THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995
MODULE 5
HARBERTON HOUSE ASSESSMENT UNIT and
FORT JAMES RESIDENTIAL HOME
SUBMISSIONS ON BEHALF OF THE DEPARTMENT OF HEALTH SOCIAL SERVICES and PUBLIC SAFETY

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1. For the purpose of these submissions:-

   (a) the term "the Department" includes the Ministry of Health and Social Services, the Department of Health and Social Services and the Department of Health, Social Services and Public Safety;

   (b) the term "SWAG" refers to the Social Work Advisory Group;

   (c) the term "SS1" refers to the Social Services Inspectorate;

   (d) the term "WHSSB" refers to the Western Health and Social Services Board;

   (e) the term "the Boards" refers to all 4 Health and Social Services Board in Northern Ireland;

   (f) the term "the 1968 Act" refers to the Children and Young Persons Act (NI) 1968

   (g) the terms "the Harberton House Departmental statement" or "the Departmental statement" refer to the Departmental statement of Dr Hilary Harrison regarding Harberton House children's home dated 10 June 2015 and submitted to the HIAI on that date.

2. <u>Background</u>

Fort James opened as a children's residential home in 1973 and closed in 1995. Harberton House Assessment Unit opened in 1980 and closed in 2004. Both homes

fell under the responsibility of the WHSSB although some of its functions and responsibilities were delegated to the Foyle Unit of Management.

Although intended as an assessment unit Harberton House quickly found that it was becoming a children's residential home and, indeed, in 1995 when Fort James closed some of its residents were brought into Harberton House which caused the accommodation limit of that home to be exceeded.

Both homes can be classified as "statutory" children's homes. Children accommodated in these homes will have been made the subjects of "Fit Persons Orders", or "Parental Rights Orders" to the Board or may have remained in the care of the Board under section 103 of the 1968 Act (i.e in care by voluntary agreement with parents). Fort James had been subject to the Children and Young Persons (Welfare Authorities Homes) Regulations (Northern Ireland) 1952 which were superseded in 1975 by a Direction issued by the Department namely "the Conduct of Children's Homes Direction 1975". This became effective on 1 December 1975 and thereafter governed Fort James and Harberton House when it opened in 1980.

It is suggested that the most relevant requirements of this Direction were:-

(a) that a member of the Board's Personal Social Services Committee would visit the home at least once a quarter and thereafter make a report in writing to the Personal Social Services Committee;

(b) that a social worker would visit the home at least every month and thereafter make a report in writing to the Director of Social Services;

(c) that the officer in charge of the home would keep and maintain records relating to each child resident in that home;

As a result of inspections carried out by the Department of both homes and following scrutiny of Monitoring Assessment reports provided by the Board to the Department, the Department was generally satisfied that the requirements of the Direction set out above were largely complied with.

3. Inspections

Although questions relating to inspections are not included directly in the four topics directed by the Inquiry to be included in the submissions, the Department considers that having acknowledged, as it did to the Hughes Inquiry, and to this Inquiry in relation to previous Modules, certain inadequacies associated with the frequency and scope of such inspections and that such inspections at times failed to ensure that the administering authorities of such homes were complying with their statutory obligations, it is not inappropriate to remind the Inquiry that inspections of Harberton House by SWAG or SSI took place sometime in the period between 1980 and 1984, possibly 1982 and in 1986, 1987, 1991 and 1994. Furthermore similar inspections in relation to Fort James were carried out in 1982, 1987, 1991, possibly 1992 and definitely 1994. The inspection reports to hand demonstrate that the inspections carried out during these years were comprehensive and covered in detail aspects of the homes' functioning and the Board's statutory responsibilities.

4. Topics for submissions

(a) Historical Underfunding of the North West

The Department respectfully suggests that at this stage the wording of this topic is somewhat unfortunate in that:-

(a) it appears to assume that underfunding did in fact occur and;

(b) this topic was identified for inclusion in submissions before any of the Department's witnesses had given evidence.

The formula which was used by the Department to provide funding to each of the four Health and Social Services Boards is based on the PARR (Proposals for the Allocation of Revenue Resources). This formula was devised in 1978 and reviewed in 1989. The Northern Ireland formula in relation to Social Services is based upon the Revenue Support Grant calculation used in England to calculate the Social Services expenditure requirements for local authorities.

Various documents which have recently come to light including the Appleby Report, the Final Report of the Review Group on Resource Allocation to Health and Social Services Boards in Northern Ireland Reports from the Capitation Formula Review Group have understandably led the Inquiry to postpone issues such as alleged underfunding until later in the Inquiry when it is understood it will be included under a module of the Inquiry dealing with "Governance" issues.

The Department is continuing to seek further historical information from documentary and former senior personnel sources regarding the financing of the four former Health and Social Services Boards.

Notwithstanding the above the Department is aware that throughout this Module the WHSSB has attributed its failure to fully implement recommendations made by SWAG and SSI inspectors following inspections of both children's homes to resource issues and, indeed, has claimed that lack of resources may well have contributed to peer abuse which occurred particularly in Harberton House from December 1989 until March 1990.

