that element. The
12 SWAG -- social work advisers looked at the use of the
13 boot room and the use of out-of-date food, and as far as
14 I am aware those situations were resolved
15 satisfactorily.

16 The next complaints that came in -- I am sorry.
17 I am not answering your question directly, but hopefully
18 I will come to it in the end. The next complaints that
19 came in -- we had had the 1983 inspection. There was
20 a further complaint in May '85 and that was by a child
21 who was now boarded out. It was a -- he was
22 a 16/17-year-old boy.

23 Q. That's HIA210.

24 A. HIA210, yes.

25 Q. Yes.

1 A. He claimed that while he was in Nazareth Lodge he had
2 been beaten with instruments, including vacuum cleaner
3 hoses, etc, etc, all of those -- that list of really
4 quite horrific things that he -- he said happened to
5 him.

6 The Board did investigate those allegations. They
7 interviewed as far as I know former staff. They found
8 that there was no evidence that any other children were
9 involved. The member of staff had left the home. The
10 member of staff against whom the allegations had been
11 made was no longer employed in the home. There was
12 ongoing discussion between the Board and the Department
13 as to what should be -- what should follow next.

14 I think at that stage the Department felt that the
15 investigation was incomplete. However, it wasn't idle
16 during that time. After a complaint came in, the Chief
17 Social Work Adviser told the Board to deal with it under
18 a departmental complaint circular. There must have been
19 some discussion with the home at that time by the
20 Department, because shortly after that on 1st July SR143
21 wrote to the Department confirming that procedures for
22 the receipt and monitoring of complaints had been
23 established in Nazareth Lodge.

24 4th July the home returned monitoring information.

25 Q. This is '85.

1 A. This is in '85. Yes, that's right. It is the '85
2 complaint we are dealing with. So if we -- there were
3 quite -- there was quite a lot of contact between the
4 Department after the -- and the home after the '85
5 complaint, and then in December -- sorry -- after the
6 May '85 complaint, and then in December we have another
7 complaint by a person who was a contemporary of
8 HIA210's, NL 145 [REDACTED].

9 Q. Yes. That's NL 145 [REDACTED], yes.

10 A. Both -- these complaints were being made in 1985. Both
11 of them had been resident in the home up to 1981.

12 Q. Yes.

13 A. So we are talking about an experience they had had four
14 years earlier. She reported fresh allegations. I don't
15 think that it is any coincidence that the Department got
16 those complaints in December, middle of December 1985,
17 and immediately an inspection was instituted in July --
18 in January 1986.

19 Q. Am I right in saying, Hilary, you are speculating that
20 that's -- that might be right, but you are saying --
21 there is nothing in the file to suggest that's the basis
22 upon which --

23 A. We don't have -- we don't have any information in the
24 files that we have at the moment, but then we have very
25 unfortunately very incomplete files and very incomplete

1 **documentation. So --**

2 Q. But what definitely did happen, although we don't have
3 the actual writing of it as yet, was SWAG did say to
4 SR143 eventually, and that was in the early part 1986,
5 "Please investigate these complaints and let us know
6 your response". You make that point in your statement.
7 We have the response of 3rd July 1986.

8 **A. Is that -- is this -- are we talking about '87? I think**
9 **the --**

10 Q. If we look at 51778 so we can see the --

11 **A. I hope I haven't got my dates wrong in the statement.**

12 Q. No, no. We'll work through it. Do you recognise --
13 this is the document where SR143 replies and explains
14 the various steps she's taken --

15 **A. Yes, I've got that now, yes.**

16 Q. -- and the interviews that she's conducted.

17 **A. Yes. That's right. She was asked to conduct**
18 **an investigation. In May '86 the Chief Inspector wrote**
19 **to her saying -- asking for some indication of her**
20 **progress. I think she sent a -- she sent the '86 -- the**
21 **July '86 report and then I think followed this up with**
22 **a fuller report at a later stage.**

23 Q. I am not sure I have seen the fuller report. This
24 document that's on the screen runs to four pages.

25 **A. Oh, then sorry. I have got the --**

1 Q. This is probably the full one that you are --

2 A. Sorry. Yes. In May '86 -- the Chief Inspector -- sorry
3 -- Chief Adviser wrote on 14th May '86 asking for some
4 indication in relation to the progress made. She
5 replied -- this is the one I am thinking to -- saying
6 she had already spoken to Sisters and members of staff
7 who were employed in Nazareth Lodge during the period.
8 All reject the allegations. She intended to speak to
9 them once again and put the NL97 account to them.

10 Q. Yes.

11 A. Then we have her full report --

12 Q. Yes.

13 A. -- in July '86.

14 Q. So it's that earlier letter we will have to identify and
15 get into the bundle, if it's not already there, but
16 what's happened, if we step back from it, the toing and
17 froing has gone on between '84 and '86, and then in
18 early '86 the Department does take a step to say -- they
19 don't themselves go in and investigate, but they require
20 a response from SR143 of the home as to what has
21 happened.

22 There's a number of issues that arise out of this
23 that we talked about beforehand. The first is that
24 essentially SR143 replies to you -- replies to the
25 Department, saying, "There is nothing in this" and

1 explains all of the people that she's spoken to.

2 I think there is a suggestion they accept that they
3 might have slapped someone on the hand, might have on
4 occasion hit someone with a wooden spoon, but as to the
5 more serious allegations they are not correct, including
6 interviewing SR62, who expressed the view that she is
7 astounded at the allegations and deeply worried that
8 such statements should be made.

9 **A. And she was no longer employed in the home. I think**
10 **we've got to make that point.**

11 Q. I am not sure -- I am not sure that that's right. If we
12 look at 517... -- 51781 is recording what she had to
13 say. I don't -- there's a lot of detail to this,
14 Hilary.

15 **A. I know there is.**

16 Q. What I want to do is drill down to a number of points
17 that arise out of it. The first we were talking about
18 beforehand was that, as it now transpires, the Inquiry
19 has heard evidence that SR62 was, in fact, removed from
20 childcare in 1981 as a result of a member of staff, who
21 is actually listed on the first page here. If you go
22 back, please, to 51778. 51778, please. It is the
23 second person said to have been interviewed on 24th
24 June, **NL 32** or **NL 20**, as her police
25 statement was, which I have previously opened to the

1 Panel. What she was -- she was responding to
2 an allegation herself, but making the point in the 1995
3 police investigation that, "No, no, I didn't do this,
4 but I can tell you that SR62 used to beat the children".

5 **A. Yes.**

6 Q. She gave a particular example of welts on the back of
7 a particular boy and then a particular episode of SR62
8 running through the dorm one evening. That caused her
9 and her two colleagues to be sufficiently concerned that
10 they went to speak to SR29. Now SR29 gave evidence to
11 the Inquiry last week, because she had been spoken to by
12 police twenty years later in 2012 and was asked about
13 **NL 20** statement. She admitted that yes,
14 she had been spoken to. She went to talk to the Mother
15 Superior, who at the time was **SR 63**, and
16 as a result of that what she described as concern -- she
17 could not remember -- did not go any further than that
18 description of the matters -- but the result of it was
19 that **SR 63** removed SR62. We can see from the
20 record she appears to have left the home for a period
21 and then comes back and takes up duties in what's
22 described as the parlour or reception, if **NL 20**
23 **is right.**

24 **A. Yes, and I understand that didn't involve any care**
25 **duties towards children. Is that right? She didn't**

1 **leave the --**

2 Q. She didn't work with children again.

3 **A. Yes, that's right, from 1981.**

4 Q. Whatever was said --

5 **A. Yes.**

6 Q. -- it was sufficient for her to be removed from working
7 with children again.

8 **A. That's right. In 1981. That's right.**

9 Q. In 1981.

10 **A. Yes.**

11 Q. Now the issue that raises is in this 1986 document that
12 set of events is not there. There's one of two reasons
13 for that. The first is that the information wasn't
14 given to SR143 in order to pass it on. Now SR143 had
15 only taken over in 1983. You recall she was the lady
16 who received --

17 **A. That's right, yes.**

18 Q. -- a copy of the regulations from Norman Chambers.

19 Prior to her had been **SR 63**. We have heard
20 other evidence of the effect SR153 moving, HIA62 as
21 a result not getting on with SR18 and wanting to go to
22 be alongside SR153, this policy that appears to have
23 taken place of you move people every few years.

24 **A. Yes.**

25 Q. If it's the case the information wasn't passed on to

1 SR143, then that's a systems issue. Do you -- did the
2 Department ever comment that you are aware of in the
3 '80s about this practice of every few years the person
4 in charge of the home might change and other -- the
5 members of staff underneath her might stay the same for
6 a longer period?

7 **A. Yes. I don't recall any comment on that, but yes.**

8 **I wouldn't like to be completely certain, but I don't**
9 **recall that being seen --**

10 Q. That's maybe something --

11 **A. -- as a disadvantage or an advantage or being commented**
12 **on to that effect in relation to --**

13 Q. It is maybe something you can -- I am not sure whether
14 you are in a position today to say whether that is
15 a disadvantage, but if the result of it is that
16 important information --

17 **A. Absolutely, yes.**

18 Q. -- is not getting conveyed back to the Department, then
19 it presumably is a major issue.

20 **A. Yes. I think changeover of staff is always a major**
21 **problem or where one staff is taking on duties that they**
22 **didn't have before, and the kind of -- there is so much**
23 **information to be exchanged that information can get**
24 **lost. I am not saying that -- this was very**
25 **significant -- this was very significant information,**

1 **that a member of staff had had to be removed because of**
2 **what was in effect cruelty to children and --**

3 Q. Not to be flippant about it --

4 **A. Uh-huh.**

5 Q. -- Hilary, but if that had come to the Department's
6 attention in 1986, one can only imagine the nature of
7 the correspondence that would have been exchanged
8 between the Board and the Department --

9 **A. Yes.**

10 Q. -- because there had been these two years of letters to
11 and fro about who would do what. The point that you
12 reach in your statement, you explain to the Panel that
13 on reflection the Department considers that a bringing
14 together of everybody --

15 **A. Absolutely.**

16 Q. -- round the table much quicker would have been
17 preferable to what, in fact, took place.

18 **A. I think that we can certainly agree that that -- it**
19 **seems strange that this communication would have gone on**
20 **for so long and the key players not brought together.**
21 **As I have pointed out, that wouldn't have been**
22 **inconsistent with the role that SWAG -- and I think for**
23 **most of this time they were an advisory body -- that**
24 **they had sought to themselves develop. Had this been**
25 **done and an agreed -- an agreed way forward -- you know,**

1 the outcome been an agreed way forward, then it's
2 possible -- it is possible that other complaints may
3 have come -- come to light.

4 Q. You --

5 A. But I think based on the information that the Department
6 had about the 1985 complaints about a Sister who had
7 moved on, and the fact that the Board were alleging that
8 other children had been treated the same way, I -- we do
9 feel the Department was right in wanting much more -- in
10 wanting more information about that, and we believe,
11 rightly or wrongly now, as our previous discussion has
12 shown in relation to the powers and duties of the --
13 under the 1968 Act, we believe that the Board did have
14 the authority to interview staff, to interview senior
15 staff and to interview former staff under child
16 protection procedures.

17 Q. That's a subject that I am -- maybe is now
18 an appropriate time to ...?

19 CHAIRMAN: Yes. I see it's after 1.20. We will take
20 a short break, Dr Harrison. Hopefully we will resume
21 again not long after 2 o'clock.

22 (1.22 pm)

23 (Lunch break)

24 (2.25 pm)

25 MR AIKEN: Chairman, Members of the Panel, just to recap on

1 one point that arose before lunch, we were looking and
2 discussing the 1984-'86 correspondence, Hilary, and we
3 had up on the screen -- if we just bring up again so
4 everybody is clear on what I am talking about 51... --
5 in fact, there it is, as if by magic.

