DEPARTMENT OF HEALTH SOCIAL SERVICES AND PUBLIC SAFETY

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 5

FORT JAMES CHILDREN'S HOMES

DERRY

10 June 2015

I, Hilary R Harrison will say as follows:

This statement is provided on behalf of the Department of Health, Social Services and Public Safety in response to the Rule 9 Request dated 22 May 2015 which requires the Department to address questions posed by the HIAI regarding complaints made in relation to Fort James children's home.

MODULE 5 – THE FORT JAMES CHILDREN'S HOME

SECTION 1

Question 1

What involvement did the Department and its predecessors have in relation to the operation of Fort James home? The Inquiry appreciates that the involvement of the Department and its predecessors may have changed over the years – if so, please explain how this evolved.

1.1 Fort James Children's Home opened in 1973 and closed in 1995. The responsible Government Department during this period was the Department of Health and Social Services (DHSS). The home was a former Western Health and Social Services Board (WHSSB) facility, managed originally by the Foyle Unit of Management on behalf of the Board. From around 1993, the Foyle Health and Social Care Trust was responsible for the operation of the home under the provisions of the Health and Personal Social Services (NI) Order 1994, which provided for certain statutory functions to be exercisable of behalf of Boards by Trusts. In contrast to the position of voluntary children's homes, Fort James was a Board facility i.e. a "statutory" home, and there was therefore no regulatory requirement on the home to be registered with the DHSS.

1.2 The Department and its predecessors were not involved in the routine day-to-day operation or management of children's homes. Prior to the transfer in 1996 of children's homes inspection functions to Boards' Regulation and Inspection Units their role, in respect of individual statutory institutions, was generally limited to:

- periodic inspection and occasional purposeful visits to homes;
- advisory, consultative and monitoring engagements with senior Board and Unit of Management/Trust officials in relation to children's homes in their area;

- examination of Boards' policies and procedures on residential child care;
- receipt of and comment on annual monitoring information and serious events/untoward incidents forwarded to the DHSS by Boards or Trusts; and
- consideration with Boards and Trusts of common themes and issues identified by or within individual institutions which had implications for professional practice, policy or strategic planning initiatives in residential care, other children's social care services and workforce training.

1.3 Other than one report of a Social Services Inspectorate (SSI) inspection carried out in 1994, and brief references within a largely unrelated file to the prosecution in 1993 of a former Officer-in-Charge on child sex offences (see section 3 of this statement), the records currently held by the Department do not contain any further information on the Fort James children's home in relation to the above activities or any other matter. The Department is therefore reliant on evidence received to date from the HIAI and only such of that evidence as has been possible for the Department to consider in the time available.

Question 2

Explain the Department's understanding of the nature and extent of its and its predecessors' responsibilities to carry out inspections in relation to Fort James Inspection powers and the MOHA/DHSS exercise of these under the Children and Young Persons (NI) Act 1968 (the 1968 Act).

1.4 Section 168 (1) of the 1968 Act provided that the Ministry of Home Affairs (MOHA) and, from 1974, the DHSS could appoint for the purposes of any enactments relating to children (including the 1968 Act), inspectors with special qualifications or experience in the care of children to perform such duties as the MOHA/DHSS might direct. Inspectors were empowered to enter and inspect any place where a child was maintained under the provisions of

the 1968 Act and to *"make such examinations of the state and management thereof and the conditions and treatment of the children therein"* as was requisite (Sections 130 (2) and 168 (2)). The Department is presently unable to determine from the information currently available to what extent MOHA exercised this power in relation to statutory homes prior to the transfer in 1974 of children's home inspection responsibilities from MOHA to the newly created Social Work Advisory Group (SWAG) within the DHSS.

1.5 With reference to the period following the transfer of inspection functions, the 1984 DHSS statement to the Hughes Inquiry noted:

"*In February 1976, the Social Work Advisers were asked to make a full report on each facility annually with reports being passed to the administrative Branch"* [1].

1.6 The proposed annual reporting arrangements included both statutory and voluntary homes. However, the 1984 statement records that the new procedures were not fully implemented because of changes in staffing within the SWAG and subsequent changes in working arrangements. It is now also known that the SWAG appears to have been established under a DHSS policy which between 1972 and 1981 promoted an inspectorate with a revised focus on advisory, consultation and support functions[2]. In addition to responsibilities *inter alia* for liaison with Boards and voluntary organisations as providers of children's residential services, SWAs appear to have made visits during this period to individual children's homes and may have carried out some inspections of homes. The Department is currently unable to ascertain whether Fort James was included in such visits or was inspected during this period.

1.7 The Department's January 2014 statement to the HIAI has set out in detail the new inspection arrangements established by SWAG following the discovery in

[1] Paragraph 31 of the Departmental January 2014 statement
[2] Paragraph 59 of the Departmental Module 4 statement

1980 of sexual malpractice at children's homes[3]. The 1984 DHSS statement to the Hughes Inquiry noted that during the period October 1980 – March 1984, all children's homes in the Province (21 voluntary and 38 statutory homes) had been inspected. Follow up visits to check on the implementation of recommendations were completed by 1985.

1.8 An SSI inspection letter from SSI to the WHSSB dated 27 September 1982[4] indicated that an inspection of Fort James by Mr D O'Brien and Mr N Chambers was due to take place during the four day period, 18-21 October 1982. The correspondence provides a helpful portrayal of the process that was adopted by the SSI to inspection at that time. Although the Department does not currently hold the report of the 1982 inspection in Departmental files, the report has now been obtained from the HIAI[5]. Evidence provided by the WHSSB[6] dated 30 April 1984 sets out how the Board had addressed the inspection findings and some 23 recommendations that were made. Those of significance to the HIAI appear to have included the need to address the following management and professional practice issues:

- urgent review of the use of Fort James for the emergency admission of children;
- pressure on children's bedroom accommodation;
- contact between residential staff and foster carers in prospective fostering placements;
- the "arrangement" implemented by the Officer in Charge to be compatible with Circular HSS (F) 12/74[7]
- clearer definition of management roles with clarification of the limits of delegated authority;
- formal arrangements for the professional supervision of staff;

[3] Paragraph 31 of the Department's January 2014 statement
[4] FJH 5327
[5] FJH 6613. The main recommendations are as reported above
[6] FJH 5239
[7] The Department has not been able to locate this circular but understands it refers to charges for young people for accommodation

- increase in the staffing establishment;
- employment of male staff to be encouraged; and
- medical book to be regularly maintained.

1.9 Internal WHSSB documentation[8] and a letter dated 25 January 1985[9] to Mr O'Brien, SSI sets out how the Board addressed the recommendations of the 1982 inspection. The latter was followed a visit by Mr O'Brien on 9 October 1984 to review the implementation of the inspection report. A report of the visit and the matters discussed are contained in Mr O'Brien's correspondence dated 28 December 1984[10] to the Board. Of note is the reference by Mr O'Brien to a discussion held in Fort James on 9 July[11] 1984, regarding the requirement of the Conduct of Children's Home Direction 1975 for the visiting social worker to report in writing to the Director through the District Social Services Officer not being met. At the time of writing, Mr O'Brien noted that this deficit had been addressed. It would further appear from the above correspondence between SSI and the Board that an acute staff shortage was a critical feature of the home's operation during the period of the October 1982 inspection. By October 1984 four additional staff had been recruited although, as Mr O'Brien pointed out, this exacerbated the male/female staff balance within the home with the only one male staff member being also the Officer in Charge.

1.10 An inspection of the Fort James home may also have taken place in 1985. Whilst the report of the 1985 Fort James inspection does not appear to be available at present, the HIAI evidence indicates that a forthcoming inspection of Harberton House was referenced by the Board as an "annual" inspection which was to take place in 1987[12], suggesting that SSI inspections were being carried out on an annual basis. An internal Board memo dated 18

[8] FJH 5264
[9] FJH 5266
[10] FJH 5269
[11] year unknown
[12] FJH 15323

November 1986 referred to Mr O'Brien's report of "last year"[13]. Further, in her letter to Mr O'Brien dated 27 November 1986[14], the Acting Director of Social Services stated that his inspection reports on Harberton House and Fort James had been reported in detail to the PSSC and enclosed the minutes of the relevant meeting, which indicate that members' attention was drawn to various aspects of the Fort James report, including the Inspector's views regarding the relocation of the home[15].

1.11 Mr O'Brien carried out a further inspection in June 1987[16] of the Fort James Home, meeting a number of children during the course of the inspection. There is reference also within the report to the DHSS and Board officers having met to discuss the Western Board's monitoring statement for 1985[17]. They appeared to find that the home was operating to a satisfactory standard in respect of each of the elements considered by the inspection, leading to just one recommendation needing to be made to bring the maintenance and decor of the home up to an acceptable standard.

