Historical Institutional Abuse Inquiry

Final Submissions by

The Department of Justice

Module 7

Juvenile Justice Institutions

St Patrick's Training School

Rathgael Training School

Lisnevin Training School

Hydebank Young Offenders Centre

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Section 1: General Overview

Introduction

1. At the opening of the Inquiry's public hearings phase in January 2013 it was said on behalf of the Department of Justice ("DOJ") that the Inquiry's work had attracted the interest and commitment of the Department at the highest level and that it would continue to do so.

2. It was also said that the Department was appreciative of the importance of the Inquiry's function, and that it was sensitive to the requirement to work with the Inquiry in a collegiate fashion so that the Inquiry could comply with its terms of reference and the demands of the timetable. The Department gave a commitment to co-operate fully with the Inquiry in a spirit of openness and transparency.

3. The Department trusts that the Inquiry found that these commitments were honoured during the investigative and hearings stages of Module 7.

4. The Department has deployed considerable resources in an effort to make good on the commitments that have been made to the Inquiry. This has resulted in the production and delivery to the Inquiry of 100 witness statements; six witnesses nominated by the DOJ have been called to give evidence at the Inquiry's oral hearings; and hundreds of staff hours have been devoted to the task of answering Inquiry questions and to searching for and identifying documents, or endeavouring to understand and explain the absence of documents to the Inquiry.

5. It has been important to make this effort not least because as a Department in the devolved institutions in Northern Ireland, the DOJ is conscious that it has a central role to play in ensuring so far as it is possible, that a comprehensive story is told about life in the juvenile justice system in the period relevant to the Inquiry's terms of reference. It will be recognised, of course, that the DOJ did not itself exist within this reference period. It is a relatively new department. As Mr. Nick Perry (Permanent Secretary, DOJ) outlined in his statement, *"there is limited institutional knowledge of events which took place during the Inquiry's terms of reference." (SPT - 1592, para 1*]

6. When telling the story of life in the juvenile justice sector through the witnesses who have been nominated to give evidence on behalf of the Department, there has been

no attempt to sanitise or disguise the reality of life in the various institutions. All of the witnesses have let it be known through their evidence that day-to-day existence in a juvenile justice setting was rarely straightforward: many things were done well, there were ground-breaking initiatives and positive outcomes, but not everything was done correctly, mistakes were sometimes made and some members of staff did not always comply with the high standards which were expected from them.

7. In essence the DOJ has sourced witnesses who retain open and independent minds, and who have been prepared to provide the Inquiry with “warts and all” accounts of their time working at senior levels within the juvenile system system.

8. Dr. Bill Lockhart, for example, expressed his misgivings about the Board of Management of Lisnevin Training School, and he identified a number of adverse developments when Lisnevin moved from Kiltonga to Millisle. He also expressed some concerns about how the “punishment block” was used.

9. In his evidence Mr. Campbell Whyte reflected upon the difficulties experienced within the Rathgael Centre when girls were transferred there from the Whiteabbey Training School and he criticised what he viewed as a lack of effective planning. He also tried to assist the Inquiry by highlighting those incidents where there was suspicion that staff had transgressed the rules in their dealings with young people.

10. Mr. Lindsay Conway considered that some staff at Rathgael tended to operate an approach to children which was too “regimented” and he indicated that such staff might have been less inclined than others, to ask why certain child behaviours were happening.

11. In his statement to the Inquiry and again in his oral evidence, Mr. Max Murray candidly recalled for the Inquiry some of the harsher aspects of the regime at Hydebank which predated his arrival there. He also brought to the attention of the Inquiry entries in his journal which revealed that young people had raised complaints of assaults by staff.

12. The DOJ has recognised from the outset of this Inquiry that those who have been harmed by their experiences of the juvenile justice system are entitled to have their stories heard so that they can find healing and possible closure in the telling of their accounts and in the assessments which the Inquiry must necessarily make about them.

13. The Department trusts that the information contained in the statements made by Departmental officials and witnesses, as well as the work which it has undertaken to locate and produce many thousands of documents, has assisted the Inquiry in gaining a fuller understanding of the issues of concern, and has helped those with complaints to make about their experiences to articulate those complaints in a more meaningful way.

14. The DOJ welcomes this opportunity to provide the Inquiry with its written submissions. The submissions have been formulated with due regard to the definitions of abuse and systemic failings delineated by the Inquiry in its definitions document on the 13 June 2013.

15. This section of the submissions contains a broad overview and it will address a number of themes which are of general application to the four institutions which the Inquiry has considered in Module 7.

16. The submissions will then look at each of the institutions in turn, in four separate sections. Each section will focus on the specific issues relevant to the particular institution and to the Department in its relationship with that institution. In a final section the key submissions which are advanced on behalf of the DOJ are summarised.

Obstacles

17. Despite the endeavour and resources which has been applied to mining available records and memories to obtain information relevant to the Inquiry's terms of reference, it is self evident that a number of obstacles exist which have made it difficult for the DOJ to produce for the Inquiry a comprehensive response to what are often complex issues and complaints.

18. The vast majority of the complaints that have been registered with the Inquiry in relation to experiences within the juvenile justice system commence, broadly speaking, in the 1960s and span a period of more than three decades. The Inquiry, conducting its work in 2015, is examining the performance of systems and the behaviour of people working within those systems, from a distance of at least 20 years. More often than not, the complaints relate to matters which are thirty or forty years old.

19. The Department has carried out extensive searches in an effort to uncover for the Inquiry documentation which is relevant to such matters. Many documents have been produced. However, for the reasons explained in its statement dealing with records management (RGL 4868 - 5085) many documents which would have been relevant to the Inquiry's considerations have been legitimately destroyed in accordance with applicable destruction schedules. The Inquiry will no doubt recognise that the destruction of records is a normal and ongoing process.

20. It is obvious that a vast number of documents must have been generated in relation to people, incidents or routine matters, which have been destroyed, or which cannot now be found. For example, very little record remains of the important work of the Social Work Advisory Group ("SWAG") in the training schools during the seventies and up to the early eighties, and there is an incomplete picture of the work in the training schools of the Social Services Inspectorate ("SSI").

21. In addition, very few records exist in relation to the work of Hydebank Young Offenders Centre. Of those who have complained to the Inquiry about their experiences within Hydebank, only one personal file has been found.

22. It is known that a file was created in the aftermath of the abduction and murder of Bernard Teggart (because it has been referred to in police papers), but that file cannot be located. Likewise, it is highly likely that the NIO created a number of documents following the meeting between officials and the Auxiliary Bishop of Down and Connor to discuss the police investigation into allegations which had been made against BR 26. Again, those papers cannot be located.

23. The Department regrets the fact that it has been unable to deliver to the Inquiry all of the relevant documentary material which might once have existed on issues of relevance to the Inquiry's work. It recognises that this represents a set-back to the Inquiry's work, and that it has adverse implications for complainants as well as the institutions. It is of little consolation to tender the explanation that the non-availability of certain documents is an inevitable consequence of the historical nature of this Inquiry.

24. It is another feature of the territory which the Inquiry is working in that many of the incidents which have given rise to complaints to the Inquiry, have only been exposed to scrutiny in recent years. It is a stark fact that despite the availability of a

variety of internal and external complaints mechanisms, very few complainants to this Inquiry raised their concerns contemporaneously.

25. This is not intended as a criticism - the Department accepts that there are many good reasons why a young person may not have felt inclined or able to complain at the time of their residency within an institution, although it is quite clear that others did complain and that the institutions were receptive to investigating those complaints or referring them to external agencies such as the police. The point remains, however, that where complaints are made many years after the event, the opportunity for gathering the most reliable evidence has been lost, and documentary records will not have been generated.

26. In turn this creates a fairness problem: those who worked in the juvenile justice sector and the institutions which employed them are being invited to confront historic allegations whilst deprived of the facilities which would have existed at the time of the alleged incident to fully explain or defend their actions.

27. Even if a record is in existence to address a particular incident, the account contained in that record might well be lacking the kind of detail which might have been sought had a complaint been made at the time. The record may, for example, not include accounts from other witnesses to an incident which could help to exculpate a former staff member, whether by providing an alibi or an explanation to help connect the impugned behaviour with its appropriate context.

28. An overarching obstacle is the fact that for many witnesses who have come before this Inquiry to give evidence, the passage of time has had the effect of impairing memory. Those who have been the subject of allegations before this Inquiry, frequently have difficulty remembering the person making the complaint. It is often then an impossible task to respond in any meaningful way to the allegation itself, beyond a bare denial. It is obvious that an immediate complaint and a timely investigation could have empowered the alleged abuser when giving evidence to this Inquiry and could have helped to resolve controversial issues.

29. Of course the frailty of memory and its impairment pales into insignificance where witnesses, particularly those alleged to have engaged in wrongdoing, are now deceased, or unable to give evidence because of infirmity. There may also be a cadre of witnesses who have felt unable to co-operate with the Inquiry because,

deprived of the tools which would have enabled them to adequately defend their actions, they have feared the consequences of becoming involved in the Inquiry's work.