6 This is the reply that's four pages long from SR143
7 as to her findings. She speaks to both NL 32 or
8 NL 32 and SR29. That's something that
9 Mr Montague is going to look into with the Congregation,
10 but this letter refers and you were referring, Hilary,
11 to the fact there was an earlier letter of 22nd May.
12 I said we would try to put our hands on that. So we
13 have. If we can bring up 51793, please. This is the
14 earlier letter I think you were referring to, Hilary,
15 where --

16 **A. That's right, yes. That's right, yes.**

17 Q. If we can get it to come up. It again is written to
18 Mr Armstrong:

19 "Dear Mr Armstrong,

20 I received your letter of 14th May ..."

21 I am not sure we have found that letter of 14th May
22 as yet.

23 "... in reference to the inquiries being made about
24 alleged incidents having taken place in Nazareth Lodge.

25 I have already spoken to Sisters and members of

1 staff who were employed in Nazareth Lodge during the
2 period and so far I have been unable to obtain any
3 information which supports the allegations. I have also
4 written to SR62 and received a letter from her
5 completely rejecting the allegations",

6 which is your point that by this stage in 1986 she
7 has gone and the records appear to --

8 **A. In 1981, yes. Uh-huh.**

9 Q. She certainly stopped working with children in '81. She
10 appears on the records again in the home in '83 and '84,
11 but by '86 she is clearly not there anymore.

12 Then she explains what she proposes to do, which is
13 to speak to the various members of staff employed and
14 put to them the latest information which Mr Moore has
15 given to you:

16 "I intend to document the statements made by Sisters
17 and members of staff and I will let you have this
18 information as quickly as I can."

19 She raises the difficulty with the passage of time,
20 even at the remove of five, six, seven years, but she
21 says the Order --

22 "I can assure you that the Order in this home will
23 make every effort to establish the facts, whatever they
24 be, and I can assure you that the policy of the Order,
25 which does not permit any physical abuse of children, is

1 rigorously adhered to in Nazareth Lodge."

2 So that's the signal of intent. She has the
3 preliminary reply by SR62 denying and then the more
4 detailed document of 3rd July '86.

5 The issue we were talking about that hindsight
6 demonstrates, the point that you were making, as I
7 understand it, is the Department can only work on the
8 basis of what it is told. So if for whatever reason
9 SR143 is not in a position to or is not prepared to tell
10 the matters that might cause a recognition --

11 **A. Yes.**

12 Q. -- of the fact that what the Board were complaining
13 about actually has substance to it or that the children
14 who the Board were talking to has -- their complaints
15 have substance, unless -- the only other way is for the
16 Department to do the investigation itself. You have
17 made the position of the Department plain --

18 **A. Yes, yes.**

19 Q. -- that the Department does not consider that was
20 an appropriate thing for it to do.

21 **A. Yes. I am assuming that some of the young people**
22 **mentioned by NL 145 and HIA210 would have been**
23 **adults by this time -- by this stage -- might have been**
24 **adults by this stage, because the complaints were**
25 **reported -- the earliest complaint we got about SR62 was**

1 reported in 1985, when she had already left four years.
2 Certainly the children who are mentioned do not appear
3 or the young people who are mentioned do not appear to
4 have been resident in the home at the time they were
5 making or corroborating the allegations.

6 Q. Can I pause you there, Hilary? The focus there is on
7 the complaints and the individuals.

8 A. Yes.

9 Q. But who is asking the question, "How did you come to
10 have a member of staff of that type? How do you ensure
11 you won't have another one?"

12 A. Yes. I take that point and I think that then it's very
13 difficult for me to go back into the mind of the
14 Department at the time, but I --

15 Q. In fairness to you the Department at the time were being
16 told -- the Board were wanting them to investigate.

17 A. Yes, yes. Uh-huh.

18 Q. The Board -- the Department were being told, "There is
19 nothing to the allegations".

20 A. Yes, while some of them --

21 Q. I am asking you --

22 A. Yes, yes.

23 Q. -- in terms of approach.

24 A. Well, you see I hope I have pointed out in my statement
25 that during this time the Department did conduct

1 an inspection. They were in regular contact with the
2 home. The Department had to satisfy itself that the
3 home was being run in an efficient and -- sorry -- in
4 a manner which demonstrated that the welfare of children
5 was being looked after --

6 Q. Yes.

7 A. -- and given that the member of staff against whom
8 the -- we are talking about one member of staff at the
9 moment -- against whom the allegations were made was
10 not -- was no longer in the employ of the home, they --
11 I'm not saying that that -- that that then shouldn't
12 have been followed up. I think they would have seen
13 that as the responsibility of the Board and -- as they
14 have said, and I would have seen it also as the
15 responsibility of police in conjunction with the Board
16 to follow it up, and that should have been done, had
17 child protection procedures been instigated at that
18 stage, but the Department are saying, "Well, look, we
19 have sent in an inspector. We are in regular contact
20 with the home". The Regional Superior, the officer in
21 charge, has carried out an investigation. We have asked
22 for all of these things to be done. We are satisfied
23 that we are not getting any further concerns about the
24 quality of care within this home at this present time.

25 Again if I might refer then to the inspection which

1 took place subsequent to the January '86 inspection, and
2 the reports that the inspector got back from the various
3 units of management in the Eastern Board, who had
4 children placed in the home, were extremely positive.
5 One of them referred to the fact that investigations in
6 relation to children formerly resident were ongoing, but
7 social workers in all of those cases reported an
8 extremely positive experience of care given by Nazareth
9 Lodge to children currently there.

10 Q. If we look at paragraph 37 of your statement at 9562 --
11 we began looking at a sentence of it, and I want to move
12 on to the next sentence in the paragraph. 9562, please.
13 You have made the point the Department -- as to where
14 the Department sees responsibility lying, but you then
15 say:

16 "SWAG had expressed the willingness of the DHSS to
17 consider the implications of the findings for the
18 current and former operation of the home."

19 What do you -- what are you referring to there?
20 What do you mean by that, that they were wanting the
21 Board to investigate, but that they indicated
22 a willingness to consider the implications of the
23 findings of the investigation?

24 A. Yes. Well, on 21st January -- and I'm sorry. I don't
25 have the SNB number -- but when these --

1 Q. Which year? Which year, Hilary, are we --

2 A. It's '86.

3 Q. '86.

4 A. When these debates were going on --

5 Q. Yes.

6 A. -- the Department wrote stating that it wanted the Board
7 to investigate the incidents and this would -- again
8 investigate the children who were in the home in 1981
9 who were making these allegations, and to bring that
10 information to the Department, and I'm quoting from the
11 departmental letter:

12 "... to enable consideration of relevance and
13 important -- relevant and importance" -- sorry --
14 "relevance and importance of issues involved to the
15 current and former operation of the home."

16 In order that the Department might consider the:

17 "... relevance and importance of the issues involved
18 to the current and former operation of the home ..."

19 Q. I think from the Board's perspective they regarded
20 themselves as already having done that by bringing these
21 matters forward and then that's when the tennis
22 correspondence, as it were, as to whether it has been
23 right or done fully or --

24 A. Yes. At that stage if I may say the Board was claiming
25 that, "We didn't only have these two or three children

1 **who had stated that they had had a problem with one**
2 **member of staff", but that other children had been**
3 **abused, and it would have been that information that it**
4 **would have been very important for the Department to**
5 **know about.**

6 Q. Yes, but the difficulty -- this is where we come back
7 to, because you take issue in your statement at a later
8 point with **DL 518** adding them up and getting
9 sixteen. I was saying to you he was doing that based on
10 the five you've referred to, the five complaints, but
11 then those children also saying, "But so-and-so was also
12 hit" or "There were others", and he gets to sixteen.

13 **A. Uh-huh.**

14 Q. In fact, ultimately in the police investigation a number
15 of these children aren't involved making allegations
16 against SR62, but there is about fifteen or sixteen
17 others.

18 **A. There is, yes, you were explaining, yes.**

19 Q. Ultimately was the issue not more of, "How is the home
20 being run?" and -- as opposed to adding up whether it
21 was five children, ten children, one member of staff,
22 two members of staff -- that regulatory function of
23 ensuring the home is being properly run. Have the -- do
24 you feel, reflecting back on the material, doing the
25 best that you can, that conflation has occurred between

1 the Department's regulatory responsibility and the
2 tussle over how the new complaints procedure is executed
3 --

4 A. Uh-huh. Uh-huh.

5 Q. -- and has the eye come off the ball a little?

6 A. I think to a certain extent yes. I feel that had -- and
7 I link the Department with this -- I feel that if the
8 Department had perhaps directed the Board to its child
9 protection responsibilities and the fact that these
10 children whom they were alleging -- whom the Board was
11 alleging -- and quite possibly that was right -- that
12 they had been abused while they were in care, they were
13 in the care of the Board. The Board had
14 a responsibility to follow that up and I would suggest
15 with the police to check out whether these allegations
16 were, in fact, true, and having received that
17 information -- because the Department as far as we can
18 ascertain had no evidence to suggest that at the time
19 the allegations were reported to it that there was
20 any -- there were any matters of concern in that home at
21 that time. There appeared things -- there were
22 certainly no -- even in Mr Chambers' first critical note
23 or critical initial impressions --

24 Q. Yes.

25 A. -- there was no indication that children were being

1 harshly treated, physical punishment was being used, and
2 that continued to be the case right through this --
3 these episodes, and indeed, as we have noted now, in '97
4 the inspector was asking about a retrospective period in
5 relation to children who were in the care of the Board
6 and asking social workers -- asking units of management
7 to come back with information about how -- how they
8 considered the care of children, and it was all
9 extremely positive.

10 Now the children whom she was asking about there,
11 I would -- I would imagine that most of them -- I can't
12 say for certain, because I don't have the details -- but
13 most of them would have already been in Nazareth for
14 significant periods of time, and social workers were
15 saying, "These children are extremely well cared for.
16 Yes, there are some investigations going on in relation
17 to former residents about a member of staff who is no
18 longer there, but the present situation in this home is
19 as it is".

20 Having said that, we -- the Department also had the
21 report of SR143. Now again one might be very critical
22 and say, "Well, it might have been better had, you know,
23 someone who had been professionally qualified, you know,
24 carried out the investigation, perhaps someone a little
25 more distant from the immediate operation of the home",

1 because SR143 had been responsible. It turns out she
2 may not have been there during SR62's time. I haven't
3 really (inaudible) yet, but, you know, you might be
4 critical, but certainly during SR143's -- SR143's --
5 when she was in charge of the home, the Department had
6 received no complaints about the care of children while
7 she was there. So they possibly felt, "Well, this is
8 an appropriate person to carry this out. She knows
9 exactly what good care is" and so on.

10 Q. Let me pose this question, Hilary.

11 A. Uh-huh.

12 Q. Even if the position that the Department has adopted is
13 entirely appropriate to adopt, the allegations are made
14 and there doesn't appear from what material is available
15 from the file that -- I think both witnesses yesterday
16 made the point that inspection was a blunt instrument.

17 A. Absolutely.

18 Q. You got to see what you saw at the time and what was put
19 in front of you to some degree. You were there over
20 a number of days and therefore got the best assessment
21 that you could, but one of the points that Kevin McCoy
22 mentioned in his statement was about the option of
23 an unannounced inspection --

24 A. Yes.

25 Q. -- that you would just land in and see whether what you

1 were seeing on an organised basis was actually the way
2 it would be found when they weren't expecting you.

3 **A. Yes.**

4 Q. I think he said, and we need not get into it, you know,
5 it had been considered not necessary, but I think he
6 accepted there hadn't been any consideration of that as
7 a way of performing a check.

8 **A. Yes.**

9 Q. Because you have got -- am I right in saying you have
10 got an unusual scenario of a Board fairly belligerently
11 raising the need for the Department to investigate a
12 voluntary home that they are making use of and
13 presumably needed to make use of because of the
14 facilities available to them.

15 That option of, "We will just go in and have a look"
16 doesn't appear between '84 and '86. Other than going
17 into the '84 **NL 157** issue alongside **DL 518**,
18 the making use of that unannounced visit doesn't appear
19 to have been something considered as something that
20 should be done.