1.12 It is noted in his evidence to the HIAI, FJ 33 who was t[redacted] Fort James from 1984 to 1990, has stated:

" .. During my time at Fort James there were a number of inspections carried out by Mr Dennis [sic] O'Brien, an inspector from the Social Services Inspectorate at the DHSS. These were thorough inspections of all aspects of the Home usually lasting two days. As well as checking records and viewing the home the inspector took the opportunity to speak with staff and residents and took note of issues and concerns raised. The findings of these reports were shared with the staff team through the management structure. There was then a process of engagement between the Inspectorate and Board Officers in relation to the implementation of these recommendations. In

[13] FJH ??
[14] FJH 16290
[15] FJH 16291
[16] FJH 6728
[17] FJH 6740

subsequent inspections, the progress made in implementing the recommendations was noted and further action taken as required"[18]*.*

1.13 The discovery in May 1990 of serious incidents of peer abuse in Harberton House home, together with a sudden and unexpected increase in the number of children being admitted to residential care, due to issues of abuse and neglect in the community, resulted in significant overcrowding in both Harberton House and Fort James children's homes. This led the Chief Inspector, Dr K McCoy, to visit the Western Board in June 1990 to discuss the situation. Whilst the purpose of the contact was to engage in further strategy discussions with the Board, Dr McCoy made a point of visiting Fort James and Harberton House Homes with a view to speaking with staff and gaining first-hand knowledge of their experience. The full context of this contact is considered in detail in paragraph 2.6 of the Harberton House statement.

1.14 Mr O'Brien wrote to the WHSSB in October 1990[19] making reference to the SSI's commencement in the 1980s of a programme of annual inspections of children's homes and subsequently replaced, by approval of the then Minister, with 3-yearly inspections of Boards' homes. As stated by Mr O'Brien, this was due to the sufficient development of the Board's own monitoring procedures. It should be noted that the DHSS Circular HSS (CC) 6/83 "The Monitoring of Residential Child Care and a further Departmental Circular issued in 1988 had by this stage served to enhance and improve scrutiny by Boards and the DHSS of the management arrangements and professional practice standards governing the operation of children's homes. It is noted that Mr Gabriel Carey, a Principal Social Worker within the Foyle Unit of Management, carried out an "inspection" of the Fort James home in January 1989[20] which would appear to have been part of the Unit's monitoring arrangements at that time.

[18] FJH?
[19] FJH 5291
[20] FJH 6751

1.15 Mr O'Brien's October 1990 correspondence to the Foyle Community Unit[21] signalled his intention of inspecting the Fort James home during the week beginning 15 January 1991. The full inspection report is contained in the evidence received from the HIAI[22]. The recommendations of this inspection, which are of relevance to the HIAI included the need for:

- A review of the aims and objectives of the home;
- The policy of staff 'acting up' to fill senior staff vacancies to be reviewed;
- Better staff cover to be introduced at weekends;
- The arrangements for the supervision of young people during the night to be reviewed;
- Formal staff supervision arrangements to be revised, if necessary, and fully implemented;
- Care and supervision of young people in the independence training unit to be reviewed;
- Urgent consideration to be give to the location of the home and to whether a security service should be employed to patrol and check the buildings at night.

1.16 On 17 December 1991, Mr O'Brien and an Assistant Chief Inspector (ACI) met with the Unit General Manager and Mr Carey (then Assistant Unit General Manager) to review the progress made by the Unit in implementing the recommendations[23]. It is noted that there had previously been correspondence with SSI related to the Unit of Management's dissatisfaction with some aspects of the inspection report[24]. The report of the December meeting entitled "Follow up inspection report"[25], which appeared to resolve any difficulties, concluded that the majority of the recommendations made in the January 1991 report had been given due consideration by the Board. At

[21] FJH 5292
[22] FJH 6896
[23] FJH 6928
[24] FJH 7047
[25] FJH 7066

least 3 had been fully implemented and another 3 were being addressed. It was anticipated that some of the outstanding recommendations could only be fully actioned in the longer term. The Inspector concluded that the Board should be commended for the considerable progress it had made in taking forward the recommendations of the report.

1.17 A record contained in the Fort James daily log in an entry dated 16 October 1992 noted that "*Inspectors visited today".* This may be a reference to SSI Inspectors. The Department does not currently have any further information regarding this visit.

1.18 One full report of an SSI inspection of Fort James is held in Departmental files. This inspection, which was part of the SSI's triennial inspection programme of statutory homes, was carried out in January 1994 by Miss M Reynolds. Mr Chambers, then Assistant Chief Social Services Inspector commented on the draft report and in addition to drawing out key points for the Board's attention, reflected that the presented a balanced view of the care provided with well substantiated findings which should be of assistance to the Board in its strategic planning.

1.19 The final report concluded with 22 recommendations and was issued in March 1994. The findings of particular relevance to the HIAI included the need for:

- the Board's policy on dealing with sexual acts between children as complaints to be operationalised (Recommendation 5 based on paragraph 4.3 of the report);
- strategies to deal with bullying and incidents of peer abuse (Recommendation 6 based on paragraphs 4.3 and 9.3 of the report)
- staff to ensure that children know how to make a complaint and contact card complaints to be dealt with by a senior manager (Recommendation 7 based on paragraph 4.3 of the report);
- Health and sex education programmes to be available to young people and care plans to address issues of sexuality, sex education and self

protection (Recommendation 10 based on paragraphs 6.3 and 9.3 of the report);

- Staff to have regular consultancy service access to the Board's Adolescent Psychiatry and Psychology Services (Recommendation 11 based on paragraphs 6.3; 9.3 and 11.3 of the report);
- Incidents of restraint to be recorded and these records subject to managerial monitoring and evaluation (Recommendation 17 based on paragraph 9.3 of the report);
- Team leaders to receive regular formal supervision from the line manager (Recommendation 20 based on paragraph 11.3)
- The practice of employing temporary staff with no experience or qualification within the residential sector at times of considerable disruption should be reviewed (Recommendation 21 based on paragraph 11.3);
- The monthly monitoring report to provide comment on professional and care issues (Recommendation 22 based on paragraph 12.2 1st tiret);and the Board to clarify for the Board member expectations regarding his role within the monitoring arrangements for residential care (Recommendation 22 based on paragraph 12.2 2nd tiret);
- The complaints register to be subject to regular monitoring by the Visiting Social Worker and the Board Member (Recommendation 22 based on paragraph 12.2 12th tiret); and
- The home's managers to establish a system to monitor social work visits to children and the information from this to be monitored by the visiting social worker and used to inform the monthly monitoring report (Recommendation 22 based on paragraph 12.2 13th tiret).

1.20 The report contained detailed consideration of complaints, care and control and child protection issues (chapters 5, 8 and 9 respectively). SSI's concerns regarding these matters are comprehensively reflected in the recommendations of the report which set out strategic, operational and professional issues to be taken forward by the Board to improve the care of children. The final inspection report was issued in April 1994, together with

the Harberton House report.

1.21 By letter dated 4 January 1995 to the Board, Miss Reynolds sought to know when the Board would be in a position to provide the requested response to the inspections' recommendations. The Department does not presently have any further information available in relation to this request.

1.22 Following the completion of inspections of children's homes in the Western Board's area (i.e. Fort James; Harberton House, Coneywarren Children's Home, Omagh and the home run by the Sisters of Nazareth in Londonderry i.e. Nazareth House), the SSI undertook to present an overview of the findings to a group of the Board's senior staff in June 1994. A follow up letter to the WHSSB from Mr Chambers dated 2 November 1994 detailed several strategic issues which the DHSS considered that the Board should address[26]. These included:

- the need for any retraction of residential care to be based on an analysis of recent demand and usage;
- the demand placed on the Extern project[27] to be evaluated to ensure that resources are available to promote the development of the project;
- the need for the Board to rationalise its existing stock of provision in order to have a range of smaller homes;
- the need for residential care services to be differentiated to provide for children with special difficulties including those hitherto transferred to training schools;
- retraction of residential care to be preceded by the development of preventative and foster care strategies to ensure that in the short-term undue pressure would not be placed on Harberton House in particular.