30. Taking all of these obstacles into account, witnesses are often reduced to generalising or dealing in broad brush strokes, without allowing for important nuances. It is very likely to have been the case that many incidents that occurred within the juvenile justice setting which have now given rise to complaint, were complex and multi-faceted. Yet what has been portrayed to the Inquiry by complainants when speaking about their experiences is very often communicated in black and white terms with no allowance for context.

31. The Department is confident that the Inquiry will review and reach conclusions about the evidence which it has read and heard, having regard to the factors which have impeded the production of a comprehensive explanation of many of the incidents which have been considered, and the systems and environments within which they occurred.

The Legislative and Regulatory Framework

32. The statements of Nick Perry (SPT 1592 - 1678), and Dr Hilary Harrison (SPT 1684 - 1691), as well as the joint statements of Karen Pearson and Dr Hilary Harrison dated 21 August 2015 (SPT 1723 - 1998) and 21 September 2015 (RGL 1608 - 1710), provide a detailed account of the legislative framework within which the training schools operated. The statement of Mr. Max Murray (HYD 469 - 1671) dated 11 September 2015 provides an account of the background to the establishment of Hydebank Wood Young Offenders Centre and of the Rules which governed its operation.

33. As it appears from these statements, and from the written submissions made to the Inquiry on behalf of DOJ in the context of Module 4, from 1922 to 1950 the Ministry of Home Affairs (MoHA) was responsible under the Children Act 1908 for the exercise of inspection functions in relation to reformatories and industrial schools.

34. The Children and Young Person Act 1950 introduced the legal framework for the operation of training schools and empowered the courts to impose training school orders in appropriate cases. The subsequent Children and Young Person's Act (NI) 1968 ("the 1968 Act") effectively re-enacted the provisions relating to training

schools contained in the 1950 Act. The three training schools with which the Inquiry is concerned in this Module - St. Patrick's, Rathgael and Lisnevin - were certified as training schools under this legislation.

35. The MoHA introduced Training Schools Rules in 1952 (SPT 80063 - 80083). The Rules endeavoured to provide the regulatory parameters within which the training schools were required to operate. A system of inspection was implemented to ensure that the Rules were complied with. The Inquiry has heard evidence that the system of inspection was the subject of significant development and change during the Inquiry's reference period. The Rules and the systems of inspection are the subject of further detailed comment and analysis elsewhere in these submissions.

36. Following the deteriorating political situation in Northern Ireland and the proroguing of the Northern Ireland Parliament in 1972, the Northern Ireland Office ("NIO") was established and assumed many of the responsibilities of the MoHA, including those relating to training schools.

37. A Training Schools Branch was established within the NIO to provide policy direction and funding for training schools. The Inquiry has heard that officials held regular meetings with the Boards of Management for the training schools: see in particular the witness statements of Alan Shannon (RGL 4351 - 4772) and Mary Madden (RGL 1247 - 1331).

38. As was the case under MoHA, the DOJ accepts that there was a more hands on relationship between the NIO and the training schools in what might be described as the "State sector," as compared with the relationship with the voluntary schools such as St. Patrick's. The Secretary of State appointed the Board members for the state sector schools and officials were more involved with staffing matters for these schools. By contrast, whilst officials had frequent contact with the managers of those schools operated by religious orders, those schools had voluntary Boards, the members of which were appointed by the Church, and departmental officials would have had little involvement in day-to-day decision making.

39. The Training School Branch of the NIO introduced monthly meetings with management and Board members of each of the training schools. Retained minutes indicate that these meetings were mainly about administrative issues, particularly finance, accommodation and legislative developments. Training School Branch also

appear to have received the Management Board minutes covering issues such as litigation, finance, education, reports of Board visits, and staffing issues. (see for example the minutes at LSN 12778-12820, 12836-12893, 13131-13267 and RGL 10777-10786).

40. Training School Rules required at least one member of the Board of Management to visit their school once a month (Rule 10(3)). The reports of Management Board visits appear to have been sent to the Board Secretary and shared with management. It is not clear if they were shared with the NIO or MoHA. Early records indicate that visits took place at intervals of around 4-8 weeks (see for example the records for Rathgael at 22716-22771 and 23834-23872). The focus tended be on the quality and cleanliness of facilities and the general atmosphere in the school or the particular Unit visited.

41. The 1950 Act which established Training Schools and the 1952 Training School Rules provided clear policy direction and stronger administrative structures than had been the case before. The school Boards of Management were responsible to MoHA/NIO for the effective conduct of schools, and inspections by MoHA/NIO were the main vehicle for providing assurance that schools were being run effectively and providing appropriate care and services.

42. The legislation provided that the MoHA/NIO had the power of inspection, which it exercised by retaining the expertise of the Social Work Advisory group (SWAG) and Social Services Inspectorate (SSI). The DHSSPS statement to the HIAI dated 30 July 2015 provides information in relation to the frequency of inspections (SPT 1684 - 1691).

43. Inspection reports and possibly feedback from Inspectors' visits to the schools were submitted to the appropriate policy branches within MoHA and NIO. The responsible policy branches within these Departments directed any necessary follow up action. For example, the Inquiry will recall that following the 1988 SSI inspection at St Patrick's and the 1990 follow-up inspection, Alan Shannon wrote to the Chair of the Management Board advising that the Chief Inspector would have no choice but to advise the Health and Social Services Board that children should not be sent to St Patrick's (SPT 10420-10423).

44. As the Inquiry has heard, all of the training schools received grant funding from the State. St Patrick's Training School was no different in that respect although as was noted above, it fell within the group of schools that while funded by MoHA/NIO, was managed by a voluntary Board. In effect, this meant that whilst the MoHA/NIO grant-funded St Patrick's it had less control over the day-to-day operation of the school than it did over the State sector institutions.

45. The Inquiry will have observed that MoHA developed policy in respect of the juvenile justice system, created the legislation necessary to deliver policy objectives, and put in place oversight arrangements to provide arms-length control of training schools. Essential to the oversight of Training Schools were a number of controls:

    (a). Finance Committees

    (b). Board of Management Minutes

    (c). Standards of care

    (d). Visits and Inspections.

46. Hydebank opened in 1979. It operated under the terms of It was initially designed to accommodate young offenders between the ages of 17-21 who had been ordered to be detained in custody for a period of less than three years. However, several years after it opened, a Juvenile Remand Unit was accommodated within its existing buildings.

47. Hydebank was expected to operate within the terms of the Young Offenders Centre Rules (NI) 1979 (subsequently revised, becoming the 1982 Rules). It was subject to the inspection arrangements of Her Majesty's Chief Inspector of Prisons, who reported directly to the Secretary of State. It was also the subject of monitoring by the Visiting Committee. The Governor of Hydebank reported to the Director of Prison Operations. The arrangements for scrutinising the operations of Hydebank will be considered in further detail at section 5 of these submissions.

Training School Rules 1952

48. The introduction of the training school structure to replace that of the reformatory/industrial schools was facilitated by the enactment by MoHA of the

Training School Rules 1952 (SPT 80063-80073), pursuant to Schedule 4 of the Children & Young Persons Act (Northern Ireland) 1950.

49. In conjunction with the 1950 Act, these rules formed the basis for the management structure, practice and delivery of services by the training schools over the following decades. They provided the foundation stone for a properly functioning training school environment. They signalled clear policy direction and introduced the basis for robust management arrangements. They provided for transparent operating arrangements by requiring detailed record keeping. The Rules remained in existence until 1999 at which point they were revised.

50. The Inquiry is referred to the statement of Mr Alan Shannon (LSN-254) in which he explained that as NIO exercised a general oversight role in training schools, it relied upon the 1952 Rules for governance. The minutes of Board of Management meetings were scrutinised within NIO.

51. The Rules provided for,

(a). The composition, role, remit and responsibilities of the Board of Management, whose meetings would be minuted and open to inspection by an Inspector of the MoHA. A member of the Board was to visit the School at least once a month and enter his conclusions in the Log Book.

(b). The Board's responsibility for the appointment, suspension or dismissal of staff of the school, provided that no person shall be appointed without the Ministry's approval

(c). The keeping of a Punishment book

(d). The provision of basic needs including food, bed and clothing

(e). The provision of education based on the Education Act

(f). The provision of recreation facilities, visits and letters from parents, relatives and friends and visits home

(g). The keeping of records and the sending of records to the Ministry

(h). The school to be open for inspection by the Ministry

(i). Discipline and punishment

Discipline and Punishment in the Training Schools

52. Given the nature of the concerns raised by the complaints made during this Module of the Inquiry, it is important to examine in some detail the provisions relating to discipline and punishment contained at Rules 38 - 45.