21 **A. Yes. I think Miss Beagon maybe addressed the issue of**
22 **unannounced visits, and I appreciate that Dr McCoy did**
23 **state that these weren't necessarily policy of the**
24 **inspectorate. Certainly to the best of my recall it was**
25 **a recommendation of the Hughes Inquiry, but Miss Beagon**

1 pointed out that inspectors would often call unannounced
2 at children's homes. Now it wasn't -- it wasn't
3 an unannounced inspection, but that she would call in
4 from time to time just to check how --

5 Q. That was her practice.

6 A. That was her, yes, and I understand now that that
7 possibly was done by other inspectors. I'm not saying
8 that -- I can't say that it happened in this case, but
9 it did happen.

10 With -- again just to point out that the **NL 157**
11 **██████████** complaint did -- did result in departmental
12 action. They went in and had a look at things. In
13 May 1985, by that time we had one child and then another
14 child in December corroborating some of what this --
15 HIA210 had said. We had an inspection then immediately
16 in '86, which was within a couple of weeks of the second
17 complaint having -- having been made.

18 Q. Yes. Unfortunately we just -- we don't have the result
19 of that.

20 A. And there was ongoing -- a lot of ongoing correspondence
21 toing and froing in relation to monitoring meetings and
22 so on. This wasn't -- I would stress this was not the
23 only contact --

24 Q. Yes.

25 A. -- that SWAG had with the home.

1 Q. In paragraph 39 of your statement, if we look at 9562,
2 you make the point about the various tensions that there
3 were, and you make the point about the meeting on the
4 next page, 9563, meeting being convened. Then you make
5 this point at the end:

6 "The model adopted by the Management Committee and
7 Boards in respect of the investigation of the 1995
8 complaint is an example of how a joint voluntary and
9 statutory approach is plainly a more robust process that
10 was capable of delivering more acceptable outcomes."

11 Now is that because on reviewing the material that
12 the Inquiry has and that the Department had to do with
13 the 1995/'96 issues that resulted in SR18 resigning the
14 Department is of the view that that is a good example of
15 a process sorting out these types of difficulties?

16 A. Well, I need to be careful with my language here. I did
17 say that the model adopted was capable of delivering,
18 you know, better outcomes, and the model adopted was --
19 is, in fact, the kind of model that is suggested in the
20 Children Order Representation and Complaints Procedure,
21 where you have a panel set up with one independent
22 person. Now where the child -- under the complaints
23 procedures, of course, where the child is in the care of
24 the Board, regardless of whether the child is in
25 a voluntary home, it is the -- sorry -- in the care of

1 the Trust, it is -- it would be the Trust who would be
2 responsible for convening that panel.

3 I -- like you, we are getting -- we are getting
4 information very quickly. At times we don't have time
5 to look at the detail of that. Certainly when we did
6 receive the rest of the informations in relation to how
7 this complaint was handled, it would appear that it
8 wasn't a very satisfactory process, but that was not
9 anything to do I think with the model -- the model in
10 principle. It was to do with how that -- that was
11 worked out.

12 Q. The execution of it?

13 A. Yes, the execution.

14 Q. The difficulty with the model, again just to cut right
15 to the chase of it with you, if I may, is that you have
16 Boards taking forward the investigation and multiple
17 liaison going on between them, and they are liaising
18 with and the investigation is being conducted by the
19 Management Committee of the voluntary home.

20 A. Uh-huh.

21 Q. Then they appear to be in the correspondence that flows
22 after it struggling to get information sufficient that
23 they felt could bring the complaint to an end for the
24 individual.

25 A. Yes.

1 Q. So even from their perspective of -- leave aside the
2 regulatory -- ensuring the home is being run properly --

3 **A. Uh-huh.**

4 Q. -- in the complaints process of giving enough
5 information back to the Boards to let them communicate
6 with the family of the child and with the child
7 themselves, they did not feel they were getting the
8 level of information or the detail of information they
9 felt was appropriate.

10 **A. Yes.**

11 Q. How -- would that be dealt with differently today, or
12 are you saying, given that this model that we have
13 looked at at the end of the Inquiry's terms of
14 reference, this particular method of dealing with issues
15 like this would still happen in the same way today?

16 **A. Well, I would absolutely -- I don't think that would be**
17 **possible, because if in these circumstances the child**
18 **were in the care -- as in these circumstances, the child**
19 **is in the care of the Board -- and I am a bit rusty on**
20 **my Children Order -- but I do -- my understanding is**
21 **that the Board -- sorry -- the Trust is then**
22 **responsible -- when the child is in the care of the**
23 **Trust, the Trust is responsible for establishing the**
24 **Panel. Therefore it would highly unlikely that a Trust**
25 **would not share its own information with itself.**

1 Q. Yes.

2 **A. The only circumstances -- sorry.**

3 Q. Isn't that part of the -- the difficulty here is that --
4 if you don't agree with this, you say so -- that the
5 mechanism for dealing with these issues as they played
6 out in a voluntary home where the children were placed
7 by the Boards and the Department was regulating, this
8 doesn't seem to have been a satisfactory way of getting
9 to the bottom of what happened, getting there quickly
10 and disseminating to those who needed to know what they
11 needed to know.

12 **A. No. That particular -- that -- the particular approach**
13 **in '95 was clearly not -- was not -- did not deliver**
14 **satisfactory outcomes in a timely manner, but if I may**
15 **--**

16 Q. Yes.

17 **A. -- before '95 if I may refer to other complaints that**
18 **were received by the Trust in relation to -- sorry --**
19 **the Board and subsequently Trusts in relation to other**
20 **children --**

21 Q. You were making the point to me earlier.

22 **A. -- who were making allegations that, you know, they had**
23 **been mistreated by staff, there were obviously other**
24 **complaints that were dealt with and they were complaints**
25 **about other children, but with particular reference to**

1 any -- to mistreatment by staff, there were a number of
2 other complaints during this period that were
3 satisfactorily examined by both the home and the Board
4 and the Board/Trust and which came to satisfactory
5 conclusions and the Board reported that they were happy
6 with the --

7 Q. With the outcome?

8 A. -- outcome and the way the investigations had been
9 conducted. The Department wasn't involved in any of
10 those.

11 Q. So that's the complaints mechanism working effectively?

12 A. And child protection mechanisms working, because in some
13 cases police were brought in too, yes.

14 Q. In this case we know from the 11th December '95 letter
15 from Judith Chaddock that she wanted a report. So she
16 decided on behalf of the Department to write, saying,
17 "Here is these six issues. I want you to investigate
18 those". She is saying to the -- was writing to the
19 Mother Superior in Dublin or the Superior General in
20 Dublin -- the Superior Regional -- Mother Regional that,
21 "I want you to investigate these six issues and I want
22 you to provide me with a report".

23 A. Yes.

24 Q. That -- you have made the point that, you know, she did
25 all the things and I think colleagues of her also made

1 the point she did all that would be expected of her to
2 set the various trains off, tells the right people.
3 They begin their work. She does her communication
4 looking for information, but she doesn't it seems get
5 a reply as far as we can tell from the material that's
6 available. The Sisters of Nazareth have not produced
7 any reply from them to the Department. The Department
8 don't have a reply to Judith Chaddock's letter, and am
9 I right in saying there's no information to suggest that
10 any steps were taken by the Department on foot of
11 becoming aware, if they became aware, that SR18 had
12 resigned?

13 **A. Yes. I'm just trying to determine the date at which the**
14 **--**

15 Q. She resigned in March of '96.

16 **A. Right. Uh-huh.**

17 Q. The letter of 11th November '95 was Judith Chaddock's
18 letter asking for a report.

19 **A. Yes. Yes.**

20 Q. The investigation then kicks off, takes place. By
21 March 1996 the report is produced. The Management
22 Committee have a meeting on 4th --

23 **A. Uh-huh. Uh-huh.**

24 Q. -- and the letter comes on 6th March resigning. Then
25 there's another meeting on 12th. Then the Trust is

1 engaged for a number of weeks and months getting
2 adequate responses as far as they saw it to speak to the
3 children, but from the Department's perspective now you
4 have a set of complaints that have resulted in the head
5 of a unit in this home -- you know there is three units.
6 It is like three children's homes almost --

7 **A. Yes.**

8 Q. -- in terms of the statutory sector. One of them has
9 had to resign because of childcare issues. There
10 doesn't appear to -- as you know, over the last couple
11 of days I have been trying to find what the rubicon is
12 over which then the Department would engage --

13 **A. Yes, the department would -- Uh-huh. Uh-huh. Uh-huh.**

14 Q. -- as the regulator to satisfy itself that this home was
15 being run in the best interests of children. Where you
16 have the head of a unit having to resign over their
17 behaviour, is the rubicon not then crossed?

18 **A. Yes. We don't have any information to suggest that the**
19 **report -- report did come back to Miss Chaddock. We**
20 **don't know whether it did or not, but we don't have any**
21 **evidence of that.**

22 Q. In fairness to you there are two things that do happen,
23 though, but whether they are relevant or not to that
24 question one cannot tell. That is that the RQIA is set
25 up.

1 **A. Yes. This is what I was pointing out earlier that in --**

2 Q. Then the home --

3 **A. Yes. Uh-huh.**

4 Q. -- was also closing in 1997.

5 **A. ...7. That's right, but in 1996 RQIA became responsible**
6 **for inspections of children's homes, and as far as I can**
7 **recall from my personal memory during 1995/'96 there**
8 **would have been -- there was some kind of induction**
9 **process of staff from RQIA into the inspection of**
10 **children's homes. So it was a period where there was**
11 **a transfer of responsibility and --**

12 Q. So it may be something that --

13 **A. -- I think if a head of home had to resign, it is**
14 **something that the Department most certainly would have**
15 **wanted to know about and would have had questions about,**
16 **not least of all where was the person going to? Was**
17 **that person going to be employed in another situation**
18 **involving children?**

19 Q. The difficulty -- I am not trying to be difficult with
20 you, Hilary -- the difficulty with a lot of what you
21 have had to say and the exchanges you and I have had to
22 have --

23 **A. Yes.**

24 Q. -- is that we are arguing from silence, because it
25 doesn't appear that those things were done, or if they

1 were done, there's no documents --

2 **A. There's no --**

3 Q. -- for them, and we are not talking about a period of
4 '50s, '60s, '70s --

5 **A. Yes.**

6 Q. -- when files might more understandably not be
7 available.

8 **A. I accept that.**

9 Q. This issue of the action or lack of action, depending on
10 how you characterise it, comes into sharp focus then in
11 1993, because, as you know, you have NL 269
12 getting in touch with Marion Reynolds, which in her
13 evidence was -- that's an exceptional thing, that --

14 **A. Yes.**

15 Q. -- she would have received a call from someone who used
16 to work in the place who wanted to talk to her about
17 something that had happened there. In her memo, which
18 I can't now find -- just bear with me for a moment,
19 please. If we can bring up 19070, please. So, just to
20 ground this, there is a document the Panel have seen
21 before, but it is the note of his conversation with
22 Marion. Marion records in what --

23 **A. Yes.**

24 Q. -- Kevin McCoy says is a very detailed memo a record of
25 what is being said. Having done that, and just cutting

1 to the chase again, the -- Norman Chambers in fairness
2 to him analysed and pointed out the three things that
3 were different from -- in what NL 269 was saying
4 from what had been already identified in the inspection
5 that had taken place. One in particular that I just
6 wanted to raise with you is the NL165 presence as it
7 turns out, what's described colloquially by NL 269
8 as someone with a --

9 **A. Yes.**

10 Q. -- difficult history having the run of the home.

11 You have on the second page, please, if we move down
12 through the memo on 19071, the -- while it is doing --
13 you are familiar with the annotation in any event, the
14 instruction that unless he is prepared to put it in
15 writing.

16 **A. Yes, I am familiar with that.**

17 Q. Everybody has been keen to say how thorough Marion would
18 be in her work, and I am not really interested in
19 getting into all of that, but -- and therefore the
20 suggestion is being made in the statement, "Oh, well,
21 she would have brought it up with the Board, brought it
22 up with the Management Committee in discussion. No
23 reason to believe she wouldn't have". I think she
24 herself is not prepared to say that she did and --

25 **A. Uh-huh.**

1 Q. -- the record, if we look at her letter which Kevin
2 McKay reached for, which was 29th March '93 -- 9515,
3 please -- where you can see it is said very --

4 "As I have not yet received your written comments on
5 the issues raised, I am unable to seek the views of
6 either the Order or the home's Management Committee on
7 the matters you raised."