1.23 The Department does not have any further information available in relation to the Western Board's action on these matters. However, it would appear that

[26] See Annex C attachment to Harberton House statement
[27] A diversionary project aimed at helping prevent young people enter/re-enter care

the issue of the Board's residential care provision was the subject of further consideration by the DHSS in September 1994 when the Chief Inspector requested Miss Reynolds to summarise the main findings of the triennial WHSSB inspections. Miss Reynolds's summary contained several comments related to the structure of the service, staffing, professional practice and monitoring and fire regulations[28]. The Department has presently no access to information indicating how these matters were taken forward with the Board. However, the 1998 DHSS publication "Children Matter – a Review of Residential Child Care Services in Northern Ireland"[29] made use of the information from such overview findings to inform a comprehensive review of children's residential care services. This led to a regional action plan which was taken forward by the Department on behalf of the DHSS health and Social Services Committee.

Question 3

How and to what extent does the Department say that it (and its predecessors) fulfilled its legal responsibilities towards children sent to the Fort James home?

1.24 The DHSS and its predecessors had responsibility for establishing the policy and legal framework in which residential child care services were to be delivered. The Children and Young Persons (Welfare Authority) (NI) 1952 governed the operation of the Fort James home until 1975 when the Conduct of Children's Homes Direction (NI) came into effect. Under the 1952 Regulations and the subsequent 1975 Direction there was, amongst other responsibilities, a general duty on the relevant welfare authority or Board to ensure that each home in its charge was conducted *"in such a manner and on such principles as will further the wellbeing of children in the home"* . The Regulations were underpinned by a memorandum from the MOHA dated September 1952 and entitled "Memorandum by the Home Office on the Conduct of Children's Homes" which was progressive for its day and has

[28] See Annex D attachment to Harberton House statement
[29] Attached at Annex E of the Harberton House statement

been considered in detail in the Department's January 2014 statement.

1.25 The DHSS did not hold the legal responsibility for the individual care of children in care. Under section 113 (1) of the 1968 Act this rested with the statutory authority i.e. a welfare authority or Board, who on receiving a child into care, had a general duty *"to exercise their powers with respect to him so as to further his best interests and to afford him opportunity for the proper development of his character and abilities".*

1.26 With regard to its exercise of the power of inspection, the Department has already acknowledged in its evidence to the HIAI, the criticisms of the Hughes Inquiry of the frequency, nature and scope of inspections undertaken by the MOHA and the DHSS during the 1960-1980 period. However, as noted above, the Department sought during this period to encourage the development of best practice in residential care services through a series of visits which promoted an advisory and consultative approach to the development of best professional practice in residential care. After 1980, the Department believes it discharged its power of inspection in a rigorous and exemplary manner and there is sufficient evidence before the HIAI to indicate that the Department's range of inspections and the implementation of their recommendations during the 1980s and 1990s effected positive change within children's homes.

1.27 The Department also believes that the range of measures which it introduced in the areas of:

- comprehensive monitoring arrangements for authorities responsible for children's homes which included annual reporting to and comment by SSI and the DHSS within a format devised by the department for monthly and annual monitoring reports which ensured consistency of reporting arrangements across Boards;

- establishing standards for the care of children and inspection including the continual development of care standards and inspection methodologies;
- introducing a complaints procedure for children in residential care and their parents, among the first of its kind in the UK;
- professionalisation of the residential child care service to the extent that the numbers of qualified staff in residential children's homes in Northern Ireland far exceeded that of other parts of the UK or Ireland; and
- encouraging the establishment of dedicated services to address the needs of children who were abused and those who had abused other children[30].

1.28 Although such measures were not aimed at individual children, these together with the emphasis placed on Boards by the DHSS regarding the need for the strategic development of residential care services, could only serve to benefit the individual child and help create a quality care environment during the 1980s and 1990s i.e. the main period in which the Fort James and Harberton House homes were operating.

Question 4

Outline what the Department's (or its predecessors') responsibility was in relation to providing funding to Fort James over the period of its operation.

1.29 Fort James was a children's home established by the former Western Health and Social Services Board. The DHSS did not provide revenue or capital funding directly to statutory homes. The funding which the DHSS received for the delivery of health and social care was part of the Northern Ireland block grant from the Treasury. The DHSS in turn allocated funding to each of the four Boards based on the Northern Ireland capitation formula which took account of local population needs. The Department and its predecessors traditionally made bids for additional funding from the block grant in advance

[30] See Harberton House statement paragraph 2.7

of the financial year or as part of the in-year monitoring round to address priority issues. Funding so obtained was then allocated to Boards in a proportionate way or in a manner aimed at addressing specific or regional needs. Each Board was responsible for ensuring that the financing of children's social care services was sufficient to enable the Board to discharge its statutory obligations towards children in an effective manner.

Question 5

Describe the Department's role in relation to receiving and/or investigating complaints from residents within Fort James. Was there a complaint and investigation procedure and if so, what steps were taken to bring it to the attention of the residents in the homes or their parents?

1.30 Based on the limited records held by the Department in relation to the Fort James home, the Department has no evidence to suggest that the DHSS received any complaints directly from children in the home. An internal WHSSB memo dated 26 March 1990 and forwarded to the DHSS[31] (date indecipherable) referred to a letter of complaint received by the Board from a child in Fort James with reference to the fact that there were three children in his room and that his privacy was being invaded as well as the overcrowding in the house putting additional pressure on him and the staff. The memo referred to the fact that there were nineteen children and young people in the main house, which was meant to accommodate fifteen. The child was assured that steps would be taken to reduce the overcrowding as soon as this was feasible. The author in a footnote anticipated that there might be a number of similar complaints from other residents of the main building.

1.31 The Department's January 2014 statement[32] sets out in detail the process by which it issued guidance in May 1985 on a complaints procedure for children and their parents. This required Boards to develop their own procedures and to provide to all children in residential care and their parents with a contact

[31] Annex A

[32] Paragraphs 89-97 of the January 2014 statement

card and an explanatory booklet explaining the process. The guidance contained various other provisions regarding the monitoring and review of complaints by senior management. Due to concerns on the part of statutory sector staff about the implementation of the guidance, however, a joint working group was established by the Social Work Staffs Joint Council and the procedures did not become operational within Boards until January 1990.[33]

1.32 It was the responsibility of the Board and the home's staff to ensure children and their parents were given copies of the complaints booklet and were familiar with the process. Inspectors were, however, from 1985 reviewing the way complaints operated within homes and the children's knowledge about how to complain. The 1994 SSI inspection of Fort James considered this issue in detail[34]. There was evidence of good practice within the home and whilst there were concerns about how some complaints and child protection issues were handled, there was recognition of the difficulties encountered by staff in managing such complex situations as that presented by the group of children resident in Fort James at the time.

1.33 The procedures developed in 1985 by the Department remained in force until the introduction in 1996 of the Representations Procedure (Children) Regulations (NI) established under the Children (NI) Order 1995.

Question 6

What documents does the Department of any of its predecessor bodies hold in relation to Fort James?

1.34 The Department holds one report of the 1994 SSI inspection and some documentation and other correspondence associated with this inspection. This, together with the inspection report has been sent to the HIAI. A Departmental file entitled "Planning for New Committee of Inquiry into

[33] See Annex L attachment to Harberton House statement
[34] Section 4 page 12 of the 1984 SSI inspection report

Administration of Children's Homes and Hostels – Action taken 1983." contains brief references to the prosecution of FJ 5, a former Officer-in-Charge of Fort James for homosexual offences against a child resident in the home during his period of employment in the home[35]. Apart from the evidence now received from the HIAI, as far the Department can ascertain, these are the only records which it currently holds in relation to the Fort James children's home.

[35] These references are appended at Annex ?

SECTION 2 - PEER ABUSE IN FORT JAMES

Question 1

Was the Department made aware that peer abuse had occurred in Fort James, If so, when and how?

2.1 The Department is not currently aware of any information referred to the DHSS regarding historical peer abuse in Fort James. The 1994 SSI inspection pointed to several issues regarding the sexual behaviour of residents, some of which were the subject of complaints by their peers[36]. Whilst some of these events had not been treated as complaints in compliance with the Board's guidance on the management of sexuality in residential care and there was evidence that one issue of particular concern had not been properly investigated, staff appeared to be alert to the risk of inappropriate sexual behaviour but recognised that given the age group of the residents, their past experience of abuse and the layout of the building that it was often difficult to detect incidents[37]. It is evident on reading the daily log of Fort James that there were a number of "untoward incidents" some of which included peer involvement and which the home would have been required to report to the Board but not to the Department. Certain events had to be reported to the Department under the 1975 Conduct of Children's Homes Direction i.e.