53. The rule made clear that corporal punishment, which was a recognised sanction at the time of enactment of the Rules, and which was of course common outside of the training schools, was to be avoided "*as far as possible*" (Rule 38).

54. The Ministry mandated that the primary methods of discipline for minor acts of misbehaviour would be forfeiture of rewards or privileges, temporary loss of recreation, alteration of meals and separation from other pupils (Rule 39).

55. The Inquiry has read and heard descriptions of how these methods were applied in the training schools. Many of the schools operated a points system, with points being awarded or deducted depending upon behaviours exhibited. A common sanction was the cancelling of home leave, but other sanctions such as the loss of cigarettes, monetary penalties, early to bed and separation also featured.

56. The provisions governing the separation of pupils were set out at Rule 39(d). This enshrined the use of separation as an "exceptional" measure, and one which was the subject of a number of preconditions: children under the age of 12 could not be kept in separation; the room used for separation would be light, airy and kept lighted after dark; children would be given some form of occupation, and would have a means of communicating with a staff member; importantly, if separation was to be maintained for more than than 24 hours it would require the written consent of a member of the Board of Management, and the case would be notified to the Department.

57. The restrictions and strict control of corporal punishment was reflected in Rules 40-44 which concentrated solely on corporal punishment. Corporal punishment was broadly defined (Rule 44). It was not to take place other than in accordance with the Rules, and then only in the form of caning, and limited to a maximum of 6 strokes for older children (Rule 40(1)(a). It was not to be administered in the presence of another child. The application of corporal punishment by one staff member had to be witnessed by another member, and a record of the use of corporal punishment had to be entered into the punishment book. The punishment book was to be

signed once a week by a manager, and it had to be examined at each meeting of the Board of Management and signed by the Chairman. Furthermore, the punishment book had to be sent to the Ministry for inspection once a quarter.

58. It follows that the striking of a child except in accordance with the Rules was absolutely forbidden. Of course the general law would have entitled staff members to use reasonable force in self defence, and it was recognised in each of the training schools that staff members might have to engage in the physical restraint of a child to prevent harm to that child or to others. In this respect, the Inquiry is referred to the statement of Karen Pearson which addresses the use of restraint in training schools (RGL 1871 - 1917).

59. An example of the punishment report book can be found at SPT-47359. The entries on the following page (SPT-47360) indicate that the book would contain information as to the identify of the boy disciplined, the offence for which he was being disciplined, by whom it was reported, the punishment which had been applied and any remarks on the case. This particular page is signed by Ms Forrest of the Ministry indicating that the punishment books were actually being examined by officials of the Ministry as was required by the Rules.

Inspection Regime

60. In essence the Training School Rules contained the statement of principle. It was necessary to have an inspection regime to ensure that they were complied with.

61. In her statement to the Inquiry, Dr Hilary Harrison (SPT-1685) set out the legislative powers and administrative responsibilities in relation to the inspection of training schools. She also described the MoHA arrangements and those established between NIO, SWAG and the SSI (including communication between SWAG/SSI and the NIO in relation to adverse inspections). In essence, as she explained in her oral evidence, the NIO entered a quasi-contractual agreement with DHSS by which it “borrowed” (or seconded) their expert Inspectors and applied them to the work of advising and inspecting in relation to the training schools (see transcript for day 163 at page 65).

62. The statement of Dr K McCoy (a former Chief Inspector) can be found at SPT-2000 to SPT-2003. He set out the main function and role of the Chief Inspector, the agreements between the NIO and the SSI, frequency of inspections, standards and

staffing, the reporting arrangements, monitoring arrangements and SSI relationships.

63. Victor McElfatrick, a former Assistant Chief Inspector, also gave a statement to the Inquiry in which he set out the agreements between the NIO, DHSS and SSI in relation to the provision of advice, the standards used in the inspection process and reports of visits (SPT-2005). He stated:

"*There were different types of inspections. These included major inspections which, in agreement with the NIO, were carried out every four years, involving a team of inspectors … in addition to these major inspections there were also Regulatory Inspections (which involved a single inspector) spread over two days. These appear to have taken place annually*".

64. Mr McElfatrick described how the reports were sent to the NIO and more often than not they included recommendations to be actioned by the training schools. From the files he had managed to read, he could see that there was a formal response by the Management Boards of the training schools and some recommendations were actioned immediately but others could only be implemented in the medium or long-term. Follow-up visits were carried out the following year to allow time for most of the recommendations to be implemented.

65. The approach taken at specific SSI inspections will be the subject of analysis in later sections of these submissions. The Inquiry is invited to consider in detail the available reports. It is submitted that the approach adopted by the Inspectors was rigorous and robust and that Boards were challenged to make improvements where this was necessary. The inspections that were conducted were exacting, and they included discussions with the children present at the time of the inspection. There was an obvious determination on the part of Inspectors to identify and highlight any departure from recognised standards. There has been no suggestion in the evidence that the SSI inspections were conducted in anything other than a thorough and professional manner, and consonant with the regulatory standards of the time.

66. When he gave evidence on Day 161, Dr. Lockhart agreed with the observation of another witness, that the arrangements under SWAG were akin to an *"old boy's network*" in terms of its dealings with the training schools.

67. In her evidence to the Inquiry (see the transcript for day 163, particularly pages 71-75), Dr. Harrison robustly rejected that label and suggested that it was unfair. She highlighted for the Inquiry that the role of SWAG in the regulatory context of that time, building on the conclusions of the Seebohm report, was somewhat different from the approach which was subsequently fulfilled by SSI. She explained that SWAG's role in the difficult and challenging environment of the training schools was to provide "*advice, consultation and I think, unapologetically, support*" (page 74).

68. In this context the Inquiry is also referred to the witness statement of Mr. Wesley Donnell, where he explains the nature of the duties which he performed within SWAG and SSI, in a detailed and practical fashion (SPT - 3004 - 3011).

69. It is submitted that the arrangements operated by both SWAG and SSI satisfied the requirement for rigorous scrutiny of the training schools. The approach adopted under SWAG was more obviously advisory in nature when compared with the more recognisable inspectorial approach of SSI. However, there appears to be no question that each system encapsulated and complied with the standards and policy considerations of the time, and was staffed by experts who took a scrupulously independent and professional approach to their work.

Challenging Environment and Valuable Work

70. It is necessary to comment upon the challenging working environment which faced staff who worked within the juvenile justice institutions, and the value of the work undertaken by those whose vocation it was to work there.

71. In their report following the 1987 inspection (RGL 23626 - 23752), the SSI remarked upon the characteristics of the young people who were resident in the Rathgael Centre. Some were described as being "*withdrawn, manipulative, or aggressive*," requiring the supervision of a Consultant Psychiatrist and the administration of "*daily medication to ameliorate their behaviour*" (RGL - 23667, para 6.12).

72. The Inspectors referred to the challenging behaviour of one girl (identified only as [redacted]) who was a resident on the adolescent care side (House Units 1, 2 and 3). Her behaviour included 10 assault situations during the first two months of her placement. Over an 11-month period, whilst she was working with the Centre's psychologists and psychiatrist, she was reportedly involved in "*between some 50 and 60 incidents ranging from absconding, assaulting staff with knives and*

attempting to set her room on fire." It was noted that a number of intervention strategies were applied in order to seek to modify her behaviour, although the most effective approach was the use of isolation for limited periods (RGL 23667, para 6.12).

73. Another adolescent resident, referred to as [redacted], had severe psychiatric problems. Despite periods of hospitalisation in a psychiatric unit, his behaviour was not controlled when he returned to Rathgael. He engaged in assaults on staff and on his fellow residents, including the use of a knife and a lighted cigarette to inflict harm. He lacerated his own arm and killed his own pet as well as pets belonging to others in the unit. There was a requirement to administer medication in an effort to modify his behaviour (RGL - 23668, para 6.12).

74. The report of the 1987 inspection indicated that on the Youth Treatment side of the Centre, the residents presented "*considerable problems of management*" including the demonstration of "*varying degrees of disorder, aggressiveness and disturbance*" (RGL 23684, at 7.11). The Inspectors indicated that staff within Youth Treatment "had to develop a range of skills in order to enable them to carry out a form of meaningful intervention" (RGL 23684, para 7.11).

75. The challenge of working with aggressive and often violent children was no different in the other institutions. The Inquiry heard that in St. Patrick's a female social worker suffered severe injuries when a resident assaulted her with a pool cue. However, the account provided by HIA 96 at SPT 220, para 11, wrongly suggested that the employee had been killed in the attack.

76. Dr. Bill Lockhart described how HIA 94 was "*one of the most disturbed and violent young people I have known*" (LSN 1248, para 73). In his statement to the Inquiry, a former teacher and key-worker at Lisnevin, LN 8, referred to "*the very aggressive and often physically threatening behaviour [that HIA 94] displayed towards both staff and other young people in the Special Unit*" (LSN - 372, at para 6). Nevertheless, it is clear from his statement that LN 8 did not give up on HIA 94 and endeavoured to work closely with him to overcome his difficulties. On one occasion he even allowed HIA 94 to stay at his home at the request of management (LSN - 373, at para 10).