8 Marion's evidence seemed to be, "That's the
9 instruction I was given". You didn't go beyond your --
10 you know, if the Assistant Chief Inspector told you
11 that's the way it was, that's the way it was.

12 The difficulty that you have -- when you go back to
13 the piece of information that wasn't going to be pursued
14 at 19071 -- 19071, please, and point (iv) just at the
15 top of the page. I am sure you could try and imagine
16 but it would certainly rank up there, would it not, with
17 one of the most serious allegations that you could find?

18 **A. Oh, yes. There were at least three issues in that**
19 **minute that were very serious including -- yes --**

20 Q. Four in particular --

21 **A. -- including that, yes. Yes. Uh-huh. Uh-huh.**

22 Q. -- and I am focusing on it because actually we can be
23 sure that is a reality in that this individual was, as
24 it turns out -- now this -- as I was saying to Marion
25 and Norman, this note was this man was working in the

1 place at the end of 1992. It brings the date at which
2 he is there after he has formally left the home much
3 further back and he is still there in 1994/1995 --

4 **A. Yes.**

5 Q. -- whenever there's a series of events that happen in
6 relation to other children.

7 The issue that it raises -- well, there are a number
8 of issues. The first one is not taking this forward
9 regardless of whether the person would sign a statement
10 or not, not investigating it to see is there such
11 a person actually in this children's home, is that not
12 an extremely serious issue?

13 **A. Yes.**

14 Q. If you were to put that alongside -- and please feel
15 free to say, "No, it is not fair to characterise it in
16 that way" -- that if you put that alongside the not
17 getting involved, if that's a -- that's one way of
18 characterising the approach in the earlier period -- and
19 we do inspections and the Inspector has done
20 an inspection and has found lots of these things, but we
21 don't get involved in -- beyond that, whether the thing
22 was in writing or not, surely because of its nature, it
23 really shouldn't have made any difference?

24 **A. That's absolutely right. I don't think the Department**
25 **can offer any defence at all against the -- in relation**

1 to the advice given there. I think, as Marion -- as
2 Miss Reynolds said in her evidence, this was again
3 a child protection issue. It was not a complaint as
4 such. It was a child protection issue and should have
5 been thoroughly investigated.

6 Q. There are -- I am going to ask you this question,
7 because I don't know the answer, and I will give you the
8 opportunity, if you are in the same position, to check
9 and then you can confirm it and we can make the Panel
10 aware of it, unless you are in a position to answer
11 today, but I am going to surmise that the inspection of
12 1994 and of 1995 doesn't identify that this is taking
13 place.

14 A. That this young man has been seen --

15 Q. This young man has returned and has been given a bed for
16 the night, however one wants to -- "harboured" I think
17 was the word --

18 A. Yes.

19 Q. -- the Sister accepted from the investigation that took
20 place -- and obviously there are best of motives, as she
21 explained, for the doing of it and difficulties that it
22 created, according to others, for some of the children,
23 and she accepts it wasn't appropriate that this was
24 taking place, but the Department are notified of it in
25 early 1993. You have candidly accepted the difficulty

1 in not pursuing it at the time, but if it is the case --
2 and perhaps it is something you can go away and check to
3 be certain of -- but I am not aware that the '94 or '95
4 inspection identifies this problem.

5 **A. I think that would be correct.**

6 Q. The difficulty that that creates is that the people
7 going to do the inspection in '94/'95, what are they
8 going armed with in terms of knowledge, because this is
9 on the file, and surely one of the first questions that
10 you -- maybe not the first question you would ask, but
11 one of the first questions you would want an answer to
12 before you leave is: "Is that guy living here? Is he
13 still here? Is he gone now? What is the situation?"
14 Subtly, however you want to do it, but you would satisfy
15 yourself that it's -- this isn't a problem.

16 **A. Yes. I think that what has been established before is**
17 **that whilst the Department had files containing**
18 **information and various aspects of the functioning of**
19 **the children's home that as far as inspectors were**
20 **concerned -- and again thinking about the really very**
21 **high demands on inspectors to get these inspections**
22 **done, to attend to other sort of policy advisory**
23 **responsibilities as well -- that probably the most that**
24 **inspectors looked at would have been the previous**
25 **inspection report and the extent to which**

1 recommendations contained in that report would have been
2 implemented and they would have used that as
3 a foundation for going on to the next inspection. This
4 information wasn't in the inspection report. I would
5 think it highly unlikely it was -- when we saw the
6 document, it was in a file probably about six inches
7 thick, which contained a lot of very helpful
8 information, pre-inspection information, and this
9 document was in the middle of it -- that it is highly
10 unlikely that the Inspector coming along to do the next
11 inspection would have located it, would have found it,
12 and that was the situation.

13 Q. That was the difficulty.

14 A. Yes.

15 Q. Of course, as I have said to every witness, it is very
16 easy for me coming forensically, looking at particular
17 documents, particular points in time, and you are
18 describing a busy practice coming to do inspections,
19 coming to files that are thick and so on, but there
20 doesn't appear to have been a system of -- you know,
21 a chronology, even it is only three or four entries
22 added per year --

23 A. Yes.

24 Q. -- that someone could go back and consult and say --

25 A. That's right. Yes.

1 Q. -- "Oh, there's a problem here, a problem there".

2 A. Uh-huh. Uh-huh.

3 Q. Looking back on it, that's not an ideal scenario. Is
4 that fair?

5 A. That's right. Ironically the very situation that you
6 have described is something that we would have made
7 a point of making recommendations about when we examined
8 Trusts -- when we were looking at Trust services. We
9 had very thick, for example, children's files and we
10 always made a recommendation that there should be
11 a chronology of significant events in the child's life
12 so that people having to quickly get up to speed on
13 information could look at that and determine what -- you
14 know, what significant events had occurred.

15 Q. Yes.

16 A. We didn't have that system within our own situation
17 unfortunately.

18 Q. I wasn't going to be smart about it, Hilary, but now you
19 have given that example, the other example is in
20 schedule 2 to the regulations. We were requiring the
21 home to keep --

22 A. Yes, that's right.

23 Q. -- a record of significant events.

24 A. That's right, yes. Uh-huh.

25 Q. We were having a discussion beforehand and we were doing

1 it in a very limited way, because I think it's a more
2 serious issue that arises between the Board and the
3 Trust, and that is about in paragraph 21 -- and with
4 this, Hilary, you will be pleased to know I am not going
5 to ask you any more questions --

6 **A. Uh-huh.**

7 Q. -- although the Panel may want to ask you some. If we
8 look at 9555, please, paragraph 21 of your statement,
9 you make reference to -- when it comes up -- section 94
10 of the Children and Young Person's Act 1968. It is in
11 response to one of the points that **DL 518** made. The
12 point that you are making from the provision was that
13 this was statutory permission or power available to the
14 Board to carry out inquiries.

15 I was saying to you when I first looked at
16 section 94, when I was looking at it, it was more about
17 children who weren't yet in care, who were coming into
18 care -- and I know Ms Smyth has adopted a similar
19 approach -- and yet in return you have identified or, to
20 give him credit, your counsel has identified,
21 Mr O'Reilly -- or maybe it was you told him to tell me
22 -- that there is an entry in one of the Board's policies
23 --

24 **A. In the Board's policies and procedure, yes.**

25 Q. -- about child protection that does refer to section 94.

1 **A. Uh-huh. Uh-huh. Uh-huh.**

2 Q. But in essence for the purposes of today the point you
3 are making is well, there was some authority to take
4 some steps. The Board were -- are taking a different
5 view about it, and I think the best way to proceed is
6 probably if each of the bodies takes a step back and we
7 will look at the provision again on another occasion and
8 they can set out in advance why they say this allowed
9 them to do certain things and the Board can say why they
10 felt --

11 **A. That it didn't, yes.**

12 Q. -- that it didn't.

13 Another point in this that I will flag up at this
14 stage is that the Board draw attention to section 117 of
15 the Act, because it was the power given to the voluntary
16 home and to the Department to compel the Board to remove
17 a child that they had placed in a voluntary home --

18 **A. Yes.**

19 Q. -- and I will just give the Panel the reference. That's
20 HIA-375 is the reference to section 117 and HIA-358. So
21 in keeping with -- I am not going to tackle the
22 section 94. I am also not going to tackle the
23 section 117 other than to flag up that's a point the
24 Board make, and they give the example of HIA62 back in
25 1974, the fall-out with SR18 and the social worker is

1 called. The child has to be removed the next day. It's
2 demonstrating the level of independence with the
3 Management Committee and the Board replacing children in
4 the home, but it was not a Board home, but yet the
5 regulator was the Department.

6 So if I park that squabble for today --

7 **A. Yes.**

8 Q. -- other than to note it publicly that it is there and
9 allow both Ms Smyth and Mr O'Reilly to address it
10 further and we can look at it further with the Panel as
11 needs be --

12 **A. Uh-huh.**

13 Q. -- in due course.

14 Hilary, I know that there are a couple of points
15 that you wanted to explain. I dealt with one of them,
16 that there are inspections from the earlier period in
17 time.

18 **A. Yes.**

19 Q. You are going to do some further work on that, but
20 I know you heard Kevin McCoy say something yesterday
21 that you didn't feel was accurate that you wanted to
22 talk about, which was that there was actually a lot of
23 interaction and linking between the SWAG, as it was, and
24 then the SSI as it became and the Policy Branch.

25 **A. Yes.**

1 Q. Do you want to just give the Panel some examples of that
2 connection that there was, because you felt he had given
3 the impression that really the two sides didn't -- of
4 the one Department didn't engage much.

5 **A. Yes. Well, probably unintentionally, but I am coming to**
6 **it with the advantage of having recently reviewed and**
7 **revisited all of this material whereas Dr McCoy is**
8 **a number of years removed from it now, but there were**
9 **significant -- there was significant communication**
10 **between Childcare Policy Branch and the professionals in**
11 **the Social Services Inspectorate and SWAG in that we**
12 **were asked to -- I was in the inspectorate. I wasn't in**
13 **SWAG, but I am able to tell from the documentation that**
14 **I have reviewed in the files that this was the case**
15 **before I personally came to the Department, but we would**
16 **have been asked to comment on the monitoring, all of the**
17 **monitoring, annual monitoring statements by the**
18 **voluntary homes and --**

19 Q. Let me just pause you there. What you are talking about
20 is the requirement that was introduced for voluntary
21 home to submit information. That went to Childcare
22 Branch.

23 **A. Yes, that's right.**

24 Q. What you are saying is Childcare Branch would have sent
25 that monitoring information to the Inspectorate --

1 A. That's right.

2 Q. -- to engage them about it.

3 A. That's right, and that would have included -- that
4 monitoring information included a list of all complaints
5 that had been received by each home during the year. We
6 were asked to not just comment on that but also to
7 meet -- there were a number of meetings held. Certainly
8 when the monitoring requirements were introduced, there
9 were annual meetings with voluntary organisations and
10 I know that -- and statutory providers, but not in
11 relation to every single home, and I know that, for
12 example -- I have just lost my train of thought. There
13 were these meetings that took place regularly.

14 Q. So if the --

15 A. Professional advisers attended the monitoring meetings.
16 I noted that whilst I had given evidence to the effect
17 that there was only one -- to my knowledge one kind of
18 general review of the registration of voluntary homes
19 in -- I can't remember exactly when I said that had
20 happened. I think when I was giving evidence in
21 an earlier module I said this, but, in fact, I notice
22 from recent documentation that some of those monitoring
23 meetings were actually called review of registration
24 meetings. So they were quite -- quite significant
25 meetings where the Policy Branch and the inspectors

1 would sit down together with representatives of the home
2 or the statutory agency and look at what had been
3 provided and identified.