- death of a child in the home;
- an accident resulting in serious injury to a child or member of staff;
- outbreak of infectious disease: or
- outbreak of fire in the home

2.2 The 1985 Complaints Circular also required Boards and voluntary organisations to notify the Department of complaints referred to the police. Nevertheless, Boards as a matter of custom and practice generally referred

[36] Sections 9 and 4 of the 1994 inspection report at Annex B.
[37] Page 27 of the 1994 inspection report.

other events of a particularly serious nature to the Department, such as the peer abuse incidents in Harberton House home. As part of annual monitoring statements to the Department, Boards and voluntary organisations were required to comment on the frequency of reports of untoward incidents and the nature of the incidents. Where relevant, the DHSS sought further clarification/information. Inspectors also reviewed the untoward incidents book during the course of each inspection and where necessary made recommendations.

2.3 Although the focus of DHSS circulars regarding the reporting of serious adverse incidents tended to focus on medical and allied services' incidents, the DHSS circular HSS (PPM) 05/05[38] reminded HPSS organisations that incidents regarded as falling into the following categories should be notified to the Department:

- Incidents regarded as serious enough to warrant regional action to improve safety or care within the broader HPSS;
- Incidents which are likely to be of public concern; and
- Incidents which are likely to require an independent review.

2.4 The Department is currently unable to find similar reference to these categories in circulars currently available that were previously issued during the period of interest to the HIAI. Historically, it was nevertheless common knowledge within Boards that only where social care incidents met any of the above criteria, were these to be reported to the DHSS.

Question 2

Does the Department consider that there were any practices or policies within the home that permitted or facilitated such behaviour?

2.5 There were no policies or practices that permitted peer abuse and none that appeared to contribute directly to the incidents reported. It may be inferred

[38] Annex C

from the information received in relation to the 1982 and 1991 inspections that matters such as staff shortages, coping with a high number of emergencies, pressure on children's bedroom accommodation, staff supervision and management issues might have contributed to the number of untoward incidents. The 1994 inspection report detailed a number of areas in which the care of children in Fort James might be improved, including those relating to the sexual behaviour of young people in the home, supportive services and training opportunities for residential care staff and the need for the use of temporary staff to be reviewed. If the Board was subsequently able to take forward the recommendations, the resulting improvements might well have minimised further the opportunities for untoward incidents involving sexual behaviour between peers to occur.

Question 3

What was done by the Department, if anything, in relation to this issue?

2.6 With reference to Fort James, the recommendations of the inspection reports referred to above were followed up with the Board by the SSI. However, the issue of peer abuse within children's homes in the Western Board is considered in detail in the Harberton House statement.

Question 4

Were any management or operational changes recommended to seek to prevent such behaviour?

2.7 With reference to Fort James, a number of the inspection report recommendations regarding the care and supervision of children and the staffing of the home were operational matters and matters to be taken forward by management to improve the general quality and oversight of children's residential services. Regarding the specific issue of peer abuse, the Harberton House statement sets out in detail how this issue was taken forward with the Board by the DHSS.

Question 5

If so, please explain what steps were taken and when.

2.8 Please note the responses to questions 3 and 4 above.

SECTION 3 - THE CASE OF R V FJ 5

Question 1

Was the Department informed of this matter? If so, by whom?

3.1. The Department refers the HIAI to a minute dated 3 November 1983 from Mrs D Brown to senior DHSS officials making reference to their awareness of the allegations concerning FJ 5 and his impending appearance before Londonderry Magistrates Court on 4 November 1983[39]. This and the references to the case contained in the remaining Annex C documentation is the only information the Department holds in relation to FJ 5. The Department was clearly aware of the case and whilst it is not known by whom the information was shared, it is evident from this minute that there was communication between the DHSS and the Board regarding the progression of criminal proceedings against FJ 5

Question 2

Did the Department carry out any investigations into this matter? If so, please provide details of what steps were taken.

3.2. It is not presently known by the Department whether the DHSS or the Board carried out any investigations into this matter.

Signed:

Dr Hilary R Harrison

Date: **10 June 2015**

[39] Annex D

DEPARTMENT OF HEALTH SOCIAL SERVICES AND PUBLIC SAFETY

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 5

HARBERTON HOUSE CHILDREN'S HOMES

DERRY

10 June 2015

I, Hilary R Harrison will say as follows:

This statement is provided on behalf of the Department of Health, Social Services and Public Safety in response to the Rule 9 Request dated 22 May 2015 which requires the Department to address questions posed by the HIAI regarding complaints made in relation to Harberton House children's home.

MODULE 5 – HARBERTON HOUSE CHILDREN'S HOME

SECTION 1

Question 1

What involvement did the Department and its predecessors have in relation to the operation of Harberton House home? The Inquiry appreciates that the involvement of the Department and its predecessors may have changed over the years – if so, please explain how this evolved.

a. Harberton House Children's Home opened in 1980 and closed in 2004. The responsible Government Departments during this period were the Department of Health and Social Services (DHSS) until 1999 when the DHSS became the Department of Health, Social Services and Public Safety (the Department). The home was a former Western Health and Social Services Board facility, managed originally by the Foyle Unit of Management on behalf of the Board. From around 1993, the Foyle Health and Social Services Trust was responsible for the operation of the home under the provisions of the Health and Personal Social Services (NI) Order 1994, which provided for certain statutory functions to be exercisable on of behalf of Boards by Trusts. In contrast to the position of voluntary children's homes, Harberton House was a Board facility i.e. a "statutory" home, and there was therefore no regulatory requirement on the home to be registered with the Department.

b. The Department and its predecessors were not involved in the routine day-to-day operation or management of children's homes. Prior to the transfer in 1996 of children's homes inspection functions to Boards' Regulation and Inspection Units, their role, in respect of individual statutory institutions was generally limited to:

- periodic inspection and occasional purposeful visits to homes;

- advisory, consultative and monitoring engagements with senior Board and Unit of Management/Trust officials in relation to children's homes in their area;
- examination of Boards' policies and procedures on residential child care;
- receipt of and comment on annual monitoring information and serious events/untoward incidents forwarded to the DHSS by Boards or Trusts; and
- consideration with Boards and Trusts of common themes and issues identified by, or within individual institutions which had implications for professional practice, policy, or strategic planning initiatives in residential care, other children's social care services and workforce training.

c. Departmental files containing documentation relating to the above activities have been submitted in full to the HIAI. This statement draws on the content of these files and such evidence forwarded by the HIAI as has been possible for the Department to consider in the time available.

Question 2

Explain the Department's understanding of the nature and extent of its and its predecessors' responsibilities to carry out inspections in relation to Harberton House

Inspection powers and the DHSS exercise of these under the Children and Young Persons (NI) Act 1968 (the 1968 Act)

d. Section 168 (1) of the 1968 Act provided that the DHSS could appoint for the purposes of any enactments relating to children (including the 1968 Act), inspectors with special qualifications or experience in the care of children to perform such duties as the DHSS might direct. Inspectors were empowered to enter and inspect any place where a child was maintained under the provisions of the 1968 Act and to *"make such examinations of the state and*

management thereof and the conditions and treatment of the children therein" as was requisite (Sections 130 (2) and 168 (2)).

Inspections carried out by SSI

e. As noted above, Harberton House opened in 1980. The Department's January 2014 statement to the HIAI has set out in detail the new inspection arrangements established by the Social Work Advisory Group (SWAG) following the discovery in 1980 of sexual malpractice at children's homes[1]. The 1984 DHSS statement to the Hughes Inquiry noted that during the period October 1980 – March 1984, all children's homes in the Province (21 voluntary and 38 statutory homes) had been inspected. Follow up visits had been conducted by the end of 1985 to check on the homes' implementation of the inspection recommendations. It may be inferred from this information that Harberton House was included in the 1980-84 statutory homes' inspection programme and that at least one follow up meeting with the Board/Unit of Management may have taken place during this time. Indeed there is a reference in the HIAI evidence to a 1983 Social Work Advisory report[2]. It is likely that this was an inspection report; however, the Department has been unable to locate further information relating to this inspection.

f. The Department currently holds two reports of inspections of Harberton House carried out in 1987 and 1994 and has obtained further reports dated January 1986 and February 1991 from the evidence received from the HIAI.

g. **The 1986 SSI inspection** was carried out by Mr D O'Brien. The inspection report[3] indicated that:

a) The home had an occupancy capacity of 25 places for children; there were 20 children in residence at the time of the inspection;

b) Staff ratios met the Castle Priory standards but there was some lack of opportunity for staff secondment to professional and in-service training;