77. Consideration of the papers available to the Inquiry will reveal that the risk of assault was a fact of life for many staff working in Lisnevin. Some of the attacks on staff were extremely violent and often led to injuries which required medical treatment: there is a report that in December 1985 a staff member required hospital treatment for an injury to his lip suffered when trying to restrain a violent and aggressive boy (LSN - 12955); in July 1995 a "*very determined rape assaul*t" by a boy on a member of nursing staff was reported (LSN - 13927, 13930, 13935, and see police file at 30295); it is documented that two members of staff were "*badly injured*" following an attack by a boy in June 1986 (LSN -12959); considerable damage was done to the property and a night supervisor suffered an injury to his mouth following an incident in October 1986 (LSN - 12959); in December 1986 a boy attacked a member of staff with a stick, placing it around his neck, threatening to break his neck and demanding the keys of the unit when another member of staff tried to intervene, going on in concert with others to cause significant damage to the facility (LSN - 13979); in May 1989 it was reported that a teacher was assaulted by a pupil, necessitating a period of absence from work (LSN - 12965).

78. It would appear that the threat to staff at Lisnevin became so significant that in June 1989 it caused the Joint Negotiating Committee Sub Committee to ask the Board of Management to provide clarification of the procedures which were applicable when staff were assaulted by staff (LSN - 12965). It was subsequently noted that a control and restraint programme was being drawn up to assist staff in their efforts to deal with violent pupils.

79. However, attacks on staff continued to be a regular feature of the Lisnevin environment. In September 1989 it was reported that one member of staff sustained an injury to his tooth when assaulted by a pupil, and another had his glasses broken in the same incident (LSN - 12966). In 1991 a teacher was assaulted by a pupil (LSN - 12972).

80. In his evidence to the Inquiry LN 25 did not indicate that he had been seriously assaulted by a boy. The records show that when LN 25 was engaged in searching a boy's room, a search which located cigarettes and matches hidden behind a notice board, he was punched in the face, leaving him in pain and "*badly shaken*" and in need of hospital treatment (LSN - 13960).

81. It is submitted that the omission of LN 25 to speak about this incident in his evidence was in keeping with the character of many training school employees who took great pride in their work, and whose main interest was the welfare of the children they worked with. The Inquiry will be aware from the papers that many injured staff declined to make complaints to police. It seemed that LN 25 merely wished to defend his reputation and that of his colleagues, without seeking to raise allegations against boys who were under his care, including the one who punched him. Perhaps, an assault such as this was all in a day's work for a man like LN 25, as it must have been for many of his colleagues and those doing similar work at Rathgael and St. Patrick's.

82. In Lisnevin a frequent strategy on the part of some boys was to take over a room, establish a barricade and cause significant damage within the room. The report of a 1994 incident is not untypical of a number of such incidents which appear on the Inquiry papers:

"*The afternoon shift on 5th April commenced with a severely understaffed situation. At 7.30pm the general alarm sounded and several boys barricaded themselves in the Remand Unit Servery. The boys were belligerent and resisted encouragement to come out. A fire was started in the servery and as a consequence all other boys were evacuated to the dining hall. As the last boy entered the dining room the phone was ripped out and staff had chairs and tables thrown at them. The boys then proceeded to wreck the dining hall and areas of the main kitchen. Eventually a number of them broke out through a skylight in the kitchen and escaped using stolen kitchen knives to help scale the security fence…."* (LSN - 12985)

83. It is submitted that when addressing the allegations of abuse in its report, the Inquiry might also pay tribute to the courage and fortitude of the majority of staff who continued to work with difficult and often violent children at considerable risk to themselves.

84. It is quite clear that staff needed to develop strategies to deal with instances of aggression and violence. The Inquiry has heard that there was a need on occasion to apply control and restraint techniques when faced with challenging behaviour. Moreover, there was also a need to separate children from their group if circumstances warranted it. Both approaches have attracted criticism from some complainants.

Separation

85. A number of complainants to the Inquiry, for example, HIA 389, HIA 434, and HIA 172 in relation to Rathgael, and HIA 94, HIA 138 and HIA 418 in relation to Lisnevin, have made complaints about the use of separation in the training schools.

86. In the statements and oral evidence of both complainants and witnesses various terms have been used in reference to the practice of separating a young person from their group and placing them in a closed (sometimes locked room) for a period of time: "*time out", "D Room", "isolation", "exclusion", "punishment block" and "quiet room".*

87. The main complaints which have accompanied the allegations which have been received by the Inquiry in relation to the use of separation include:

    (a). being placed in isolation frequently

    (b). being placed in isolation for prolonged periods of up to several days at a time

    (c). isolation rooms containing only a blue gym-type mattress and blanket

    (d). staff not responding to signals from the isolation room that the young person needed to use the toilet

    (e). poor provision of food and water.

88. It has been noted elsewhere in these submissions that Rule 39(d) of the Training School Rules provided for the use of separation and sought to regulate its use as an "*exceptional*" measure.

89. The Department submits that it was appropriate for staff at the training schools to use separation, in accordance with the Rules, in order to control behaviour and as a form of punishment. Separation was a necessary tool in the armoury of staff to reduce the risk of harm, to protect staff and children, and to sanction unacceptable behaviour. The Department would condemn any abusive use of separation, but it takes the view, having considered the evidence, that there is no clear indication that separation was used abusively in the vast majority of cases.

90. As will be explored in later sections, the SSI had occasion to carry out inspections at both Rathgael and Lisnevin. It did not identify any issue with the use of

separation at Rathgael apart from record keeping. It is right to say that SSI expressed some concern about how separation was being used at Lisnevin, particularly during a period when there were acute staffing difficulties. This issue will be explored in greater detail in the Lisnevin section of these submissions.

Control and Restraint

91. The Inquiry is referred to the statement of Karen Pearson dated 25 September 2015 which focusses on the use of restraint in the training schools (RGL 1871 - 1917).

92. The Inquiry will recognise that much of the discussion at Board of Management level which focussed on the need to develop safe methods of restraint, occurred in the aftermath of assaults on staff: see for example paragraphs 3 and 9 of Ms Pearson's statement. Another clear message which emerged during such discussions was that staff may need to use force to defend themselves or to protect others, but only a minimal amount of physical control was appropriate: see paragraph 6 of Ms. Pearson's statement.

93. The Department recognises that the provision of appropriate guidelines and formal training for staff in the application of safe restraint techniques may have been too long delayed, although there appears to be some confusion in the evidence in relation to what was provided to staff and when.

94. Ms Pearson has suggested (at para 7) that at Rathgael, for example, draft guidelines on control and discipline which were circulated at a Board meeting in November 1993 "appear[ed] to be the first attempt to formalise guidelines regarding restraint at Rathgael…"

95. At Lisnevin, Board members were invited to observe a demonstration of restraint techniques in June 1989 (at para 16 of Ms. Pearson's statement), but according to the records referred to by Ms Pearson it was not until September 1994 that training was provided to staff. At that time a policy document entitled, "*Policy Guiding the Management of Situations Involving Disruption, Aggressive Behaviours, Violence and the Exercise of Physical Restraint as a Last Resort*," was approved in principle (para 23).

96. At Rathgael, training (described as 'Child Management Course') was not made available until September 1995 (para 27 of Ms. Pearson's statement). The position

regarding training at St. Patrick's is uncertain although the Inquiry heard evidence that before the opening of the Slemish Unit, SPT 2 received restraint training which was arranged through the NIO and provided to him by prison officers at Millisle: see the transcript for day 143.

97. While Ms. Pearson's statement sought to accurately reflect the records describing the progress which was made at the institutions on the issue of restraint training, the Inquiry has heard evidence from staff at both Lisnevin and Rathgael that different training in various restraint techniques was provided throughout their careers.

98. In his statement LS 25 explained that, "*Staff members were properly trained to use certain restraining techniques in the event of violent or disruptive behaviour in order to minimise the risk of injury to the young person, staff and/or other residents*." (LSN - 1225, at para 8).

99. During his oral evidence he expanded upon the issue:

"Well, in Newtownards in Kiltonga there was no set out training, but when they moved to -- when they moved to Millisle, when I went back, there was people brought in to show proper techniques how to restrain young people without hurting them." (Day 162, page 97, line 3).

100. LS 25 recalled that regular training updates were provided which staff were required to participate in. However, the only records available to the Department which document the provision of training to staff are those annexed to Ms. Pearson's statement, and these show that training was not made available until 1994 at Lisnevin, and 1995 at Rathgael. It is possible that less formal training was provided at earlier stages as suggested by LS 25, and was not documented.