4 Q. Can I pause you there for a moment? Did you find any
5 for Nazareth Lodge?

6 A. Yes.

7 Q. There are some for Nazareth Lodge, are there?

8 A. Yes, there are. Yes, there are, and they are in the
9 files that --

10 Q. They are in one those files that --

11 A. -- should have been -- would have been sent to you.

12 Q. -- we'll wade through and have a look for?

13 A. Yes, yes. So there was that. We were also heavily
14 involved in Boards' planning for children's services,
15 which would have included planning for residential care,
16 and we'd have attended strategic -- we would attend
17 strategic planning meetings. We would comment on
18 Boards' plans, for example, to both open and -- to open
19 new facilities and to close existing facilities, and,
20 you know, I know that my colleagues, for example -- some
21 of -- one of them at least would have been involved in
22 getting the Department to write to one of the Boards
23 where we -- where the Department felt that its plans to
24 close a children's home was not congruent with the sorts
25 of demands for residential care that were coming through

1 in other documentation.

2 As a kind of example of this -- it is outwith the
3 period of consideration by the review -- but in 1996 SSI
4 led -- my colleague Marion Reynolds led a massive
5 strategic development initiative around residential
6 childcare services, which really established the pattern
7 and the profile of residential care services in Northern
8 Ireland. I can make that available to the Inquiry if it
9 would be helpful, but it was commissioned in '96 and
10 I think published in '98. It's called the "Children
11 Matter Report", but it gives a flavour of the extent to
12 which we were involved in all sorts of ways with
13 Childcare Policy Branch and Boards and Trusts, who we
14 were -- there was a lot of --

15 Q. So it was one department.

16 A. Yes, yes.

17 Q. Different functions being carried out, but a lot of
18 interaction as well?

19 A. That's right.

20 Just one other minor point in relation to Dr McCoy.
21 He did say that inspection reports were made available
22 to Boards in 1986.

23 Q. It was an earlier date you think.

24 A. Yes. My understanding from the evidence given to the
25 Hughes Inquiry is that that must have been from at least

1 **1984, because that's when the Department was giving its**
2 **evidence, and the Hughes Inquiry noted with satisfaction**
3 **in '86 that Boards now received copies of inspection**
4 **reports.**

5 Q. And that would sit potentially with the exchange you can
6 see at the meeting early in 1984 whenever **DL 518** is
7 told by Norman Chambers that there are what's described
8 in the correspondence --

9 **A. Yes.**

10 Q. -- as major concerns --

11 **A. Yes.**

12 Q. -- but not about inappropriate chastisement.

13 **A. Yes, yes, it would have been around then --**

14 Q. What you are saying is after that period --

15 **A. -- it was around then that that began to be shared.**

16 Q. -- then the policy was adopted to share the report?

17 **A. Those were the matters in relation to (inaudible).**

18 Q. You'd one other matter you wanted about --

19 **A. Well, about some of the evidence given yesterday.**

20 Q. Mr Duffy had given evidence that you felt touched on the
21 Department's position?

22 **A. Sure. Yes. I happened to be here during Mr Duffy's**
23 **evidence, which I found very interesting. He did make**
24 **a couple of points and I felt that they merited further**
25 **explanation.**

1 One of the points that he made was that practice --
2 professional practice in Northern Ireland moved -- was
3 kind of moving ahead of a legislative framework, which
4 is very true, and, you know, an example of that would
5 be, for example, the introduction of child in care
6 reviews, which then were introduced initially by the
7 Eastern Board way back in 1977. These were review
8 meetings. Before that there had been paper reviews, but
9 the actual requirement to establish child in care
10 reviews did not come in until the 1995 Children Order
11 here. So that is true and that's just one example.

12 With reference to the complaints procedure, though,
13 I would be concerned that the Inquiry might get the
14 impression that somehow we moved ahead with a complaints
15 procedure that did not have a statutory framework and by
16 inference then we did not understand the context which,
17 you know, this was being developed within.

18 The complaints procedure in -- for children in
19 residential care and their parents came as a consequence
20 of one of the recommendations of the Sheridan Report,
21 which was produced in 1982 I think. The first
22 complaint -- there were -- there was certainly no
23 statutory framework for complaints for England at
24 that -- sorry -- for complaints for children in
25 residential care in England at that stage. In fact,

1 there were very few examples of English local
2 authorities having -- having adopted complaints
3 procedures, and we were told by Sheridan that that was
4 indeed the case, and, in fact, we might be able to look
5 at the few examples that existed.

6 The complaints procedure, therefore, was developed
7 as a matter of good practice here. It was subject to
8 wide consultation over a period of three years. The
9 voluntary organisations adopted it I think when the
10 final paper was produced in 1985. As a consequence,
11 however, of difficulties in relation to staff concerns
12 it could not be adopted by the Boards until 1991, by
13 which time, of course, England had their Children Order
14 1989 Act and the statutory framework was in place in
15 England, but, you know, I would not -- I wouldn't want
16 the Inquiry to think that, you know, somehow there was
17 a statutory framework that, you know, we didn't know, we
18 didn't understand.

19 Q. No, I don't think that's a --

20 A. We'd developed this. So there was that.

21 The other thing that he -- that Mr Duffy mentioned
22 was the fact that in England -- maybe Ms Smyth mentioned
23 it as well -- that in England there had -- sorry -- that
24 we had had no childcare legislation really between 1952
25 and 1968 and then 1968, of course, to 1995.

1 I understand -- and I just didn't have to time to
2 check this -- but I understand that there were two
3 pieces of legislation in England during those dates.
4 I think Mr -- one 1967, the other 1969. I think
5 Mr Duffy made the point that our '68 Act did not kind of
6 pre-empt the changes that came in the 1969 Act and that
7 we more or less lived without those until '95.

8 My understanding -- and I could be wrong -- but is
9 that the 1969 Act in particular was -- the main thrust
10 of that Act was to establish community homes with
11 education in place of approved schools.

12 Now had we -- that -- in England that suited the
13 kind of structures and so on that they had, because
14 obviously local authorities are responsible for both
15 education and Social Services. It wouldn't have easily
16 translated into our situation here.

17 I would like the opportunity to look at those two
18 Acts again to see whether, in fact, there were any
19 significant changes brought about by those Acts that
20 might have impacted on the quality of care of children
21 here, had similar legislation been implemented here.
22 I am not sure that there were, because I do recall that
23 when the Children Act in England was introduced, they
24 referred to the '89 Act as the most significant piece of
25 legislation, you know, in a century, and I imagine that

1 **all of the changes came about -- the significant changes**
2 **came about (inaudible).**

3 Q. I have good news for you, Hilary. You have got one year
4 and one month and after that there will be no more time.

5 A. **Right. Okay. Thank you. That was -- I am sorry**
6 **(inaudible).**

7 Q. Not at all. Those are the issues that you -- that you
8 in addition wanted --

9 A. **I felt that we should --**

10 Q. -- wanted to cover, and I know that -- and I am just
11 going to draw attention to the fact that you did it --
12 you went to the effort of writing to Sir William Utting,
13 who was performing a similar role at the head of the
14 Social Services in England --

15 A. **Yes.**

16 Q. -- in order to ask him for clarification of various
17 matters, and I know that the Panel will find --

18 A. **Uh-huh.**

19 Q. -- both your letter to him and the appendix reply from
20 him in your statement illuminating.

21 A. **Thank you.**

22 Q. So I am not going to ask you any more questions. The
23 Panel may want to ask you something. So just bear with
24 us for a short while, please, Hilary.

25

1 Questions from THE PANEL

2 CHAIRMAN: I wonder if I could ask you really to take
3 an overview of some of the matters you have been going
4 into in very considerable detail both in the documents
5 in the form of your report and the references in your
6 oral evidence today, but if we just look at one or two
7 things in relation to the way in which inspections were
8 carried out and what actually happened in the context of
9 the statutory obligations placed on the homes in
10 relation to monthly visiting in particular, my
11 recollection -- and I am subject to correction about
12 this -- is that there were one or two reports that we
13 came across when we looked at Termonbacca and Nazareth
14 House in Bishop Street -- whether they were from Ms
15 Wright or Miss Forrest I can't now remember -- but on at
16 least one occasion reference was made to the absence of
17 a visiting committee.

18 **A. I recall that.**

19 Q. I think that was in possibly the very late 1950s or at
20 the latest the first couple of years in the next decade.
21 It appears to be the position that thereafter, certainly
22 because there is no positive reference to this and any
23 documents that have survived don't refer to it, but
24 no-one seems to have paid any attention at all to the
25 observance or non-observance of the regulations. The

1 homes didn't and the inspectors don't appear to have
2 picked it up or thought it was relevant. Do you agree
3 with me so far?

4 **A. Absolutely, yes.**

5 Q. If I have understood what you are saying correctly, you
6 recognise that in effect that was a major error, because
7 a fundamental part of any inspection process, if I may
8 put it this way, the bottom line is --

9 **A. Yes.**

10 Q. -- you must check against the statutory requirements and
11 that simply wasn't done. Isn't that right?

12 **A. That's right.**

13 Q. It doesn't mean you can't look at things that are added
14 on on top --

15 **A. Yes. Uh-huh.**

16 Q. -- by way of developments for best practice, but you
17 must look at the statutory requirements. Isn't that
18 right?

19 **A. Absolutely.**

20 Q. That appears to have lasted as a situation for the best
21 part of two decades at least, because it is not picked
22 up again until in or around the time of the Hughes
23 Report or the Hughes Inquiry --

24 **A. That's right.**

25 Q. -- because it is 1983 or '84 that we suddenly see it

1 appearing here and elsewhere in other homes. Have you
2 come across anything that would suggest why that
3 happened? Was there a policy decision that it was no
4 longer necessary or how did that situation come about?

5 A. I really wish I knew the answer to that, because it is
6 one of the mysteries that I have found I just cannot
7 resolve in any way. There is no reference -- for
8 example, in the very early inspection reports we have
9 found no guidance given to inspectors. When I speak
10 about the very early inspection reports, I'm going back
11 to 1922 this Inquiry would be concerned with. We cannot
12 find any reference in whatever documentation exists at
13 the time to the effect that "This is the role of the
14 inspector and these are the things that you must look at
15 as part of your annual inspection".

16 There seem to be a policy of annual inspection and
17 we can -- I think we can determine that from the
18 frequency of inspections maybe as against England where
19 at the time we have the evidence that thousands of
20 children -- voluntary children's homes were not
21 inspected, and I've made reference to that somewhere,
22 but, you know -- so there definitely does seem to have
23 been a policy of annual inspection.

24 There seems to have been a policy too that
25 inspectors were asked to look at the "statutory books",

1 which would have included the menu book, the --

2 Q. Punishment book.

3 A. -- punishment book and the third one was the fire --
4 fire drills, etc.

5 Q. Yes.

6 A. Then later, of course, the complaints book was
7 introduced by departmental circular. Those seem to me
8 to be -- they are not minor in the sense that they were
9 important things too, but the fact that the only -- if
10 you like, the only kind of perhaps independent oversight
11 of the way a home was looking after children in its care
12 would have been that monthly visitor report, the visitor
13 had a duty then to report to the administering authority
14 what he or she found.

15 To me that was probably one of the most important
16 elements within the regulations, and I just cannot find
17 why that was not scrutinised and why it was not -- you
18 know, why that was not pursued with homes. I do recall,
19 Mr Chairman, the reference to the visiting committee not
20 having been established, and I thought, "Well, someone
21 was thinking about it at the time", but, as you say,
22 there is no further reference to it even within our
23 early inspections in the 1980s. It is only round about
24 '84 that we begin to get references to that.

25 Q. So nearly a quarter of a century goes by.

1 **A. Yes.**

2 Q. I appreciate it is perhaps stating the obvious, but it
3 is sometimes useful to have the obvious on paper, but,
4 as you have pointed out, the monthly visitor, the
5 concept was that someone was coming from outside on
6 a much more regular basis than the annual inspection by
7 the Department or the Ministry, as it was --

8 **A. Yes.**

9 Q. -- and, therefore, if something is obviously going
10 wrong, whatever it might be, that person hopefully would
11 pick it up. Now they may not. The child may not have
12 told them, for example, but at least the mechanism had
13 been put in place to allow that sort of more frequent
14 visit and inspection by an outsider --

15 **A. Yes.**

16 Q. -- to come in and then say to the administering
17 authority, "Look, you need to change this" or "Are you
18 sure you're doing that?"