[1] Paragraph 31 of the Department's January 2014 statement
[2] FJH 15445 Paragraph 3.10
[3] FJH 15429-15465

c) Night staffing cover had been reviewed by management as the result of a recommendation in the 1983 SWAG report. Senior staff were "on call" but not necessarily on the premises overnight;

d) Only two out of a required four visits annually by the Board's Personal Social Services Committee had been made. There was, however, a significantly high level of visitation (122 visits) by the Board's nominated visiting social worker during the year;

e) Departmental representatives were to meet with the Board's officers to discussion monitoring arrangements and the Board's 1984 monitoring arrangements;

f) The Board's complaints booklet had not been issued to children due to the embargo by staff representative agencies. One complaint had however been received from the mother of a child who had dislocated her elbow while fighting with another resident;

g) 5 residents had been removed to training school, resulting in a recommendation by the Inspector that the decision to place a child in training school should only be taken following a review by senior management; and

h) Parts of the home were in need of decoration and furniture needed replacing.

h. In his statement to the HIAI[4], Mr Downey records that the 1986 inspection report was provided to members of the WHSSB Personal Social Services Committee (PSSC) and a presentation on the report was made to the PSSC. In her letter to Mr O'Brien dated 27 November 1986[5], the Acting Director of Social Services stated that his 1986 inspection reports on the Harberton House and Fort James homes had been reported in detail to the PSSC and enclosed the minutes of the relevant meeting which indicate that several of the issues raised by the report regarding Harberton House had already been actioned by management[6]. It was noted in Mr O'Brien's 1987 report that the Board had not, however, implemented some of the recommendations

[4] FJH 784
[5] FJH 16290
[6] FJH 16291

regarding the standard of decor in the home.

i. **The 1987[7] SSI inspection** which was conducted by Mr D O'Brien found that:

a) There were 20 children in the home during the period of the inspection;

b) The number of accidents and untoward incidents involving residents and the continuing use of training schools for short and long term placement was a matter of some concern to the Inspector. He noted that a Foyle Unit of Management Working Party Review in 1984 had proposed that the home should be divided into two units: a regional reception/assessment unit for 12 children and a medium stay unit for 13 children. The inspector commented that the recent implementation of this proposal could help to address these problems by facilitating closer supervision and involvement of staff with children[8];

c) Children who were spoken to informally had no serious complaints to make (paragraph 2.4), although the Western Board had not yet implemented the Departmental complaints circular. The officer-in-charge felt that staff sometimes had difficulty distinguishing between an untoward incident and a complaint, and the inspector recommended that this might be addressed through an in-service training course (paragraphs 7.1 and 7.2);

d) Staff ratios met the Castle Priory standards and there appeared to have been some improvements on the 1986 situation with regard to staff professional and in-service training. A senior staff member was on the premises each night (paragraphs 3.1-3.4);

e) The Board's visiting social worker, who had made 102 visits to the unit during the year, was satisfied with the care provided to children, the administration of the home and the level of fieldwork visiting (paragraph 4.5); the designated PSS Committee member had made the required four visits to the home.

[7] Annex A

[8] Page 2 paragraph 1.3 and page 16 paragraphs 9.1&2 of the 1987 report

f) Due to the number of accidents to children, there was a need for staff to be extra vigilant during the children's recreation time;

g) Some children were receiving specialist therapeutic help due to alleged or suspected sexual abuse and referrals had also been made to adolescent/child psychiatry services;

h) The Unit of Management's Principal Social Worker (PSW) expressed a view that the methods of control and discipline employed by staff were *"inadequate to cope with the type of child currently being admitted to care .... in his opinion many of them came into children's homes with well established anti-social problems which are difficult to modify and in some cases acceptable/unacceptable behaviour is difficult to identify."* The PSW felt that the sanctions used by staff had little effect on residents. The report noted that in the previous 12 months, 6 children had been discharged from the home on Training School Orders. The inspector recommended that management should review methods of control and discipline with a view to improving staff practice (paragraphs 4.10 and 4.11);

j. Departmental files indicate that Mr O'Brien sought a response from the Board to the inspection recommendations in September 1988[9]. A reply dated 28 September 1988 from Miss H Lennox; Acting Director of Social Services enclosed internal Board documentation advising that the Unit General Manager had *"taken upon himself to respond from the Committee to the Department".* The Department is presently unable to determine whether a response was subsequently received.

k. Mr O'Brien carried out a further inspection in February 1991[10], less than 12 months after the discovery of peer abuse incidents in Harberton House[11]. The full recommendations of the report are not presently available[12]. In his concluding observations, however, the Inspector commented on the reduction

[9] Annex B
[10] FJH 16514
[11] Paragraphs 2.1 to 2.11
[12] Photocopying/scanning error in the evidence received from the HIAI

in assessment and therapeutic work with children due to the home being stretched beyond its limit in its attempts to cope with excessive numbers of care admissions during the previous 15 months. With reference to the findings of the Review Team established to investigate the incidents of peer abuse, the Inspector noted its recommendation that "*there should be an immediate review of the size and function of the home, with a view to reducing the residential care component and concentrating this on one function".* The Inspector concluded: *"It would seem to be an appropriate time to review the procedures for admitting children to the home, to revise its overall capacity and to reconsider its management structure and staffing levels."*

l. **The 1994 SSI inspection**[13] undertaken by Miss M Reynolds was based on a children's rights approach. The following recommendations of the inspection are of relevance to the HIAI:

a) The implications of a reduction in the Foyle unit's residential places for the operation of Harberton House was to be addressed by the Board (Paragraph 2:10 and 2.14);
b) The Board needed to develop a range of alternatives to residential care for children (Paragraphs 2:16 and 3.3);
c) The home's admissions policy should be revised with a view to providing for planned admissions to care and stability within the unit (Paragraphs 3.3. and 6.3);
d) Staff needed to receive further training on the complaints procedure; children required information to hand on this; support was to be provided for staff who were the subject of a complaint and an independent manager should be appointed to investigate complaints of a serious nature (Paragraph 4.3);
e) The Board needed to consider the provision of a regular mental health consultancy service for staff with reference to the mental and emotional health needs of the children (Paragraph 6.3);

[13] FJH 16448

f) Restraint of children should be recorded and subject to managerial inspection and evaluation (Paragraph 8:3);

g) Children should have the opportunity to attend regular house meetings to address matters of concern to them (Paragraph 8:3 and 9.3);

h) The sharing of bedrooms should be reviewed in light of children's right to privacy (Paragraph 8.3 and 9.3);

i) Sanctions should be monitored and their effectiveness over time evaluated (Paragraph 8.3);

j) Untoward events to be recorded and guidance made available to staff to ensure consistency of practice (Paragraph 9.3);

k) Vetting to be completed on staff or adults undertaking regular contact with children (Paragraph 9.3);

l) Professional/care issues to be afforded more attention in monitoring reports and clarification for the Board member in relation to his/her duties were required. All statutory records should be signed by the Board member (Paragraph11.1);

m) The complaints register should be regularly monitored by the Visiting Social Worker and Board member (Paragraph 11.2).

m. The report contained detailed consideration of complaints, care and control and child protection issues (chapters 4, 8 and 9 respectively). SSI concerns regarding these matters are comprehensively reflected in the recommendations of the report which set out strategic, operational and professional issues to be taken forward by the Board to improve the care of children. With reference to staffing, the report noted:

"This is an experienced staff team which has worked together for many years and also a consistent group of staff with whom the children may relate. The Team Leaders described their staff as committed and generally consistent in their approach to their work. There are also a range of support systems in place for staff to enable them to function effectively and, as a social work team, which are commended. The preparation which is afforded to devising training material for the staff group is considerable and commendable".

n. Following review of the draft report by Mr Chambers, the final inspection report was issued in April 1994 together with the Fort James report. By letter dated 4 January 1995 to the Board, Miss Reynolds sought to know when the Board would be in a position to provide the requested response to the inspections' recommendations. In response, a detailed letter to Miss Reynolds dated 22 February 1995[14] from the Board, set out the extent to which recommendations had been or were being actioned.

o. Following the completion of inspections of children's homes in the Western Board's area (i.e. Fort James; Harberton House, Coneywarren Children's Home, Omagh and the home run by the Sisters of Nazareth in Londonderry i.e. Nazareth House), the SSI presented an overview of the findings to a group of the Board's senior staff in June 1994. A follow up letter to the WHSSB from Mr Chambers dated 2 November 1994 detailed several strategic issues which the DHSS considered needed to be addressed by the Board[15]. These included:

- the need for any retraction of residential care to be based on an analysis of recent demand and usage;
- the demand placed on the Extern project[16] to be evaluated to ensure that resources are available to promote the development of the project;
- the need for the Board to rationalise its existing stock of provision in order to have a range of smaller homes;
- the need for residential care services to be differentiated to provide for children with special difficulties including those hitherto transferred to training schools;
- retraction of residential care to be preceded by the development of preventative and foster care strategies to ensure that in the short-term undue pressure would not be placed on Harberton House in particular.