101. The Department recognises that a range of complaints have been registered with the Inquiry in relation to the use of this form of physical intervention. A number of female complainants have alleged that restraint was often applied in a manner which paid no regard to their dignity. Other complainants have suggested that restraint was used gratuitously, when it was unnecessary, and when the better option would have been to talk to the child to understand the reasons for their behaviour. Others have talked about the infliction of pain associated with the application of restraint, and that it was unnecessarily aggressive.

102. The Department would condemn any abusive use of control and restraint actions on the part of staff. It is recognised that staff members often found themselves in dangerous or difficult situations but this would not excuse the disproportionate application of force, or the use of physical intervention in a manner which was inappropriate or unnecessary.

Perspective and Balance

103. The DOJ is steadfast in its view that those children whose circumstances brought them to be resident at any of the juvenile justice institutions had a right to live there free from any abuse. The Inquiry has heard evidence that alleged that abuse took place at each of the institutions which it is considering. That abuse consisted of physical, sexual and emotional abuse, and was perpetrated by peers, as well as members of staff and others who had access to the institutions.

104. The Department acknowledges that some children were undoubtedly the subject of abuse when living within the juvenile justice system, and that this abuse may have caused them lasting damage. Elsewhere in these submissions further comment will be made about those abusive aspects.

105. The Department wishes to make it clear at the outset, however, that one act of abuse was too much, and that any act of abuse which did occur meets with the unequivocal condemnation of the Department.

106. However, it is also important to define as accurately as possible the extent of the problem of abuse at these institutions, and to develop a sense of balance and perspective. These words should not be interpreted in any way as seeking to deny that abuse was a painful reality for some children.

107. On the contrary, the point that has to be made is that this Inquiry is bound to hold up to scrutiny any abuse that did occur and to reveal it for what it was in its proper context. It is submitted that a substantial part of that context was the fact that the vast majority of staff were doing their level best, some going beyond the call of duty, to provide a caring environment for young people, and one in which they were sensitively challenged to confront the issues in their lives which were causing difficulty.

108. It is important to pause and to reflect upon the estimated number of children who passed through the juvenile justice institutions during the relevant period and to compare this with the number of complaints of maltreatment which have been raised.

109. Using the Department's best estimates of the number of children that passed through each of the institutions being considered in Module 7 (as set out in the Department's Rule 9 Responses), and the number of applicants to the Inquiry, the proportion of complaints received by the Inquiry represents less than 1% in respect of each of the institutions. Even if the known number of civil complaints and complaints to the police is included in the calculation as referenced by Inquiry Counsel, the number of complaints in respect of St. Patrick's and Rathgael as a proportion of the total number of children who resided there during the Inquiry's reference period, would still be less than 1.5%.

110. It is recognised that there will always be an element of under reporting; not every person who may have had grounds for complaining to the Inquiry or to the police will have done so. It is submitted, however, that the relatively small number of registered complaints must be of some significance. The Department considers that these figures should lead the Inquiry to the conclusion that while acts of abuse undoubtedly occurred, they affected a small minority of children in the four institutions with which we are concerned. Abuse was not inevitable and nor was it an all embracing feature of life in these environments. Indeed the Inquiry is respectfully invited to amplify the conclusion that the reverse was true. The vast majority of staff who worked in these institutions are not the subject of complaint. There is no evidence to suggest that many staff conducted themselves in anything other than in an exemplary fashion. The vast majority of children did not suffer abuse.

111. It is important to make these points for a number of reasons. Firstly, this is a historically significant Inquiry. It has been given the task of officially recording the nature and extent of the abuse suffered in juvenile justice institutions. Current as well as future generations will look at the Inquiry's conclusions and a key question which will be asked is, how widespread was the abuse? They will refer to the Inquiry's report and will use it to gauge how the juvenile justice system treated those who participated in it.

112. Secondly, those who worked in the juvenile justice system, and who did their jobs properly and to the best of their ability, have in recent times been compelled to read and listen to reports in the media which, whether intentionally or not, convey a view that abuse was the order of the day for everyone.

113. It is understandable that the media will report from a perspective which focuses on the plight of the victim. No one can complain about that and the Department certainly does not. However, it is important to have a balanced perspective. Not only are the complainants few in number relative to the numbers who experienced life in the juvenile justice system, but the numbers of staff implicated in those complaints also appears to be relatively small (although the Department does not hold comprehensive statistics to demonstrate the number who worked in the system). Moreover there was a substantial amount of good, positive, constructive and sometimes innovative work undertaken in these environments in an effort to bring about necessary changes in the circumstances of the lives of very many young people.

114. Those members of staff who are innocent of any wrongdoing, but who spent lengthy parts of their careers working in institutions, are entitled to look back at their careers with a sense of pride and achievement in a job well done. They have done nothing wrong, and the Inquiry is invited to acknowledge that this is so.

115. A developed sense of perspective will also involve grappling with the fact that systems and approaches which were orthodox 20-30 years ago, may not now be regarded as acceptable. Thus, nobody would suggest that the approach to inspection undertaken by the Social Work Advisory Group (“SWAG”) during the 1970s would meet today’s exacting requirement of intensive regulation. But as will be further explained later in these submissions, the approach adopted was compliant with the policy considerations which were acceptable at the time.

116. By the same token, the Inquiry has heard evidence that approaches to control and restraint have undergone a number of developments over the years, and that now there is much less resort to the use of physical intervention to prevent harm resulting from the behaviour of a volatile child, and that the area is now the subject of greater safeguards.

117. The Department recognises that the Inquiry has indicated that it will work painstakingly to ensure that it scrutinises systems and conduct by reference to the standards of the time, and that it will be careful not to import current standards.

118. For the avoidance of doubt, the Department's submission here is simply to reiterate the importance of context. There are of course certain minimum standards of behaviour which are to be expected of organisations and individuals regardless of the era. While grey areas may exist, the Department accepts that the expertise of the Inquiry will enable it to form clear judgments in relation to these issues.

Section 2: St Patrick's Training School

Background

119. The Inquiry is again referred to the statements of Nick Perry (SPT-1592) and Dr Hilary Harrison (SPT-1681) and to the joint statements of Karen Pearson and Dr Hilary Harrison dated 21st August 2015 (SPT-1723) and 21st September 2015 (RGL-1608), which provide information in relation to the legislative framework within which St Patrick's, operated.

120. St Patrick's Training School was established 1862 by the Roman Catholic Church and managed directly by the Diocese of Down and Connor. It was formerly an Industrial school and, from 1921, also catered for the reception of reformatory boys. St Patrick's School was designated a training school, following approval by the MoHA pursuant to section 106 of the Children and Young Person's Act (Northern Ireland) 1950 Act, which introduced the legal framework for the operation of training schools and enabled the court to impose a training school order, in respect of a child requiring such provision. St Patrick's was also registered as a remand home under section 104 of the 1950 Act. It continued to function as a Training School and remand home until 2001.

121. As noted earlier in these submissions, St Patrick's fell within the group of schools that were funded by the MoHA/NIO but managed by voluntary Boards. In effect, this meant that, whilst the MoHA/NIO grant-funded St Patrick's, it had less control over the day to day operation of the school than over the State owned institutes, such as Rathgael or Lisnevin. Essentially, the MoHA/NIO was responsible for funding and for the policy framework and the school's management was responsible for day-to-day operational matters.

122. The nature of the relationship between the Department and St. Patrick's was such that the Department extended a significant degree of autonomy to the school and the Board of Management which controlled it. The Board of Management consisted entirely of clergy for many years of St. Patrick's existence, although the Inquiry has heard that in and around 1989, the Chairman, Bishop Farquhar, changed the membership of the Board to involve lay members.

123. Consistent with this level of autonomy and independence, St Patrick's Training School was an employer in its own right and managed the movement of Brothers. It

also employed ancillary staff, the identity of whom would not necessarily have been brought to the attention of MoHA/NIO. The St Patrick's Board would have sought approval for the appointment of secular staff necessary to work with the children, and such staff would have been the subject of vetting procedures.

124. Whilst St. Patrick's was granted autonomy in key operational and managerial matters, it was bound to work within an infrastructure established by the State to ensure the proper care of the residents of the training schools and to prevent abuse from occurring. As was described earlier, this infrastructure incorporated two main features: the Training School Rules and a system of inspection.

125. The Department would wish to emphasise that it is unlikely that any framework of rules and inspection could ever provide a guarantee that those cared for within the system would not be abused. The objective of such safeguards must be to establish mechanisms which will make it much less likely that abuse of whatever form will occur, and to ensure that where abuse happens that it is detected, its effects minimised and brought to an end.

126. It must also be acknowledged, as has been more fully explained above, that the regime for inspecting training schools in its various changing forms, reflected the policies and "know how" of the era. Different standards and different methods are deployed today, and it is clear that the bulwark against the abuse of young people in care and the tools available to detect abuse, are of a different order than was available within the period covered by the Inquiry's terms of reference.