In the course of their evidence to the Inquiry two former Officers in Charge of both Children's homes, HH 5 and FJ 33, strongly suggested that Child Care Services within the responsibility of this Board, did not fare well in relation to the Board's allocation of resources, as compared to acute (hospital) services. Such suggestions were, however, rejected by Mr Dominic Burke on behalf of the Board. When it was put to Mr Burke that the Board had a statutory duty in relation to the care of children he responded that the Board had other statutory obligations.

Articles 4 and 5 of the Health and Personal Social Services (Northern Ireland) Order 1972 imposed a duty upon the then Ministry of Health and Social Services and thereafter upon each of the four Boards to provide or secure the provision of integrated health services to promote the physical and mutual wellbeing health of the people of Northern Ireland and to provide or secure the provision of Personal Social Services in Northern Ireland to promote the social welfare of the people of Northern Ireland, and to provide hospital

accommodation and other services such as dental, ophthalmic and pharmaceutical. However, the 1968 Act imposed specific duties on Boards in respect of children in their area. With reference to each child received into the care of the Board, section 113(1) of the Children and Young Persons Act (Northern Ireland) 1968 required a Board:

> "to exercise their powers with respect to him so as to further his best interest and to afford him opportunity for the proper development of his character and abilities".

It is therefore the Department's contention that priority had to be given by the Board to the discharge of its statutory responsibilities for children.

(b) **Rationale for wanting to reduce the consideration of resource implications within the remit of the Bunting Report**.

This issue arises from a memo sent by Dr Kevin McCoy, the then Chief Inspector of SSI to Mr John Hunter, Chief Executive of the Department's Management Executive, on 28 August 1990 and that memo can be found at FJH 10985. It related to a proposed investigation to be carried out by WHSSB into revelations that peer sexual abuse activity had taken place on a number of occasions between December 1989 and March 1990 among young children then resident in Harberton House. Dr McCoy was expressing his concern that the Board's Terms of Reference, firstly, failed to include the fact that these incidents had occurred in Harberton House and, secondly, that a conclusion seemed to have been already reached by the Board prior to the investigation of the incidents, that an alleged underfunding and/or lack of resources was a factor in the Board not detecting this abuse for a period of approximately four months.

Dr McCoy gave evidence to the Inquiry on 15 June 2015. In his evidence to the Inquiry (which can be found at page 112 of the transcript for 15 June 2015) Dr McCoy stated:

"A group of children, very very young children, engaged in sexual activity with clearly abusive behaviour by some of those older children, even though they were children themselves. It went on for a long period of time. What we needed to know was why it went on and how was it that it wasn't detected by the group of staff who were in the Home at that time".

From his evidence and from documents contained within the HIA Bundle the following can be ascertained.

(1) On 26 June 1990 Dr McCoy visited both Fort James and Harberton House and met with staff employed at both houses.

(2) On 29 June 1990 Dr McCoy briefed senior staff in the Department and, at a further meeting in the Department on 9 July 1990, it was agreed that a formal investigation of the Board's actions should be undertaken.

(3) At FJH 15499 is a memo from Mr Gabriel Carey, Principal Social Worker to Mr Tom Haverty, General Manager of the Foyle Unit of Management, which refers to a telephone conversation that Dr McCoy had with Miss Heather Lennox, the Acting Director of Social Services, WHSSB. Dr McCoy affirmed in evidence that he had suggested the Board should make use of child protection procedures to investigate the incidents. Miss Lennox and Mr Carey were against such a proposal. The same memo noted that Dr McCoy wished to obtain a report on the overall circumstances of the case that could then be distributed to the Association of Directors of Social Services to alert other Boards to the problem. Such a report, Dr McCoy indicated, could identify to the Department the problems that the Board was facing in child care and that this in turn could make the Department more amenable to a request from the Board for additional resources.

(4) At FJH 17662 is a letter from Miss Lennox to Dr McCoy in which she set out reasons for not carrying out an investigation. This letter was discussed at a meeting in the Department on 26 July 1990 when it was decided that the Board should conduct an investigation and that the findings should be shared with the other Boards.

(5) On 31 July 1990 Dr McCoy wrote to Miss Lennox with proposed Terms of Reference which included a specific focus on Harberton House and which would examine the roles and professional activities of individual staff, including key workers and management staff with responsibility for supervision of children during the period in question.

(6) A letter from Miss Lennox dated 8 August 1990 with her suggested Terms of Reference caused concern for Dr McCoy in that they did not include specific reference to the events in Harberton House, there was no intent to inquire as to why activities occurring between children had not been detected sooner, that the emphasis on resource implications might well steer a review investigation in a particular direction and thereby dilute the lessons that could be learned from this episode. These concerns were conveyed to Mr Haverty by Mr Hunter, by letter from the Department dated 30 August 1990.