[14] FJH 800
[15] Annex C
[16] A diversionary project aimed at helping prevent young people enter/re-enter care

p. The Department does not have any further information available in relation to the Western Board's action on these matters. However, it would appear that the issue of the Board's residential care provision was the subject of further consideration by the DHSS in September 1994 when the Chief Inspector requested Miss Reynolds to summarise the main findings of the triennial WHSSB inspections. Miss Reynolds's summary contained several comments related to the structure of the service, staffing, professional practice and monitoring and fire regulations[17]. The Department has presently no access to information indicating how these matters were taken forward with the Board, however, the 1998 DHSS publication "Children Matter – a Review of Residential Child Care Services in Northern Ireland"[18] made use of the information from such overview findings to inform a comprehensive review of children's residential care services. This led to a regional action plan which was taken forward by the Department on behalf of the DHSS Health and Social Services Committee.

Question 3

How and to what extent does the Department say that it (and its predecessors) fulfilled its legal responsibilities towards children sent to the Harberton House home?

q. The DHSS and its predecessors had responsibility for establishing the policy and legal framework in which residential child care services were to be delivered. The Children and Young Persons (Welfare Authority) (NI) 1952 governed the operation of the Fort James home until 1975 when the Conduct of Children's Homes Direction (NI) came into effect. Under the 1952 regulations and the subsequent 1975 Direction, there was, amongst other responsibilities, a general duty on the relevant welfare authority or Board to ensure that each home in its charge was conducted *"in such a manner and on such principles as will further the wellbeing of children in the home"* . The regulations were underpinned by a memorandum from the MOHA dated

[17] Annex D
[18] Annex E

September 1952 and entitled "Memorandum by the Home Office on the Conduct of Children's Homes" which was progressive for its day and has been considered in detail in the Department's January 2014 statement.

r. The DHSS did not hold the legal responsibility for the individual care of children in care. Under section 113 (1) of the 1968 Act this rested with the statutory authority i.e. a welfare authority or Board, who on receiving a child into care, had a general duty *"to exercise their powers with respect to him so as to further his best interests and to afford him opportunity for the proper development of his character and abilities".*

s. With regard to its exercise of the power of inspection, the Department has already acknowledged in its evidence to the HIAI, the criticisms of the Hughes Inquiry of the frequency, nature and scope of inspections undertaken by the MOHA and the DHSS during the 1960-1980 period. However, as noted above, the Department sought, during this period to encourage the development of best practice in residential care services through a series of visits which promoted an advisory and consultative approach to the development of best professional practice in residential care. After 1980, the Department believes it discharged its power of inspection in a rigorous and exemplary manner. There is sufficient evidence before the HIAI to indicate that the Department's range of inspections and the implementation of their recommendations during the 1980s and 1990s effected positive change to children's homes and strategic planning for children's care services[19].

t. The Department also believes that the range of measures which it introduced, for example, in the areas of:

- comprehensive monitoring arrangements for authorities responsible for children's homes which included annual reporting to, and comment by SSI and the DHSS within a format devised by the department for

[19] See paragraph 2.7 - 2.10

monthly and annual monitoring reports which ensured consistency of reporting arrangements across Boards;

- establishing standards for the care of children and inspection including the continual development of care standards and inspection methodologies;
- introducing a complaints procedure for children in residential care and their parents; among the first of its kind in the UK;
- professionalisation of the residential child care service to the extent that the numbers of qualified staff in residential children's homes in Northern Ireland far exceeded that of other parts of the UK or Ireland; and
- encouraging the establishment of dedicated services to address child protection needs as well as the needs of children who were abused and those who had abused other children[20].

u. Although such measures were not aimed at individual children. These, together with a continuing emphasis placed by the DHSS regarding the need for Boards to develop a planned approach to residential care, could only serve to benefit the individual child and help to create a quality care environment. The above initiatives were prevalent during the 1980s and 1990s i.e. the main period during which the Harberton House and Fort James homes were operating.

Question 4

Outline what the Department's (or its predecessors') responsibility was in relation to providing funding to Harberton House over the period of its operation

v. Harberton House was a children's home established by the former Western Health and Social Services Board. The DHSS did not provide revenue or capital funding directly to statutory homes. The funding which the DHSS received for the delivery of health and social care was part of the Northern

[20] See paragraph 2.7

Ireland block grant from the Treasury. The DHSS in turn allocated funding to each of the four Boards based on the Northern Ireland capitation formula which took account of local population needs. The Department and its predecessors traditionally made bids for additional funding from the block grant in advance of the financial year or as part of the in-year monitoring round to address priority issues. Funding so obtained, was then allocated to Boards in a proportionate way or, in a manner aimed at addressing specific or regional needs. Each Board was responsible for ensuring that the financing of children's social care services was sufficient to enable the Board to discharge its statutory obligations towards children in an effective manner.

Question 5

Describe the Department's role in relation to receiving and/or investigating complaints from residents within Harberton House. Was there a complaints and investigation procedure and if so, what steps were taken to bring it to the attention of the residents in the homes or their parents?

w. Based on the limited records held by the Department in relation to the Harberton House home, the Department has no evidence to suggest that the DHSS received any complaints directly from children in the home.

x. The Department's January 2014 statement[21] sets out in detail the process by which it issued guidance in May 1985 on a complaints procedure for children and their parents. This required Boards to develop their own procedures and to provide to all children in residential care and their parents a contact card and an explanatory booklet explaining the process. The guidance contained various other provisions regarding the monitoring and review of complaints by senior management. Due to various concerns on the part of statutory sector staff about the implementation of the guidance however, a joint working group was established by the Social Work Staffs Joint Council and the procedures did not become operational within Boards until January 1990.[22]

[21] Paragraphs 89-97 of the January 2014 statement
[22] Annex F

y. It was the responsibility of the Board and the home's staff to ensure that children and their parents were given copies of the complaints booklet and were familiar with the process. Inspectors were however, from 1985 reviewing the way complaints operated within homes and the children's knowledge about how to complain. The 1994 SSI inspection of Harberton House considered this issue in detail[23]. There was evidence of good practice within the home and, whilst there were concerns about how some complaints and child protection issues were handled, there was recognition of the difficulties encountered by staff in managing such complex situations as that presented by the group of children resident in Harberton House at the time.

z. The procedures developed in 1985 by the Department remained in force until the introduction in 1996 of the Representations Procedure (Children) Regulations (NI), established under the Children (NI) Order 1995.

Question 6

What documents does the Department or any of its predecessor bodies hold in relation to Harberton House?

aa. File materials currently held by the Department in relation to the Harberton House Home include:

- reports and correspondence related to the two inspections carried out by the Social Services Inspectorate (SSI) in 1987 and 1994;
- internal and external Departmental correspondence related to peer abuse in Harberton House in 1990 and the report of a Western Health and Social Services Board investigation into this issue;
- internal Western Board and Foyle Trust correspondence related to the demands on residential care services[24];

[23] Section 4 page 12 of the 1984 SSI inspection report
[24] See paragraph 2.3

- internal Departmental correspondence regarding concerns about the Western Board's child care services including residential child care strategies.

bb. The Department's documentation also contains correspondence and Western Board/Foyle Trust reports of investigations in 1995 related to allegations of organised community sexual abuse of significant numbers of children in the Creggan, Tullyally, Ballymagroarty and Carnhill areas of the former Foyle Unit of Management/Foyle Health and Social Services Trust, as well as a report on the death in a joy riding incident in 1994 of a former resident of Harberton House who had been transferred to St Patrick's training school on a Place of Safety Order.

cc. Although newspaper reports at the time referred to children having been victims of organised abuse whilst in care, no evidence of this was found during the investigations. The reports of the community child abuse investigations are not considered within this statement as they are not directly related to Harberton House home. They nevertheless serve to demonstrate something of the culture and challenges faced by children and families in the areas from which children were admitted to the Western Board's residential services and the demands in general on the Board's child care services.

dd. The Departmental files containing all of the above information have been submitted to the HIAI.

SECTION 2 - PEER ABUSE IN HARBERTON HOUSE

Question 1

Was the Department made aware that peer abuse had occurred in Harberton House. If so, when and how?

2.1 A copy of the Harberton House untoward incident report dated 15 March 1990, which detailed the discovery by staff of sexual abuse activities amongst a group of young children aged 9/10 years and two 12/13 year olds, was forwarded to SSI by letter from the Board dated 8 May 1990[25]. It would appear from this letter that informal notification to Mr O'Brien had been made some time before this.