127. The Department contends that the entrenchment of the Training School Rules coupled with the advice and inspection arrangements (provided from the 1970s through SWAG and then SSI, and before that, by the Ministry inspectors) represented a genuine attempt to ensure that the residents of St. Patrick's Training School were cared for in accordance with the highest standards of the day and protected.

Finance

128. A history of funding arrangements can be found at SPT-1327 and SPT-1328.

129. St Patrick's was fully funded by the NIO through a grant-in-aid. A grant-in-aid is payment by a Government department to finance all or part of the costs of the body

in receipt of the grant-in-aid. This form of financing will apply in circumstances where the Government has decided, subject to the necessary Parliamentary controls, that the recipient body should operate at arm's-length. The sponsor Department does not therefore seek to impose the same detailed controls over day to day expenditure as it would over a grant. In the case of St Patrick's, as with all of the juvenile justice centres, the grant-in-aid was issued in accordance with the conditions for the payment of grant by the NIO to training schools/remand homes.

130. Witnesses to the Inquiry have commented on the role that the MoHA and the NIO had in ensuring that there was adequate funding for the school. For example, Fr Bartlett in his statement to the Inquiry stated:

"*In subsequent years further sums were advanced to the Trustees by the MOHA towards the cost of the various enhancements of the facility, inter alia, a gate lodge, classroom accommodation, ancillary accommodation, a pre-licence hostel, a playing field, children's playground and other recreational facilities*" (SPT-847).

He added:

"*I offer the observation that throughout the history of Milltown and St Patrick's the level of funding by the State, the level of regulation and inspection provided by the statutory authorities and the frequency of supervision and inspection carried out by the Management Board appear to have been consistently more substantial and qualitative than in the case of Rubane. Particularly following the establishment of the new site on the Glen Road, this included closer collaboration between St Patrick's and the management of the other Training Schools such as Rathgael, as well as the more comprehensive and better funded provision of in-service training for staff*" (SPT-855).

131. It is submitted that, whilst allowing St. Patrick's its considerable autonomy, the MoHA and NIO also provided sufficient funding for the school's purposes. It is also submitted that, by contrast with some of the complaints made by complainants in previous Inquiry modules, there have been few allegations made in relation to the lack of material comforts, services or facilities at St. Patrick's following its move to the Glen Road site in 1957.

Building, Equipment and Resources

132. BR 39 on his arrival in St Patrick's (then at Milltown) in 1942 found the conditions "*depressing and challenging*" and he oversaw the move from Milltown to the new site on the Glen Road. As early as 1943, steps were initiated to undertake the establishment of a new school but finance was problematic. Initially, the Ministry of Home Affairs (MOHA) was in favour of taking responsibility for the school but met with Diocesan opposition. The Management Committee approved the purchase of a farm for £20,000 and the property was owned by Diocesan trustees with the Board of Management having a lease over the farm.

133. Following the passing of the Children and Young Persons Act 1950, the MOHA agreed to the purchase of a site for the school. SPT-10516 sets out the details of the Order's discussion with the MoHA. In his statement to the Inquiry, Br M (no designation) mentions a Belfast Newsletter Article (1957) in which the Assistant General of the De La Salle Order stated that:

"*he had never before come across such a palatial building, and it was the MoHA, a liberal and benevolent Ministry, which had provided the money without which the De La Salle Order could not carry on*" (SPT-653).

Other news articles in relation to the opening of St Patrick's noted its excellent facilities (SPT-677 to 684).

134. In his statement to the Inquiry, BR26 highlighted:

"In the summer of 1957 both boys and staff … moved into the new, state-of-the-art building … many boys were simply spellbound by the size and newness of their new home. Almost overnight it was christened Butlins …" (SPT-1229).

135. Chalets were introduced to St Patrick's in the early 1970s and the 'block' style dormitories were sub-divided to provide single rooms for the boys in keeping with the developing theories on child care.

136. Many witnesses to the Inquiry have mentioned the excellent facilities offered by the school including the food, clean bedding and washing facilities (SPT-40529 and SPT-40530). Br 26's statement to the Inquiry sets out the multiple recreational activities available to the boys:

"*After the evening meal some of the teachers would take different activities which meant the boys could be divided into smaller groups. There was on site a swimming pool which was very popular; there was table tennis, billiards, snooker, basketball, boxing, art, craft and TV during the winter months. In summer we encouraged everyone to take part in outdoor activities like football (soccer and Gaelic), hurling, rounders, handball, athletics and swimming*" (SPT-1235).

137. In addition, between 1992 and 1995, the NIO provided a major capital investment of over £1.9m in the school which allowed for the building of two new purpose built units and the refurbishment of an existing double unit.

138. Again, it is submitted that the MoHA/NIO supplied sufficient, and indeed for their time, excellent resources for the operation of the school.

Responding to the Need for Specific Facilities and Services

139. Witnesses have given two examples of where the relevant Ministry provided support for new initiatives: the introduction of the 'chalet system' and the implementation of the Black Report recommendations.

140. In his statement to the Inquiry, BR94 commented:

"*During 1969 it was suggested that we should develop a 'chalet system' for the junior section. After lengthy discussions with the MOHA on staffing and costing the green light was given. Two units were designed and built each capable of accommodating upwards to 14 boys. By the end of 1970 the buildings were occupied thus reducing the numbers in the main block. The next project was to create individual rooms for those remaining in the main block and this operation was successfully carried out" (*SPT-1236).

141. SPT-26 in his statement to the Inquiry remarked:

"From 1980 onwards there was a slow implementation of the principles of the Black Report … however, notwithstanding (this) in addition to the main school block there were three chalet units in operation … they tended to house children on the 'care' side for a variety of reasons some educational, some emotional/behavioural who it was felt would benefit from a more homely atmosphere …" (SPT-1680).

Sufficient Staff

142. The DOJ/DHSSPS Joint Statement to the Inquiry sets out the funding arrangements for training schools including the issue of staffing (SPT-1327). The Joint Statement highlights:

"A key resourcing matter for Training Schools was staffing. The legislation has indicated that although Boards of Management had responsibility for acquiring and releasing staff, staff could only be appointed by the Board after the approval of the MOHA/NIO was obtained. St Patrick's was an employer in its own right and managed the movement of Brothers within the school. They also employed ancillary staff, who would not necessarily have been brought to the attention of the MOHA/NIO's notice. The St Patrick's Board would have sought the approval of the appointment of secular staff necessary to work with children. The MOHA/NIO would have provided vetting of staff prior to their appointment".

143. The Joint Statement also indicates that the DOJ/DHSSPS were at that time unable to locate any information relating to staff ratios or staffing requirements prior to the 1980s. However, the SSI provided advice on the applicable staffing ratios and training needs, and there has been no suggestion that this advice was not complied with. The information available to the Department would suggest that the 'Castle Priory' formula was used to calculate the staff requirements of the schools, allowing for differing staffing ratios per type of unit i.e. Open Units, Assessment/Reception Units and Closed/Secure Units (SPT-1322).

144. Alan Shannon in his statement to the Inquiry verified the position:

"the institutions were funded by the NIO in terms of running costs and capital. The Boards of the Institutions were responsible for the employment of staff although the NIO was involved in the recruitment of Directors. Staff numbers were controlled by the NIO and appointees were subject to NIO security vetting … most staff were either qualified teachers or social workers (field or residential). Night supervisors were sometimes unqualified but qualified senior staff were on call. I recall chairing meetings of a Criminal Justice Training Strategy Group considering the scope for improving qualification levels in light of developments in NVQs and CQSW" (SPT-2225).

Inspection Arrangements

145. Extracts from MOHA inspection reports for St. Patrick's can be found from SPT-10376 to 10386. The Joint Statements given by the DOJ/DHSSPS to the Inquiry set out the inspection regime and guidance for inspectors (SPT-1323 to 1326 and SPT-1747 to 1751). The reports available to the Inquiry in relation to these historic inspections are unfortunately limited, but there are a number of entries in the log books showing visits by MoHA Inspectors Simpson and Forrest.

146. Br Manning also made mention of MOHA inspections in his statement to the Inquiry:

"A log book (punishment) would have been maintained and it would have been available for inspection by the MOHA" (SPT-317).

147. SPT53 stated that he recalled the "*frequent*" SWAG/SSI inspections by Wesley Donnell, commenting "*you would have thought he was a member of staff he was there so often*" (Day 145, page 70). BR26 agreed, noting that Donnell was "*part of the furniture*" (Day 157, Page 66).

148. BR26 described a close relationship with Wesley Donnell, being on hand to advise and assist over a period of years (Day 157, Page 66). He recalled that Inspectors would raise issues and ultimately steps would be taken to implement those matters that it was agreed needed to be dealt with (Day 157, Page 67 & 68). Training and qualifications of staff became a more major focus, including the training of staff in social work. Donnell would have spoken to individual staff and management about the prospect of some of them going for further training. He also would have been aware of the issue of absconding and tried to help BR26 with it (Day 157, Page 76). BR26 recalled random unannounced inspections, including in the evening and at the weekends (Day 157, Page 107).