19 This in a sense surely is a reflection of a very
20 long established principle that I imagine one could
21 trace back to mid-Victorian or later times where the
22 idea of the inspector coming into whatever it is, a
23 prison or any other place where the public don't
24 normally go to just see that things aren't going wrong.
25 So it is a very fundamental requirement. Isn't that

1 right?

2 **A. Absolutely, and it -- you know, to me it would have been**
3 **a very helpful tool for an inspector to have seen those**
4 **reports made by the -- I know it doesn't -- I can't**
5 **remember whether it says a written report, but to have**
6 **had an overview of those written reports is a very, very**
7 **valuable tool in determining -- for the inspector to**
8 **come to conclusions about issues and quality of care in**
9 **the home, and I just cannot explain --**

10 Q. To give a simple example, if an inspector recorded every
11 month that the children were being given watery stew
12 seven days a week --

13 **A. Yes.**

14 Q. -- somebody should have started asking questions.

15 **A. Absolutely.**

16 Q. Then if we go to the next stage of this process, you
17 through your very thorough and careful examination of
18 the foundation books and related records have been able
19 to fill in the missing points in the jigsaw, but it is
20 clear that there were annual inspections or nearly
21 always annual inspections, although sadly we don't know
22 what the outcome was, but as I understand what you said
23 in relation to Nazareth Lodge, you are confirming that
24 the inspections stopped in 1972. That's the last one
25 until about nine years later?

1 A. That's right, yes. '83, yes.

2 Q. So not only were the previous inspections not picking
3 something up, but the inspections actually stopped.

4 A. Yes, they did and they were replaced by these visits,
5 which would appear to be part of this new policy of
6 having an advisory, consultative role rather than
7 a regulatory role. I am not defending that in any way,
8 but I am saying that appeared to be the understanding at
9 the time, and, in fact, if we look at some of the
10 documents -- the kind of social historical writing about
11 that period, that that also -- I think in the history of
12 the Social Services Inspectorate in England the writer
13 there points out that this would be -- this kind of
14 advisory, consultative role clearly took precedence over
15 the inspection duties, and I would have to say it would
16 have been -- it would have been appropriate for the two
17 to have gone along hand in hand, but they obviously
18 didn't, and I can only suggest that that was perhaps how
19 Seebohm was interpreted at the time, and, "We will bring
20 these organisations along. We will not be too concerned
21 about whether they are fulfilling the letter of the
22 law". That was an unfortunate (inaudible).

23 Q. There was another unfortunate aspect of this. Isn't
24 that right?

25 A. Yes, that's right.

1 Q. Then if I could ask you to come to -- here we might have
2 SNB-14327 I think it is brought up. Now I am going to
3 the inspection that Mr McElpatrick and Mr -- no.
4 I think it is probably ...22, 14322, but while we're
5 finding this, the structure in Nazareth Lodge at the
6 time of this information in reality, though not the way
7 it was called, but in reality there were three separate
8 children's homes inside one big unit, because they had
9 got to the stage where they were completely
10 self-contained to all intents and purposes. If I am
11 right, they had somewhere in the region of twelve to
12 fourteen children each. So each group, which was the
13 responsibility of a Sister, if one stood back from it,
14 was the equivalent of a local authority children's home
15 almost, wasn't it?

16 **A. Yes, with an officer in charge, yes.**

17 Q. So we have three -- in reality, although not in form, we
18 have three separate children home -- children's homes on
19 one site under a common, in management speak, unit of
20 management.

21 **A. Yes.**

22 Q. Looking at the position of the separate children's home,
23 the regulations require there to be a person in charge
24 -- isn't that right --

25 **A. Yes.**

1 Q. -- whose appointment had always to be notified to the
2 Ministry and then to the Department.

3 **A. Yes.**

4 Q. I take it that is because the key person in the home is
5 the person who is in charge. He or she sets the tone
6 for the place, brings about improvements or lets things
7 go down by personal example or application. Isn't that
8 right?

9 **A. Yes.**

10 Q. So in that sense in reality the three people who were in
11 charge here were -- of course, we won't be using the
12 names outside the chamber -- but SR148, SR2 and SR46.

13 **A. Uh-huh.**

14 Q. Now SR148's position in the eyes of Mr Chambers, who
15 wrote this document, was she was doing the right things
16 the right way. So there you have one home being well
17 run.

18 The second home was that being run by SR2. She had
19 only just arrived, was open to ideas and suggestions.
20 So although she didn't have any experience in this field
21 or insufficient, she should be given a chance to see how
22 she coped, because she seemed to understand what she
23 should do. So far so good. Isn't that right?

24 **A. Yes.**

25 Q. But the third home, the one run by SR46, is run by

1 a lady -- and if we just scroll down a bit, please, to
2 the end of the document, if we look at the sentence
3 beginning:

4 "While one of the Sisters clearly has this ability
5 ..."

6 **A. Uh-huh.**

7 Q. "... the third Sister had little understanding of
8 residential social work and her ideas are largely
9 irrelevant to the statement of aims and objectives."

10 Now would it be fair to say that if you put that --
11 without putting it too sad, Mr Chambers was saying SR46
12 just wasn't up to the job.

13 **A. Yes, that's right.**

14 Q. So here you have a home where the person in charge in
15 the view of one of the inspectors is simply not capable
16 of doing the job.

17 **A. Yes.**

18 Q. We don't see that in the ultimate report, do we?

19 **A. No. That's right.**

20 Q. Now the way that problem could have been addressed as
21 far as I can see might have been to say, "Well, you
22 bring in someone to mentor the person concerned in the
23 hope that they may realise where they are not doing
24 well", or perhaps add to that or in place of that you
25 send them on a training course of some sort, or finally

1 you just replace them --

2 A. Yes.

3 Q. -- but none of those options in relation to this home in
4 reality appear in the end result in the report, do they?

5 A. No, although I think there is some -- I believe there is
6 some comment in relation to the need -- for the need --
7 the need to invest in staff training. Now whether that
8 was -- as far as I remember -- I may be wrong. I have
9 read so many reports, but, I mean, I may be wrong.

10 Q. I share your difficulty.

11 A. Yes. No. Certainly it doesn't appear in relation to --
12 certainly a person is not singled out as not being up to
13 the job. There are no recommendations about the need to
14 bring someone in to mentor unqualified persons who are
15 in positions of responsibility within the home.

16 In relation -- I totally accept what you are saying
17 about these three units being made -- being essentially
18 three separate children's homes. It is interesting to
19 note -- because I was thinking while you were speaking
20 whether or not the Sisters in charge of those homes were
21 notified to the Department, but, in fact, that wasn't
22 the case. It was the Mother Superior, changes to the
23 Mother Superior appear to have been notified to the
24 Department. So whilst we might look at that as
25 an analogy of three separate children's homes, to me it

1 sounded as if the Department regarded the unit as one
2 children's home with three separate groups --

3 Q. Yes.

4 A. -- as opposed to -- and perhaps if they had looked at it
5 as three children's homes and felt, "Here's the
6 equivalent of an officer in charge not performing
7 satisfactorily. How seriously would we view that in
8 another setting?", then, you know, we might have had
9 a slightly -- a different set of recommendations, but
10 I think because the unit was registered as one
11 children's home, that maybe the kind -- you know, the
12 subtlety of the fact that these three units were
13 autonomous and these people were acting as officers in
14 charge did not occur to the inspector. It should have
15 done, but it perhaps didn't.

16 Q. We know that apparently SR46 didn't leave until 1986.
17 So somebody who was condemned by one inspector as not
18 being fit for the job seems to have survived through a
19 number of succeeding inspections. So either Mr Chambers
20 was very wide of the mark or else --

21 A. We didn't --

22 Q. -- it wasn't pursued.

23 A. Yes, yes. The succeeding -- we don't have the '86
24 inspection report unfortunately. So we don't know
25 whether that issue was addressed in the '86 inspection

1 **report.**

2 Q. Just if I could follow up -- and I think this is the
3 last thing I will be asking you -- Mr Aiken asked you
4 about whether if there was a difference of opinion
5 between the two inspectors, Mr McElfattrick in this case
6 and Mr Chambers, how would that be resolved. You quite
7 correctly reminded us that where you have more than one
8 person involved, there may well be differences of
9 emphasis or opinion and in the first instance the two
10 concerned in this instance would try to see whether on
11 reflection they would stand over their position without
12 sacrificing any point of principles --

13 **A. Yes.**

14 Q. -- but if that couldn't be resolved, then there would be
15 a process of mediation; in other words, someone higher
16 up the management chain would come in and try to resolve
17 the situation or, if necessary, say --

18 **A. Yes.**

19 Q. -- "Well, I'm sorry. I don't agree with you. I agree
20 with the other person. That's the way it's going to
21 be."

22 **A. Yes.**

23 Q. I understood you to say that you would have expected
24 some form of discussion like that, if it did take place,
25 to have been recorded.

1 A. Yes. If there was sort of a divergence of opinion and
2 the -- one Inspector was saying, "I totally disagree
3 with what you're saying. This is not my experience",
4 and they couldn't come to some kind of agreement that
5 both would be happy would be a true reflection of the
6 situation, I would expect that to be recorded, but I can
7 think of many instances where we met and -- in
8 discussing reports and differences of views and we came
9 to decisions about how those views should be reflected
10 in a report and there was a consensus at the end. Now
11 that discussion wasn't necessary -- was not necessarily
12 recorded. Where that -- where the -- where changes were
13 made to, for example, a draft report, they would have
14 simply been noted that we -- you know, we agreed these
15 changes and the changes would have been made and a fresh
16 report sent out to the participants. We wouldn't
17 necessarily have recorded discussions about draft
18 reports.

19 Q. I think I was premature in saying I didn't have any more
20 questions. This is perhaps more of an observation than
21 a question.

22 Mr Chambers had just come into effectively the
23 Social Work Advisory Group quite a short time before
24 from the position of being in charge of Barnardo's
25 homes. Isn't that right?

1 A. Yes.

2 (Witness' phone rang)

3 A. I'm so sorry, Mr Chairman.

4 Q. No, no.

5 A. I'm sorry. I had that switched off earlier. I'm so
6 sorry.

7 Q. It can happen in the best regulated circumstances. But
8 he was coming from the voluntary sector from the
9 position of having run a children's home --

10 A. Well, having had management responsibility --

11 Q. -- or responsibility for.

12 A. -- for a range of services, which included residential
13 care.

14 Q. Yes, and he doesn't seem to have been impressed by what
15 he found.

16 A. No, not in the case of Nazareth Lodge. That's right.
17 He would have been -- at that stage Barnardo's would
18 have been one of the few voluntary --

19 (Witness' phone rang)

20 A. I'm so sorry. It's my husband looking for me. I told
21 him I would be back at lunch time. I am so sorry about
22 that, Mr Chairman.

23 The -- Barnardo's at that stage would have been one
24 of the few voluntary organisations that had a policy of
25 employing only qualified staff in their children's homes

1 and they were moving towards a fully qualified staff,
2 including qualified officers in charge. So the kind of
3 experience -- and indeed they -- as you will have seen
4 perhaps from some of the financial information that you
5 have reviewed, that Barnardo's would have had very
6 generous per capita payments from the Boards, because
7 they were able to argue their case very well, and so
8 they also had very large -- I hope I am not
9 misrepresenting them -- they would have had fairly large
10 capital reserves as an organisation. So they were able
11 to do innovative things.

12 You had a situation in '83 where children who could
13 not be looked after in other situations were often
14 referred to Barnardo's homes, because they had the
15 specialist expertise and so on.

16 So the difference I imagine would have been quite
17 stark. There would have been no question, for example,
18 of staff doing the kind of hours that the Sisters were
19 doing, and this must have been quite -- quite a shock,
20 and therefore perhaps some of his observations were the
21 kind of very -- kind of extreme observations were
22 coloured by having come from another extreme.