Question 2

Does the Department consider that there were any practices or policies within the home that permitted or facilitated such behaviour?

2.2 There were no policies or practices that permitted peer abuse. However, as noted above, the 1987 SSI inspection had found that a matter of some concern was the number of accidents and untoward incidents involving residents. The Inspector commented that the recent implementation of a proposal to divide the unit into two separate groups could help to address these problems by facilitating closer supervision and involvement of staff with children. Some children were also at that time receiving specialist therapeutic help due to alleged or suspected sexual abuse and referrals had also been made to adolescent/child psychiatry services.

2.3 It was apparent that the supervision of children and, in particular, the fact that a number of the children resident had been sexually abused was already an issue for this unit. This was the situation prior to a sudden and unexpected rise in the number of children admitted to care between 1 January 1990 and 31 March 1990 due to abuse and neglect in the Foyle Unit of Management. Internal Board correspondence which contained details of this matter was

[25] Annex G

forwarded by the Assistant Director of Social Services to SSI.[26] Mr O'Brien's minute dated 21 June 1990[27] to Dr K McCoy, Chief Inspector, sets out the details of these admissions which resulted in all three children's homes (including the Nazareth House voluntary children's home) holding a greater number of children than they were approved to accommodate.

2.4 Mr O'Brien noted that the influx of children had a consequential impact on children and staff, particularly in Harberton House. The Board had recruited untrained temporary workers to give assistance with the supervision of children in the homes. Permanent staff, however, considered that much of their time was given over to supervising the new recruits. Individual programmes of care and therapeutic work with children was therefore set aside.

2.5 It is evident that the combination of the above factors, in addition to those identified by the subsequent Investigation into Peer Abuse, such as the lack of detailed knowledge of staff regarding the previous history of sexual abuse in the case of some of the children, contributed to a climate which presented greater opportunities for peer abuse to take place.

Question 3

What was done by the Department, if anything, in relation to this issue?

2.6 When the DHSS became aware of the incidents of peer abuse in Harberton House, the SSI acted quickly and with concerted effort to address this issue with the Board. The gravity with which SSI viewed the issue is evidenced by the number of briefings of senior officials within the Department and actions arising. The steps taken by DHSS were as follows:

a) Mr O'Brien continued to seek and receive updated reports from the WHSSB;

[26] Annex H
[27] Annex I

b) The Chief Inspector visited the WHSSB and the Fort James and Harberton House children's homes on 26 June 1990 to consider the situation with the Board and staff from each of the homes;

c) The Chief Inspector, by minute dated 29 June 1990, apprised Mr J Hunter, the Chief Executive of the DHSS Management Executive[28], and other senior staff within the DHSS including Dr Harbison[29], the DHSS Under Secretary/Deputy Secretary, of the situation and his concerns that:

- the group activity had gone on for a sustained period of 3-4 months without being detected by staff;
- there was an apparent absence of any full investigation by the Board as to how this could happen;
- there was an absence of any response by the Board to provide psychiatric and psychological care and treatment for children or support for staff in the face of a most unusual incident;
- the prospect that this was a new phenomenon which might possibly occur elsewhere given the characteristics of children now being received into care;

d) By minute dated 9 July 1990, Mr Hunter requested a meeting with Dr Harbison and other senior officials to consider *inter alia* whether some form of formal investigation of the Board's actions should be undertaken;

e) At the Department's instigation, a Review Team which included 2 senior officers from the Board was established in August 1990. The team, led by Mr R Bunting, the Eastern Board's Assistant Director of Family and Child Care, reported in December 1990;

[28] During the 1990s, a restructuring of the DHSS resulted in the division within the Department of operational and policy matters. The Management Executive, of which Mr Hunter was Chief Executive, was responsible for the operation and delivery of the health and social services. Dr Harbison was responsible for the development of Departmental policies to inform the Department's current and future strategies for health and social care.
[29] See above footnote

f) Departmental documentation demonstrates that the DHSS Management Executive continued to monitor the situation in the Western Board, by meetings and accountability reviews held with the Board and to consider whether any further action was required by the Management Executive;

g) The WHSSB proposed significant resourcing allocations to child care services in the Foyle Unit of Management which included an uplift in the grant to the Nazareth House home, additional staffing resources for the Coneywarren Home and the establishment of an area-wide Child and Adolescent Psychiatry Service;

h) In 1991, less than 12 months after the peer abuse incidents came to light, SSI carried out inspections of both children's homes i.e. Harberton House and Fort James within the Foyle Unit of Management;

i) As part of the DHSS action plan, SSI undertook to: monitor staffing levels in homes throughout the four Boards by scrutiny of the annual monitoring reports and reports on individual homes produced by Boards; continue to consider with Board staff the extent of peer abuse among children[30], and the implementation of the Board's operational plan[31];

j) A Senior Medical Officer within the Department was to monitor the establishment of the WHSSB's child and adolescent Psychiatry service[32]; and

k) The SSI, together with the WHSSB convened a regional symposium on 4 February 1992 on the potential for abuse in residential care in which officers of the DHSS and SSI took part. The keynote speaker was Mr T

[30] See SSI report on the incidence of peer abuse at Annex J
[31] Annex K

[32] As above

White, Chair of the Committee of Inquiry into "Children and Young Persons who abuse other Children"[33] .

2.7 At the above symposium, Mr J Kearney, a former Assistant Secretary in the DHSS Child Care Policy Branch set out the policy objectives for child protection contained in the 1992-1997 NI Regional Strategy for the Health and Personal Social Services. In his comprehensive overview of the work undertaken by the DHSS, it is evident that the Department had striven to address the issues arising from the SSI inspections of children's homes (including the numbers of children who had been subject to sexual abuse prior to their admission to care); incidents such as that of peer abuse within homes, and the rising incidence of reported sexual abuse within the community. The targets and objectives set by the DHSS included the requirements for Boards to:

- establish 'Kidscape' and 'Teenscape' programmes for children of primary school age;
- ensure full implementation of the DHSS 1989 'Cooperating to Protect Children' guidance[34];
- ensure access to evaluated treatment and services for children who had been sexually abused and their families;
- encourage earlier recognition of families at risk and extension of the range of preventative and supportive service available;
- establish liaison arrangements through Area Child Protection Committees and criminal justice agencies to secure an integrated and co-ordinated response to the treatment of abusers; and
- start work to secure, in the longer term, access to evaluated treatment programmes for child and adolescent abusers aimed at containing and, if possible, reducing such behaviour.

[33] FJH 092
[34] Annex L

2.8 In addition, the Regional Strategy recognised the need for Boards to move away from multi-purpose children's homes to a range of small specialist units designed to meet clearly identified needs. In his address to the symposium, Mr Kearney proposed that significant benefits for children should also flow from action to implement Recommendation 6 of the Hughes report and that:

"*the course had been set towards resolving the historic staffing difficulties of the residential child care service and achieving its gradual professionalisation through the introduction of parity of pay with the fieldwork service, allied to a comprehensive training programme for unqualified care staff and the re-grading of staff to social worker grades.*"

Question 4

Were any management or operational changes recommended to seek to prevent such behaviour?

2.9 The recommendations of the Peer Abuse Review Report contained a number of management and operational recommendations. Those of particular significance to the HIAI included the need for:

- fieldwork staffing to be improved;
- an immediate review of the staffing levels and duty rota arrangements in the two Board homes;
- changes to the grounds of the home to facilitate supervision of children;
- a multidisciplinary team to build up expertise in the assessment of sexually abused children;
- the Board to accept a proposed training strategy and appoint additional training personnel;
- structured supervision of staff and profiling of staff development;
- management span of the Assistant Principal Social Workers to be examined with a view to achieving a more equitable workload for the APSW (Family and Child Care); and

- adolescent and child psychiatry and clinical psychology services to be introduced to assist programmes of care for emotionally damaged children.

2.10 These actions, together with the focused agenda of the regional strategy, served to develop, within a relatively short time after the peer abuse incidents came to light, both local and regional responses to the issue of the protection of children from abuse in care and in the community.