149. The evidence of St. Patrick's staff is of course supplemented by Mr. Donnell's statement to the Inquiry at SPT-3004. Taken together the evidence reveals the level of interest and dedication shown by Inspectors such as Mr. Donnell, and his commitment to driving up standards. This evidence also supports the view that the Departments were maintaining a supervisory presence over the school. Inspections were frequent and useful, and focussed on identifying any departures from recognised standards and improving the school.

150. The Inquiry has available for consideration an SSI report from 1988, following an inspection of St. Patrick's in 1987 (SPT-18358 to 18432). It also has a letter written by Dr McCoy to Mr. Alan Shannon dated 27 February 1990 (SPT-18644), which refers to Mr. Donnell's follow up visit to the school and his report. Regrettably, the 1990 report cannot be found and is not available to the Inquiry. Dr. McCoy's letter contains the complaint "the things that needed to be dealt with have not been dealt with and therefore we should not put any more kids here."

151. This indicates that it was the view of SSI that St. Patrick's had not properly dealt with the recommendations made in the 1988 report. The tone and content of the letter indicates how seriously the inspectors took their responsibilities, and the degree of pressure they were prepared to apply to ensure that there would be no departure from acceptable standards.

Good Work in Difficult Times

152. The Department wishes to acknowledge the important and beneficial impact of St. Patrick's Training School over the decades during which many thousands of boys passed through its doors. The Department agrees with the view expressed by SSI in 1988:

"During the very difficult times of the past 20 years the De La Salle Order has continued to provide a residential service in West Belfast for Catholic boys in trouble, from all parts of the Province. At times this has been a very difficult service to sustain and it is to the credit of all the staff, through their commitment and by the leadership given by the Brothers and successive directors, that it has been possible to sustain the quality of care provided for the young people". (SPT-18428)

153. The school's task was certainly not an easy one. During the harshest years of the Troubles, the staff worked with difficult boys at the most challenging of times, many of whom had already been scarred by abuse and violence. For some, their time at the school proved to be the turning point in their lives. SPT 126, for example, described himself as a "*successful product of the training school*" and that the experience helped him to move on in his life (transcript day 138, pages 65-66). He was grateful to those who took the time to try and show him a better way of going about things (transcript day 138, page 78).

"I have the greatest of respect for them. As I said earlier, they put me back on the straight and narrow and I could have just as easily went the other way. I probably didn't appreciate it very much at the time, but thinking back, I could have just went the other way, and they were very good to me." (transcript day 138, page 102)

154. Likewise, SPT-125 stated that he could have become embroiled in the Troubles but that "*in St. Pat's the system that I experienced was one of total support and trying to ensure that I could achieve my potential that they saw and that I probably didn't"* (transcript day 140, pages 104-105). He thought his "*life would have been totally different"* and that "*St. Pat's ensured that I came out the other end in a better way*" (transcript day 140, page 105). He had only happy memories of his time at St. Patrick's.

155. The Department has a high regard for the valuable work which was done at St. Patrick's. The Department considers that the few individuals who came to the Inquiry to commend the work of the De La Salle Brothers and their lay colleagues on the staff at St. Patrick's, are unlikely to be alone in owing a debt of gratitude for the care and direction that was provided to them.

Complaints

156. The Board of St. Patrick's had a high degree of autonomy as has been discussed above. The Board would have known from its contact with Inspectors and officials of MOHA/NIO, and its understanding of its obligations under the Training School Rules, that it was obliged to have proper systems of supervision and monitoring in order to ensure an appropriate standard of care was delivered to the boys under its control, and to prevent abuse.

157. It is not the Department's role and it is not the purpose of these submissions to comment in detail on the allegations of abuse relating to St. Patrick's Training School. These issues are more appropriately addressed by the representatives of the De La Salle Order, the Diocese of Down and Connor and the individuals implicated in the complaints.

158. However, it is a feature of some of the issues that the Inquiry has considered in relation to St. Patrick's that information which should have been brought to the Department's attention or that of other agencies, did not emerge. These issues and some related matters are discussed in the submissions which follow.

Peer Sexual Abuse

159. Allegations have been made that sexual activity between boys occurred in St Patrick's. A number of Brothers and lay staff have confirmed that they had some awareness that sexual activity was taking place between boys from time to time and that they did their best, through close supervision and keeping older boys separate from the younger ones, to prevent it happening.

160. Some cases of sexual activity between boys were reported to the Police, although it seems that this did not become the accepted practice until the mid-1980s (see, for example, the evidence of BR26, Day 157, page 48-52). None of the cases which were reported to the Police proceeded to prosecution.

161. There are no records to show that the Department was informed by the Board of St. Patrick's that sexual activity between boys was an issue. There is no evidence to suggest that this issue was brought to the attention of SWAG or SSI for advice and guidance.

162. The Order have indicated that they did not see this as a significant issue at the time, which may explain why the Department was not made aware. While the Department acknowledges that many organisations only changed their reporting practices in the aftermath of the Kincora affair in the mid-80s, the Department would submit that even before this event the Board of Management of St. Patrick's should have been reporting concerns about peer sexual activity to the police, the MoHA and NIO, or at a minimum, it should have sought advice from SWAG or SSI.

Death of Bernard Teggart

163. The murder of Bernard Taggart, a resident of St Patrick's, after he was abducted from the school on 12th November 1973 by the Provisional IRA, was a horrific and deplorable act upon a vulnerable and innocent young man. It was something that should never have happened, although this was only belatedly recognised by the perpetrators (SPT-2121).

164. The tragic event of Bernard's murder must be placed in the context of Belfast in 1973. There were 20 deaths in relation to the Troubles in November 1973 alone, with 9 occurring in Belfast (SPT-2144).

165. It appears that unofficial visits to the school from representatives of paramilitary organisations were reluctantly tolerated by the school (SPT-2120). The violent and fearful climate of the time might well have rendered it difficult for management at the school to resist such intrusions, but there is no evidence that the school raised any concerns with or sought assistance from the MoHA. The Department submits that the school should have raised such issues not only with officials, but also with the police, difficult though that might have been in West Belfast at that time.

166. BR52 stated in his evidence to the Inquiry that he had informed the Bishop, the Chairman of the Board of Management, that the boys had been abducted (see transcript for day 148, page 118), but it appears clear that there was no engagement between any one at any level within St. Patrick's with either the police or the Ministry until after Bernard's body was found.

167. The Department submits that when the Teggart brothers were removed from the school, the police should have been immediately informed, and, given the seriousness of the situation, the Ministry should have been notified also. Those were obvious steps to take in the interests of safeguarding vulnerable children whose removal had been secured by implicit threat. No satisfactory explanation has been tendered for the failure to seek assistance from the authorities.

168. The HET report in relation to Bernard's murder drew attention to media reports that the Department intended to review the incident (SPT 18800-18831). However, the HET team was unable to find any documents in relation to a review.

169. It is acknowledged by the Department that it would have been unacceptable if at the time, there had been a failure to conduct a review into the incident, albeit that the police investigation would have had primacy. Given the serious nature of the incident, the geographical location of St Patrick's, and the events of those times, it is accepted that there was an onus on the Ministry of Home Affairs (and subsequently the NIO) to inquire formally into the events leading to the abduction of Bernard in order to establish whether systems or security could be improved and so that lessons might be established for the future.

170. The DOJ would have expected this to have been done but it is unable to say what was done at the time. Former officials from that time have been contacted but have been unable to provide any evidence of use to the Inquiry (SPT-3002).

171. At the request of the Inquiry, the Department has taken steps to provide all available information held in relation to the incident. The Inquiry is referred to the statements of Stephen Rusk (SPT-19376) and Karen Pearson (SPT-3002). The Department's documents and electronic records have been exhaustively searched and enquiries have been made with PRONI, NIO and MOD. All information held by the Department, and sought through investigations with PRONI, NIO and MOD, has been provided to the Inquiry. Despite extensive efforts, no file has yet been located.

172. Karen Pearson indicated that she would have been "*astonished*" if the Ministry of Home Affairs had not pursued an investigation at the time. She indicated her belief that the incident would have generated a departmental file if the case had been considered (transcript for day 150, page 10).

173. The police file contains a murder log (SPT-27660), which indicates at entry 89 (SPT-27685): "*Ministry of Home Affairs file on investigation into St. Pat's school*". The entry certainly suggests that there was a file and that it was received by the RUC officers investigating the case, but it has not been possible to locate that file.