23 It would be interesting -- I don't think he was
24 asked the question, but given then his kind of
25 experience after this of doing inspections, whether he

1 **would have felt that the standards in Nazareth were**
2 **quite so low as what had appeared in his initial -- I am**
3 **being purely speculative here. I realise here, but I do**
4 **understand the situation that he came from.**

5 Q. Thank you very much.

6 MS DOHERTY: I will try and keep this brief. First of all,
7 thank you very much for the clarification about the
8 contact between the Inspectorate and the Policy Branch.
9 That was very helpful.

10 I understand that there's going to be a different
11 interpretation about the child protection regulations.
12 So I'm not -- I will leave that for better than me, but
13 I just want to look at a professional point of view. In
14 a sense if the Boards had intervened and gone in to
15 inspect and the view of the Department is that they
16 could have interviewed senior managers, they could have
17 interviewed, you know, ex-staff and whatever, would that
18 not have just been limited to these particular three
19 children? I mean, in a sense if they had a right to go
20 in and ask, they could ask about the situation of these
21 three children, but to go beyond that and ask about
22 general childcare policies, about other children being
23 involved would really be going beyond their brief.

24 **A. Yes. I agree if that had been the task envisaged by the**
25 **Department, but I don't think that was the task**

1 envisaged by the Department. I think the Department
2 were saying, "You have children here who are making
3 allegations that other children were abused while they
4 were in care. You have the authority to go in and
5 question staff about that" -- sorry -- "you have the
6 authority to go and question those former children about
7 that alleged abuse. You do have the authority to ask
8 the head of unit whether this particular member of staff
9 was employed at the time". You know, were there any
10 records or whatever relating to these allegations?

11 Also, most importantly, I think if the child
12 protection procedures had been -- had been implemented,
13 police would also have been involved. Now we see that
14 the -- that in the -- in the 1985 complaints that
15 were -- you know, took such a long time to resolve
16 somebody at the end of the day said to the children, "Do
17 you want to make a complaint to the police?" You know,
18 that should have been done right at the very beginning.
19 If you had several children who were alleging that
20 a member of staff, who was no longer in charge, had
21 abused them, that was a matter -- you know, some of
22 those complaints clearly were physical assault. That
23 was a matter for the police, and the police would have
24 been enjoined in that investigation. Obviously they
25 also could have addressed questions to staff.

1 In terms of the general running of the home, as
2 I say, I don't think that was envisaged, that the Board
3 would do that. What they would -- and again if I may
4 point to the fact that when there was a question about
5 food and the use of a time out room, the inspector went
6 and investigated both of those matters, because they
7 probably felt the Board can't go and ask about general
8 food provision. They may be able to ask about this in
9 respect of a specific child, but, you know, these --
10 they -- the police would have been enjoined in a proper
11 child protection investigation.

12 I think we've got to remember that there were no
13 concerns about the current running of the home at the
14 time these allegations were made. The children had --
15 the young people making the allegations had left at
16 least four years previously. SR62, although we don't
17 know the reason -- we didn't know the reasons why she
18 was no longer there, had been removed. So the
19 Inspectorate's view was, "Actually we don't -- we can't
20 wade in here. We are very -- we are satisfied" --
21 albeit given the comments in '83 -- "we are satisfied
22 with the way the home is being run. There is no
23 indication of punitive or harsh discipline".

24 Q. Can I ask do you think at that time the voluntary homes
25 had an understanding that the Boards could come in and

1 carry out a thorough, far-reaching inspection in
2 relation to the way that they managed their childcare
3 policies and practices both currently and previously
4 that dealt -- do you think that that exchange and the
5 Boards being able to go in like that would have been
6 acceptable?

7 **A. They would have had -- I don't think that's what the**
8 **Department was asking them to do. I think the**
9 **Department was asking them to investigate the complaints**
10 **made by the individual children. So these were**
11 **complaints that someone had beaten a child with a vacuum**
12 **hose, something like that. They had the authority to go**
13 **and ask the home, "This" -- tell them, "This member of**
14 **staff has been accused of this. The member of staff is**
15 **no longer here. Have you any knowledge that this might**
16 **have happened?" In my view they would have had that**
17 **authority. I don't know that -- you know, I may be**
18 **wrong, but we would have -- certainly -- again I am**
19 **thinking back to practice -- that if a child had made**
20 **a complaint to me when I was a social worker in the '70s**
21 **-- and, in fact, this did happen -- I immediately**
22 **questioned the head of the home about whether it might**
23 **have happened and what they had done about it. It**
24 **wasn't a complaint about abuse, but it was -- and it was**
25 **in relation to the individual child.**

1 Q. Could we agree that in relation to the Board's
2 responsibility it was about individual children --

3 **A. Yes.**

4 Q. -- and their right to protect individual children --

5 **A. Yes.**

6 Q. -- and their focus had to be on individual children,
7 what individual children rose?

8 **A. That's right.**

9 Q. But the general practice of the home, the home's --

10 **A. Yes.**

11 Q. -- issues about corporal punishment, the application of
12 corporal punishment, that that was something for the
13 Department to have an overarching concern about.

14 **A. Yes.**

15 Q. In that context then is it not surprising that, you
16 know, Dr McCoy confirmed yesterday that the Department
17 at that time didn't contact any of the other Boards to
18 say, "Have you got any concerns? Are there any matters
19 being raised with you about physical punishment in
20 Nazareth Lodge?"

21 **A. I can't remember whether -- I think -- I can't remember**
22 **whether at the time the complaints came in there were**
23 **children from other Boards placed. There may well have**
24 **been, but the point is that when the complaints came in,**
25 **there was no indication that there was anything wrong in**

1 that home at that time. The -- there would have -- if
2 child protection procedures had been implemented, the
3 Board -- the Eastern Board would have said, "We have
4 had -- we have had allegations that this child -- we
5 have had an allegation that a child has been abused.
6 This child is alleging that these other children were
7 abused". In fact, this did happen in one of the
8 complaints. "These children are in your care. We would
9 like social workers to interview. We would like you to
10 check with that child whether, in fact, he had
11 experience" --

12 Q. Can I just interrupt for a second? The only
13 organisation with overall responsibility for both
14 registering and regulating and assuring itself of the
15 quality of the childcare practice in Nazareth Lodge was
16 the Department. So if the Eastern Board was dealing
17 with these three children and their historical claims
18 and whatever -- I understand that and I understand that
19 you are saying certain things would have triggered off
20 if the child protection procedures had been used,
21 including the police being involved, but in relation to
22 the responsibility of the Department to say, "Okay.
23 This is a home we are registering. There's been serious
24 complaints. We are telling the Eastern Board to get on
25 with investigating this". Would it not have been

1 a responsibility for the Department to say, "We as the
2 regulator need to just check there is not other concerns
3 happening elsewhere that the Eastern Board may not be
4 aware of"?

5 **A. Yes, but I think that was done in the inspection**
6 **process, because, you know, we had -- we had evidence of**
7 **inspectors seeking the views of social workers who had**
8 **children placed in the home as to the quality of care**
9 **that they were receiving and there were -- satisfaction**
10 **was expressed about that quality of care.**

11 Q. I am not going to go any further with it, but just to
12 say satisfaction is expressed and then serious
13 allegations emerge which are identifying a number of
14 children. So in a sense -- we know from inspection --
15 and Dr McCoy made that point yesterday -- you can
16 inspect and things can look okay and then matters arise.
17 This seems to me a matter arises. An inspection says,
18 "It all looks okay" and then there's some serious
19 allegations.

20 **A. Uh-huh.**

21 Q. I would have had an expectation that perhaps the
22 Board -- the Department would have said at that stage --
23 I understand why you're saying to the Eastern Board,
24 "You get on with it", but in a sense the Department's
25 overarching responsibility for the registration and

1 regulation of that home would say, "We need to just
2 check there is not other things around, we as the people
3 with the overarching responsibility".

4 **A. It certainly wouldn't have -- you know, the Department**
5 **certainly could have written out to other Boards and**
6 **sought a view about whether other children were making**
7 **similar complaints. I suppose I can only go back to the**
8 **situation as it was, that when the second serious**
9 **complaint was made, the Department sent in an inspector**
10 **within two weeks of that complaint being made. We don't**
11 **have the report. We don't have any indication of what**
12 **that inspector did. It is possible that in his --**
13 **during the course of his inspection he contacted social**
14 **workers. You know, it is possible that that happened,**
15 **because the Department was able to come to the**
16 **conclusion that there were no harsh disciplinary or**
17 **punitive regimes in the home at that time. What they**
18 **were saying was, "Look, if you have evidence -- if you**
19 **feel there may be historical abuse, then this -- you**
20 **know, the Board needs to contact" -- this would not be**
21 **unusual in child protection. The Board without any**
22 **reference to a Department would contact other Boards.**

23 **Q. I understand. I mean, one of the points you make is**
24 **that the circular wasn't expected to deal with what**
25 **would happen if child protection matters came to**

1 the fore after preliminary investigations, that it
2 wasn't for the circular to deal with that. I just
3 wonder was that written down elsewhere? Was there
4 a policy and procedure agreed, you know, to say, "Okay.
5 Here is the preliminary investigation. This is the
6 Board's -- this is the Board's responsibilities. What
7 happens if issues do emerge?"

8 **A. Yes. Well, in fact, I would agree that that -- if**
9 **I were to criticise the circular, it would be to the**
10 **effect that it did not mention anything about child**
11 **protection procedures. Perhaps reflective of the kind**
12 **of impact that the complaints procedure had, it dealt**
13 **a lot with staff disciplinary procedures. That was the**
14 **thing that staff were concerned about.**

15 If I might just refer to the current Children Order
16 Guidance and one sentence in it. Had this -- had this
17 sentence been contained in the complaints circular, it
18 might have resolved a lot of confusion. It simply says,
19 and this is in the Children Order Guidance on the
20 Handling of Complaints:

21 "The handling of a complaint may be concurrent with
22 action under the disciplinary procedures or child
23 protection action and on occasion a police
24 investigation. Decisions on how to proceed will be made
25 on the basis of individual cases."

1 Had it said something like that, I think the matter
2 might have been resolved. Also the Children Order
3 Guidance -- the guidance came out of experience of
4 working with complaints -- the Children Order Guidance
5 makes it quite clear that when a complaint is made
6 against a member of staff, if it is a complaint and it
7 is against a member of staff, it should be investigated
8 under the child protection -- under the child protection
9 procedures where that is relevant.

10 Q. Okay.

11 A. **Sorry.**

12 Q. Just the last thing about the circular you will be glad
13 to hear, the circular clearly gives a prominent role for
14 Management Committees in voluntary homes, and the
15 circular actually comes out I think it is in the May of
16 1985, but it isn't until the June of 1986 that there's
17 actually any indication that Nazareth Lodge is going to
18 have a Management Committee or start, and that's
19 obviously the intervention of the Department.

20 A. **Yes.**

21 Q. But it is quite interesting that the Department has
22 a view that there's Management Committees and there's
23 Management Committees that can be given roles within
24 a circular, but yet is inspecting a home regularly or
25 having informal contact with a home regularly where

1 there is not a Management Committee. Would you have
2 expected that to have been raised earlier?

3 **A. I would have thought so. Now, as you know, there is no**
4 **requirement in the regulations for the administering**
5 **authority to establish a Management Committee, but I --**
6 **I -- I mean, given the kind of distance of the**
7 **administering authority in the case of this --**
8 **particularly the Sisters of Nazareth Order, it -- you**
9 **know, it would have been appropriate for the Department**
10 **to have suggested earlier that a Management Committee**
11 **should be -- should be established.**

12 I think I recall -- it may be one and the same
13 **thing -- I think I recall something about a monitoring**
14 **group having been established, and I think that might**
15 **have been a forerunner to a Management Committee, but**
16 **I'm not entirely sure, and you are quite right. It**
17 **would have been appropriate for, you know,**
18 **recommendations to that effect to have been made much**
19 **earlier.**

20 **Q. This is going to be my last one, and again, I mean, it's**
21 **just from a professional point of view. I mean, one of**
22 **the things that strikes me about the situation with SR18**
23 **is there's a view that SR18 behaved in particular ways**
24 **and then she goes. She is let go. She admits to some**
25 **errors and she leaves. Everybody seems to think, "Phew!**

1 That's it. You know, that person has gone. So we can
2 be content that has been dealt with", and yet the whole
3 issue of what was happening within the home in terms of
4 governing, supervision, training, monitoring of
5 practice, that this could have been allowed to go on for
6 so long, it seems that that's a gap.