Question 5

If so, please explain what steps were taken and when

2.11 Please note the responses to questions 3 and 4 above.

Signed:

Dr Hilary R Harrison

Date: **10 June 2015**

STANDARD FOR MONITORING AND INSPECTION OF RESIDENTIAL CHILD CARE

ACTIVITY	STANDARD	LEGAL, PROFESSIONAL OR ADVISORY STANDARD	EVIDENCE
ENVIRONMENT			
Siting of Building	i. Residential area - avoiding isolation and extremes of housing standards (eg upper class residential areas or slum housing) ii. Easy access (ie walking distance or good public transport to schools, shops, employment, recreational facilities etc) iii. Avoiding areas of particular sectarian tensions which would inhibit the placement of some children iv. Inconspicious - the building should not be sited where its institutional nature is readily apparent	By agreement between Department and Boards	By observation
Size of Building	The size and design should be such as to avoid institutional buildings and current stock should be suitably adapted so as to achieve an environment which is consistent with the needs of the residents.		
Accommodation	i. Size of rooms should at least be to the standards set in the Community Home Design Guide ie - a. Bedrooms - room that comfortably accommodates bed, wardrobe/dressing table and chair b. Living and dining rooms c. Kitchen d. Bathroom e. Administration	Community Home Design Guide	By measurement

inflationary pressures or services pressures in-year. Unlike e.g. Social Security, where expenditure and funding was driven by the population meeting qualifying criteria, Health and Social Care services had to be provided within the cash limits set by Parliament / the Northern Ireland Block / budgets. In practice there were opportunities for Units of Management / Boards to pursue with the DHSSPS in-year assistance (non-recurrent) with significant cost pressures depending on the performance of the total Northern Ireland Block.

2. The allocation of funds from the DHSS to the 4 Boards to commission services to meet the needs of their respective populations was roughly based on (informed adjustments to, rather than dictated) a very complex capitation formula (supported by the University of York) reflecting, by Programme of Care (Children / Elderly / Hospital etc.), the population size, age and gender profile and specific 'needs' (reflecting e.g. deprivation levels and local provision costs). It was easy to determine the population size and age / gender split by the Programme of Care but it was another matter to establish / agree the cost differentials for providing Health and Social Care for different populations and even more complicated to determine and agree needs adjustment factors. The WHSSB, although it had the smallest and youngest population profile, had the highest deprivation and therefore argued for many years, with varying degrees of success, that it was under funded through the Capitation Formula. Relative funding directly impacted on the possible spends on population / services by the Boards.

Budgets

3. The Health and Social Care operated a very sophisticated bespoke budgetary system developed and maintained in-house by the Directorate of Information Services.

4. Budgets for all services – hospitals, residential facilities, community services, social services, support services etc. - were organised to reflect management structures: largely localities within Programmes of Care, and were all split between Payroll budgets and Non- Payroll (or Goods and

social care meetings that followed the January meeting up to July 1984 but have not identified any further references that I consider might apply to the events at Fort James.

I do recall being told that these matters had been referred to the police and at a later point being advised that the matter had gone to court but that the case had collapsed.

Harberton House

Organisational Context

7. 1985 – 1995: During this period, unlike other regions in the United Kingdom because uniquely health was integrated with Social Services, Northern Ireland developed the introduction of General Management by appointing a General Manager at area level, whilst retaining multi-professional consensus teams at Unit level. The particular managerial priority during this period was to enable professionals to develop a wider managerial and organisational perspective while maintaining and consolidating their professional knowledge and expertise. In 1989 the Minister instructed Boards to develop proposals that would facilitate the formal introduction of general management at Unit level, establishing the foundations for the purchaser provider split and thus enabling the development of an internal market in health and social care. The proposals developed by the Western Board in response to the Minister's direction are contained in Better Management, Better Care. (Exhibit 2)

8. Another important backdrop to the matters being inquired into at Harberton House is the historical underfunding of health and social services in the West of Northern Ireland. This circumstance mirrored the situation in the NHS in England which established a national working group to look at how a more equitable allocation of resources formula across the English regions might be developed. A working group operating under the acronym RAWP (Resource Allocation Working Party) was established to identify a way forward. In Northern Ireland an equivalent group was established under the acronym

PARR (Proposals for the Allocation of Revenue Resources). However, the final report was only eventually published in 2003. An insight into the scale of the difference in resources between social services in the Eastern and Western areas of Northern Ireland is reflected in the Bunting Report into the circumstances surrounding incidents of peer child abuse at Harberton House (Exhibit 5). At section 2.2 of the report, titled Fieldwork Staffing, Bunting compared the social work staffing levels at Foyle Community Unit with the social work establishment at North and West Belfast Unit of Management. In Foyle there were 6 Senior Social Workers and 28.5 Social Workers. In North and West Belfast there were 15 Senior Social Workers and 53 Social Workers in the establishment for social work. While significant efforts were made to secure agreement between the Department and the four Boards on achieving a more equitable distribution of resources across Northern Ireland, agreement to facilitate any change was never reached and as a consequence only very limited progress was made.

9. In responding to its historical underfunding, the Western HSS Board was constantly required to examine what were considered controversial government policies in order to achieve financial efficiencies. In the late 1980s and early 1990s the Board tendered for what at that time was one of the highest value 'hotel services' contracts ever outsourced in the Health Service in the UK. Despite the concerns (Exhibit 5, Section 9.2(11), page 46), the contract was agreed and implemented, releasing almost £1m, part of which was allocated for investment in Social Services, including Children's Services.

10. In 1990 Northern Ireland, following the rest of the United Kingdom, introduced General Management at Unit level. (Exhibit 2) The document 'Better Management, Better Care' 'fleshed out' both the changes that were proposed at Board level to facilitate the introduction of a Purchasing function, while at the same time proposing a configuration of Units through which services could be provided that would facilitate both the introduction of Unit General Management and the development of an internal market for health and social care in Northern Ireland. When these arrangements were implemented the Board's responsibility and role in providing services changed. Its two core functions

WESTERN HEALTH AND SOCIAL SERVICES BOARD

Minutes of the one hundred and seventy fifth meeting of the Western Health and Social Services Board, held in the Boardroom, Board Headquarters, Gransha Park, Londonderry on Thursday 30 May 1991 at 10.00 am.

:SENT: [redacted]

'91
)logies: [redacted]

'91
iirman's Remarks:

The Chairman opened his comments by stating that as this was the first meeting of the newly constituted Board it was yet another historic day in the history of the Western Health and Social Services Board. He welcomed all members to their first Board meeting and thanked them for accepting the very formidable task. He said he felt privileged to lead a group of 10 people in whom he had absolute confidence. Indeed he had to have confidence in members and them in him because jointly they were taking on a tremendous and demanding role for the future.

He indicated that there will be many challenges to face in the incoming years, some more difficult to solve than others, but he was of the view that if they keep in the forefront of their minds "The Patient First" they could not go very far wrong. However they had acquired a great legacy from the efforts of all those past members, approximately 80, who had served the people of the Western Area since 1973 and whom he had the pleasure of meeting, some of them for the first time, at the recent Board members buffet.

The Chairman pointed out that the Board was still at the early stages of implementing the Government's reforms initiated in early 1989 and by and large he agreed with their general approach, with one notable exception, the proposals on Self Governing Hospitals which he viewed with some reservations.

Referring to Management at Unit level he reminded members that the four Unit General Managers had been in post for 12 months. Two

of whom had already shared with members their aspirations and problems and arrangements had been made for members to meet with the remaining two that afternoon. He said that having taken part in their selection he fully supported their approach to the introduction and development of a management culture at Unit level.

However he said despite the Board's progress and achievements to date he still had one major continuing disappointment and that was the Board's underfunded situation. In spite of well reasoned arguments put forward by the Board and which in fact had been accepted by the Department, the issue had not been addressed to his satisfaction. He emphasised that the resolution of this issue will be a major priority over the next 12 - 18 months.

The Chairman informed the Board of the Minister's recent visit to launch the Board's new Health Mobile. He said he would wish to take this opportunity to thank the DOE and [redacted] DOE Manager in Londonderry for providing the funds for this excellent and innovative vehicle.

He reported that during the Minister's visit the Board's four Executive Directors had given him a precis of the Board's activities and current needs. The Minister had also visited Altnagelvin Area Hospital where he had been reminded of the pressing need for the proposed new Services Centre and refurbishment of existing premises.

The Chairman stated that he wished on behalf of the Board to congratulate [redacted] Omagh, on his appointment as Chairman of the New Area Health and Social Services Council. He said that while the new Board as the purchaser/monitor of services will have a major role to play on behalf of the consumer, the Area Council will provide a strong consumer voice by (i) Reviewing and examining services available and testing them on behalf of the public and by identifying qualitive issues to put to the Board (ii) Visiting facilities where this is appropriate (iii) Meeting service providers and also the users of the services. He indicated that it was both imperative and incumbent on the Board to forge a very co-operative link with the AH & SS Council, realising that both agencies were two separate and distinct entities. Paying tribute to the Board's