(7) The investigation report was received by the Department in December 1990. Whilst there was general satisfaction with the standard of the report, some concerns about the report were identified by SSI and shared with senior Departmental officials. Examples included the fact that residential social workers had not been interviewed, the fact that experienced social residential workers in the Home had not been made aware that some of the child residents had been sexually abused or were sexually experienced before their admission to the home.

(8) At FJH 17642 is a letter from Mr Haverty to Mr Hunter seeking additional funding on the basis of the contents of the investigation report.

(9) At FJH 17640 there is a memo of a meeting within the Department on 28 March 1991 which considered the actions that the Board was taking to implement the recommendations contained in the investigation report and any action required by the Management Executive and the Department.

It is understandable that residential staff at Harberton House were dismayed and upset by the discovery of the peer abuse incidents which occurred between December 1989

and March 1990. Both Mr Dominic Burke and HH 22 [redacted] testified that the discovery of these incidents would have caused the residential staff to have low morale and that an investigation which would have included interviews with those residential staff members would have had a "devastating" and "crushing" impact on that morale. While it is understandable that the WHSSB did not wish any potential shortcomings on the part of the Board or staff to be brought into the spotlight, the Department's view was that the paramount concern in situations such as this must be the welfare of the children and how they came to be abused while in the care of the Board.

(c) <u>What action the Department took to ensure that other providers of residential child care were alert to the risk of peer sexual abuse?</u>

(1) In a memo dated 25 January 1991, Dr McCoy suggested that SSI Inspectors would make contact with Assistant Directors (Child Care) about their perception of the extent of this problem and existing responses to it (FJH 16358).

In his report, which set out the contact he had with the Eastern and Northern Boards, Mr Chris Walker (an SSI Inspector) stated "the quality and quantity of information on this topic is very variable. Where the senior staff have taken the trouble to find out, it is apparent that a surprisingly large problem exists both in terms of children in care and those in the community and that little is being done to tackle it in an organised way". The Southern Board responded by stating that the subject area was one of particular concern for its residential staff and residential managers, particularly given changes within the residential child care population.

(2) At FJH 16363 is a letter dated 27 June 1991 from Mr Frawley to Mr Hunter. Mr Frawley suggested that a seminar could be organised for 1992 with the key speaker being Mr Tom White, who was currently chairing the Committee of Inquiry into "Children and Young People who abuse other children". Mr Frawley also suggested that such a programme would have "a Northern Ireland flavour".

(3) Such a symposium did take place in February 1992 and the said Mr Tom White was the key speaker. Staff from the Department and SSI participated in this symposium and the Department believes that representatives of all four Boards were present as well as residential staff and managers of children's homes. A report on the symposium was published and disseminated.

(4) A report into the investigation of the Harberton House incidents which was provided to the Department in December 1990 was also provided to the other Boards.

(5) At paragraph 2.6(i) of the Harberton House Departmental statement, it is stated "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, and the implementation of the Board's operational plan."

At paragraph 2.7, the Departmental statement sets out details of the speech delivered by HH 41 which contained a compilation of facts gathered from SSI inspections of children's homes, including the numbers of children who had been subject to sexual abuse prior to their admission to care and the number of reported incidents of peer sexual abuse within the homes.

Paragraph 2.8 of the statement refers to the 1992-1997 Regional Strategy which required Boards to establishment treatment programmes for children who had been abused and those who abuse.

(6) In the early 1990s, the Department began working to produce radical new legislation in the form of the Children (NI) Order and its associated volumes of guidance. Both the Co-operating to Protect Children guidance and the Residential child care volumes of the

Children Order regulations and guidance were published in 1996 and dealt with the issue of peer abuse. It should be noted, however, that in 1989, the Department had issued the "Co-operating to Protect Children" guidance which required each Board to establish an Area Child Protection Committee. It was *inter alia* the role of these committees to take account of research, knowledge and information relevant to the protection of children, such as the emerging awareness of peer abuse in residential homes, and ensure that this was disseminated to inform the in-service training and practice of staff working with children.

(d) <u>How did the Department ensure that recommendations made in inspection reports on both Homes were implemented?</u>

SSI inspections of Harberton House (and Fort James) took place in 1991 and 1994. Both reports contained recommendations. Both reports were forwarded to the WHSSB, as is evidenced from the minutes of meetings of that Board.

Both Mr Denis O'Brien, who carried out the 1991 inspection, and Miss Marion Reynolds, who carried out the 1994 inspection, wrote to the Board seeking progress on the implementation of the recommendations in those reports.

The Board had also devised an annual Monitoring programme and monitoring Assessment reports were forwarded to the Department to demonstrate to what extent the recommendations of the inspection reports had been implemented. It has to be remembered that the Department could not compel the Board to implement the recommendations of inspection reports which were aimed at promoting best practice. The Department, nevertheless, expected the Board to comply with such recommendations and SSI continued to seek information in follow up visits and subsequent inspections regarding the extent to which recommendations had been implemented.

22 June 2015