7 The same with in a sense NL 157 [REDACTED], because
8 that was not just about one person. That was where
9 a junior member of staff was queried about her behaviour
10 and she points to the fact that she followed the lead of
11 a Sister, a more senior Sister, you know, that she seen
12 her put shampoo round a child's mouth. So it is not
13 about one member of staff being disciplined or told what
14 to do by the Mother Superior. You again have some
15 practice that seems a bit more ingrained than just one
16 individual person.

17 Would you have expected those -- you know, to have a
18 further regard to what was happening within the home,
19 that these practices were being undertaken by one nun or
20 by a nun and a lay person?

21 **A. The NL 157 [REDACTED] complaint, it was SR2 and NL 163 [REDACTED]
22 [REDACTED] were involved.**

23 **Q. Yes.**

24 **A. Now the Department wrote to SR143 outlining those
25 allegations and NL 157 [REDACTED] was interviewed by social**

1 workers, etc. A formal complaint was established.
2 SR143, she was the representative of the administering
3 authority who had responsibility for the employment,
4 etc, of staff. She confirmed to the Department that
5 a staff had been reprimanded. Now whether that was
6 sufficient or not, that's you know, debatable, but the
7 staff had been reprimanded, and that I think --
8 I haven't got all of my notes here -- but she was
9 assuring the Department at that time that that practice
10 had absolutely and utterly ceased.

11 With regard to SR18, my understanding is that the
12 first mention of SR18 is, in fact, actually in
13 a complaint which was dealt with by the Board, which one
14 of our inspectors picked up on, and that was that --
15 I am just trying to find the --

16 Q. Sorry. I mean, I suppose the issue is that I think that
17 in relation -- there's an issue about whether you would
18 accept the assurances, you know, that the two -- the two
19 members of staff had been reprimanded. I mean, there
20 might be an issue about what -- you would want to know
21 more about kind of the discipline of children, but in
22 relation to SR18 -- and I would link that to Judith
23 Chaddock, you know, not getting a response to the issues
24 she outlined -- there appears to be a focus on the
25 individual nun, and the fact that she's been removed

1 gives a level of assurance --

2 **A. Yes.**

3 Q. -- that really doesn't focus on what was happening that
4 that person was allowed to behave in that way.

5 **A. Yes, the wider picture.**

6 Q. The wider picture.

7 **A. Yes, yes. Yes, that's right, and should have been**
8 **picked up and dealt with even specifically within**
9 **further inspections and so on.**

10 Q. Thank you.

11 MR LANE: Just one loose end to start with about the
12 questions you have just been asked about the
13 disagreement between the Board -- the Eastern Board and
14 the Department about the interpretation of that.

15 You do accept, don't you, that it was for the
16 Department to clarify anything that was unclear then; it
17 wasn't the Board's responsibility to do that?

18 **A. I do. I think -- yes, I do and I think that had the**
19 **Department sought to do that at an early stage by**
20 **bringing the participants together, that it would have**
21 **led to a speedier and probably more satisfactory**
22 **resolution of the matter.**

23 Q. Thank you. The 1952 regulations which governed the
24 voluntary homes, I think they got renewed, didn't they,
25 in '75?

1 **A. '75, yes.**

2 Q. In which case this would have been during the period
3 when there was this SWAG period, when there was less
4 inspection.

5 **A. Yes.**

6 Q. Who would have been involved in reviewing those to
7 decide on the updating? Would it have been the Policy
8 Department?

9 **A. It would have been the Policy -- yes, Childcare Policy**
10 **Branch. Whilst they were updated, you will probably**
11 **have noticed they didn't actually change very much from**
12 **the '52 regulations. The updating was really about**
13 **making provision within the regulations for the new**
14 **structures, you know, the Board, etc, etc, as opposed to**
15 **Welfare Authorities. So it was -- whilst, yes, they**
16 **were updated, the actual content wasn't significantly**
17 **changed.**

18 Q. Would the Inspectorate have been or SWAG have been
19 involved in that at all? Would they have been
20 consulted?

21 **A. I would think so, yes. I mean, we were certainly**
22 **consulted on all proposed regulatory and -- all proposed**
23 **regulatory change and, you know, introduction of primary**
24 **legislation. We'd have been very closely involved in**
25 **all of those things.**

1 Q. In which case the points being raised by the Chairman
2 about the visitors' role not being checked up on --

3 **A. Uh-huh.**

4 Q. -- it could have been identified and either omitted
5 because it was something nobody wanted or alternatively
6 people should have been realerted to it at that point.

7 **A. They should have been realerted at that point.**

8 Q. I do realise that the regulations didn't change much --

9 **A. Yes. Uh-huh.**

10 Q. -- but it sounds as though they were nodded through
11 rather than really reconsidered, doesn't it?

12 **A. Yes, yes.**

13 Q. I'd like to then -- oh, one other question on that. I'm
14 sorry. That is whether you are aware of any other
15 regulations which used to get sort of overlooked or were
16 deemed less important, or is that the only one?

17 **A. In relation to children's residential care?**

18 Q. Yes. Uh-huh.

19 **A. It's the only one I'm aware of --**

20 Q. Right.

21 **A. -- up to the present, yes.**

22 Q. Okay. Thank you. I'd just like to go back to the
23 nature of SWAG and how it was set up, because you did
24 make the point that one of the reasons why the 1969 Act
25 in England and Wales was not replicated here was because

1 it didn't really relate to the Northern Ireland
2 situation. Now, if so, why was the idea of SWAG taken
3 over from Seebohm? Did that relate to the Northern
4 Ireland situation, do you think?

5 **A. It probably did, because if you recall, there was**
6 **a period of Direct Rule in '72 which -- and then a very**
7 **kind of tentative Northern Ireland Government between**
8 **'72 and '74, and then after '74 we had Direct Rule.**

9 **So we had a Westminster Minister, who would have**
10 **been implementing, you know, ideas and, you know, sort**
11 **of replicating ideas that were being implemented, you**
12 **know, in England and so on. You know, for example, the**
13 **establishment of the Health & Social Care Trusts in**
14 **Northern Ireland were a direct result of having**
15 **a Westminster Minister who related to -- you know,**
16 **during the Mrs Thatcher years of government, where this**
17 **model was being promoted in the health service over**
18 **there, but because we had joint health and social care**
19 **here, we -- it was replicated here.**

20 **Q. I appreciate it may well have been replicated, but that**
21 **doesn't necessarily mean that it suited the needs of**
22 **Northern Ireland at that time. It could have been**
23 **something seen as being imposed from the Westminster**
24 **government.**

25 **A. Yes, yes. That's right.**

1 Q. Because if it was unsuited to here, then one perhaps
2 should have looked at what was required by way of
3 an Inspectorate for Northern Ireland.

4 **A. Yes. One could have done that, but at the end of the**
5 **day the Civil Service and the Inspectorate are there to**
6 **serve the Minister and, you know, they would be greatly**
7 **influenced by what the Minister believes is an**
8 **appropriate way forward.**

9 Q. Who would have been presumably influenced by the DHSS in
10 London?

11 **A. Absolutely, yes, on what was happening.**

12 Q. The Policy Branch, was that made up totally of civil
13 servants or did it have --

14 **A. Yes.**

15 Q. -- social work professionals and so on in there?

16 **A. No, it had civil servants. They were civil servants,**
17 **yes.**

18 Q. One of the comments made was that SWAG was dealing with
19 a much wider range of things than simply inspecting
20 residential. Was there at that period a much bigger
21 range of things that needed to be addressed that
22 diverted people?

23 **A. Oh, yes, absolutely, because in '72 when the Trusts were**
24 **created and, you know, lines of accountability, etc, had**
25 **to be worked out, people were grappling with new roles.**

1 Structures -- sorry. '72 Trusts weren't created. The
2 new -- the four Boards were created --

3 Q. Uh-huh.

4 A. -- and the -- from the old welfare authorities. Certain
5 functions -- for example, the Department of Health and
6 Communities had prior to this then supported all
7 community social services operated by welfare
8 authorities whereas children's homes were -- they were
9 the responsibility of the Ministry of Home Affairs --

10 Q. Uh-huh.

11 A. -- and one of the recommendations of Seebohm, as you
12 know, is they should be brought together. One
13 Department should be responsible for the delivery of the
14 personal social services. So we -- there was the
15 transfer of responsibilities in '72 to the Department,
16 which it was getting used to. There was the creation of
17 the four Boards from having had several welfare
18 authorities and how -- you know, how the new
19 legislation, the '72 Order, would be worked out, and all
20 of the various, you know, things associated with that.
21 So inspectors actually were given -- SWAG advisers were
22 given areas of responsibility, and you'd some who
23 related to issues in the Eastern Board, etc, etc, and
24 I think I have quoted in my evidence that, for example,
25 in addition to visiting children's homes, John O'Kane

1 was to look at, you know --

2 Q. Early years.

3 A. -- provision -- early years provision, a massive kind of
4 portfolio in itself in addition to other
5 responsibilities, yes.

6 Q. Was there any additional work for the Department in
7 relation to the Troubles at that time?

8 A. Well -- additional work? I -- oh, dear! I think it was
9 such a difficult time for everyone, including Boards,
10 and I really -- because I haven't made a kind of study
11 of the impact on social work of The Troubles and its
12 impact on central government, I am, you know, not in
13 a position to say exactly what that was, but that just
14 it would have been extremely difficult for everyone
15 concerned.

16 Q. Just one last question. This role of SWAG, is it made
17 explicit in any documents at that time outlining what --
18 you know, how it was expected to work?

19 A. Yes, yes. No, and, in fact, that's why I contacted
20 Sir William Utting, because I thought, "Well, someone
21 will have an idea why there was this sudden change of
22 policy. Why would inspections, you know, become
23 defunct? Why would people who were called inspectors
24 suddenly become advisers?" and that's where I got the
25 information.

1 Q. But there is nothing specifically relating to Northern
2 Ireland?

3 **A. There is nothing that we have seen in Northern Ireland**
4 **in the documentation that we have reviewed for this --**
5 **for the Inquiry.**

6 Q. Thank you very much.

7 **A. Nothing we've seen.**

8 CHAIRMAN: Well, Dr Harrison, I am sure both you and your
9 husband will be relieved --

10 **A. Sorry.**

11 Q. -- to hear that we are not going to keep you here any
12 longer. Thank you very much indeed. I know it has been
13 a very long day for you, but it has been very helpful
14 indeed for us to explore with you on behalf of the
15 Department the intricacies of many of the things that we
16 have been discussing today, and the information you have
17 given us has been extremely helpful. Thank you very
18 much indeed.

19 **A. Thank you.**

20 Q. Whether you will be looking forward to seeing us again
21 is another matter, but I imagine we will see you again,
22 but until then thank you very much.

23 **A. Thank you very much.**

24 MR AIKEN: Chairman, Members of the Panel, that concludes
25 today's oral evidence.

1 CHAIRMAN: Yes. I should just perhaps confirm for the
2 purposes of the record we had hoped to hear the evidence
3 of Sister Brenda today, but as you and no doubt she now,
4 Mr Montague, will appreciate, it would be quite wrong to
5 start on her evidence at this late hour of the day.

6 MR MONTAGUE: Of course, certainly.

7 CHAIRMAN: We hope to be able to do so on Monday.

8 (4.25 pm)

9 (Hearing adjourned until 10 o'clock
10 on Monday, 11th May 2015)

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DR HILARY HARRISON (called)2
 Questions from COUNSEL TO THE INQUIRY2
 Questions from THE PANEL81