174. The Inquiry will recognise that any review which may have been conducted might have struggled to devise any practical solutions to prevent paramilitary intrusions into school life, let alone to avert abductions. As an open training school in the heart of West Belfast at that time of severe civil strife, the securing of the school grounds faced a number of difficulties, as described by BR26 (transcript, day 157, page 39):

"there were limits to what staff could do, what any of us could do, because we were a very, very open institution and access was very easy for anybody that wanted to come in. In the very first instance we were not allowed by the army to close the gates even at night-time because they wanted to come in. Now they found other ways of coming in and they found other ways of going out and not necessarily through the main gates, but the main gates had to remain open. Then that led to fellas coming in in stolen cars and what not. Problems were developing all the time, and you do your best to minimise them and the staff regimes and all that, but there was only so much you could do because of the environment in which we were working and the openness of it."

175. It is submitted that without access to the documents which are likely to have been generated at that time or the Ministry officials who would have dealt with the issue,

it is likely to be a difficult task for the Inquiry to reach any firm conclusions in relation to the adequacy of the actions of the Ministry following the murder. Whatever measures were taken or not taken, it appears that there were no further abductions, despite the difficult conditions in which the school operated.

Incidents involving DL137

176. In relation to allegations made against DL137, a member of staff who was employed at St. Patrick's from 1975 to 1980, and who was subsequently convicted of offences involving sexual misconduct with children, the De La Salle Order has stated as follows:

"*The Order accepts that the allegation against DL137 came to the attention of the Order and that BR95 did not deal with the 1978 or 1980 allegations appropriately."* (SPT-667)

177. BR95 was [redacted] of St Patrick's from [redacted] to [redacted]. In July 1978, BR95 met with DL137 and issued a "*severe warning'* with regard to offering money to boys at the school in exchange for "*illegal purposes*" (SPT-21382). It must have been known that this amounted to dangerous predatory behaviour in what was a school environment, the home of many vulnerable children and that it plainly constituted sexual misconduct.

178. The Inquiry will be aware that BR95 failed to report the behaviour to the Board of Management or to the NIO, and of the inadequate explanation that he tendered for his omission (at SPT 21394): "*I am satisfied that DL137's involvement with the boys did not go beyond the offer of money, otherwise the Management Board would have been informed to have further investigations made."*

179. The Department believes that there is no good reason why this matter was not reported to the police or to the NIO at that time, even if it was only to seek advice.

180. Furthermore, in March 1980, BR95 was made aware by a member of staff of further complaints of sexual misconduct on the part of DL137 in relation to young boys at the school (SPT-21392). DL137 subsequently resigned (SPT-21369).

181. The information provided to the Board of Management was anodyne and gave no hint of the history of sexual abuse which had prompted the action to procure his resignation. The minute merely recorded that, "BR 95 *also informed the*

Board of the resignation of DL137 who was [redacted] *in the school* [redacted]*. No replacement had been found for DL137.*" (SPT-80999)

182. It does seem unlikely that in the close environment of St. Patrick's that the real reason for the departure of DL 137 was not known at various levels within the school. However, the real reason for his departure did not find a place on the formal record and nor, it would appear, were any questions asked.

183. BR95 has offered the following explanation for his benevolent response to the behaviour of DL 137: "*When DL137 resigned I,* [redacted]*, decided that there was no need for any further investigation into the complaints. I cannot be certain but I imagine that I would have had some consultation with the parents of the boys concerned before I made that decision*." (SPT-21393)

184. There is no evidence of such consultation, and in any event it is difficult to understand how BR95 reconciled himself to the view that a "*say and do nothing*" approach was ever going to be remotely acceptable.

185. The DOJ submits that there should have been (with the approval of the police) an internal investigation to establish the full truth about the behaviour of DL 137, in tandem with a report to the police and notification to the NIO. No adequate reason has been given to explain why such an investigation was not carried out, and no explanation has been given for the failure to contact the police or the NIO.

186. Astoundingly, DL137 was given a reference by BR95 dated 23rd September 1980, knowing that this would have assisted him to enter into the service of another employer, and potentially into a role which would have afforded him access to other vulnerable children. The reference did not hint at the difficulties which DL137 ought to have faced by reason of his misconduct. Indeed the reference was strikingly dishonest - it indicated that "h*e resigned from his position in St. Patrick's of his own accord.*" (SPT-21368).

187. The Department absolutely rejects the approach taken by BR95. This is a matter that should have been brought to the attention of the Board of Management, the NIO and the police in 1978. To allow DL137 to escape with a "*severe warning*" was wholly inadequate. To allow DL137 to continue to work in an environment where he would be in close proximity to children was an astonishing decision. The ineptitude of the approach allowed DL137 to cause damage to other children.

188. This criticism applies equally to the approach adopted in response to the incidents of March 1980. Once again, the police were not involved when they should have been. The information given to Board of Management was essentially misleading - it suggested that a staff member had routinely resigned, whereas, taking into consideration the function of a training school, he was compelled to resign because of his suspected involvement in the gravest of matters. The suppression of the truth allowed DL137 to go freely about his business in the community where he subsequently committed further serious sexual offences.

189. Whilst it is speculative to say what the Board of Management or the NIO might have done if they had been informed in either 1978 or 1980 of the allegations against DL137, the Department is confident that the matter would have been raised with the police. It would also be speculation to suggest that further sexual offences would have been prevented, but the failure to bring suspicions about DL137's behaviour to the attention of the proper authorities at the earliest possible opportunity is not without significance in this respect.

190. The Department is concerned that BR95's inaction is again indicative of a conscious effort to prevent disclosure of an issue which risked damaging the reputation of the school and the De La Salle congregation. It is beyond question that this inaction coupled with the attempt to rehabilitate DL137 by providing him with a reference, exhibited a casual disregard for the requirements of child protection, and is worthy of the severest criticism.

Allegations against BR26

191. Police made it known to the NIO in November 1993 that they had received complaints that BR26 had engaged in acts of sexual abuse and that they were conducting an investigation. [redacted]. The Panel is referred to the statement of Mary Madden CBE (SPT-2672) and the evidence that she gave to the Inquiry on 13th October 2015 (transcript, day 149, from page 45).

192. The Department submits that the seriousness and urgency of the matter was quickly realised and swift action was taken by Ms Madden and the NIO. Not only were the most senior members of staff within the Department informed – Sir John Chilcot (Permanent Under Secretary) and John Ledlie, (Deputy Under Secretary) -

but the Ministers were also formally notified and expert advice was sought from the Social Services Inspectorate. The advice of its Chief Inspector, Dr Kevin McCoy, was noted at a meeting of 18th November 1993 which stated that Dr McCoy had advised the NIO that:

"*following allegations of sexual misbehaviour against a member of staff of any establishment such as St Patrick's the immediate action of management should be to suspend that person pending a full investigation. His concern was that if the person against whom the allegation was made remained in post there was a likelihood of further misconduct."* (SPT-12924)

193. As explained by Mrs. Madden (transcript day 149, page 51), the Secretary of State did not have the power to intervene and suspend BR26 himself. St. Patrick's was a voluntary organisation run by the Board of Management, which was appointed by the Church, and the school was managed by the De La Salle Order. The only option available to the Secretary of State was to stop sending boys (i.e. refusing further admissions) to St Patrick's which the Chairman suggested during his questioning of Mrs Madden when she appeared before the Inquiry, would have amounted to "*the nuclear option*" and potentially an *"over-reaction in the circumstances*" (transcript day 149, page 90). As Mrs Madden stated (transcript day 149, page 98), that would have been an extreme response to the situation.

194. As indicated in Dr McCoy's advice, the primary consideration had to be the safety of the children at St Patrick's. NIO recognised that this was the correct position to adopt in principle. Therefore, the Bishop in his capacity as Chairman of the Board of Management of St Patrick's, needed to be informed so that the Board could take appropriate action, particularly in consideration of BR26's position [redacted].

195. Meetings were also held with the police who advised of their concerns that notifying BR26 of the specific allegations could hinder their investigations. As the documents available to the Inquiry demonstrate, this risk was considered seriously, but ultimately the NIO recognised that the principles of child protection were paramount. The detailed memo of 25th November 2015 from Mrs Madden (SPT-12927) reflects the fact that the Department was placed in a difficult position, but consulted, sought advice, and took action promptly.

196. The sensitive nature of this matter and the importance with which it was handled is reflected in the fact that approval was sought from the Ministers to adopt SSI's suggestions to approach the Bishop and invite him to consider BR26's position [redacted] (SPT-12933).

197. As appears from the evidence of Mrs Madden, at that meeting the Bishop and LN36 were fully informed of the situation and the advice of SSI that BR26 should be suspended during the police investigation. It was indicated strongly that they understood the gravity of the situation and they agreed that they would discuss this matter at an emergency meeting of the Board (transcript day 149, page 58).

198. Mrs Madden recalled in her evidence that the response of the Board was that they had spoken with BR26, who had vehemently denied the allegations that had been made. She was told that BR26 had confirmed that he would submit to a police interview under caution at any time and he would not leave the jurisdiction pending the outcome of the investigation as he was determined to clear his name (SPT-2677). BR26 has since given evidence that these matters were not brought to his attention by the Bishop or LN36 and that the first that he was aware of the allegations was when he was approached by police and asked to attend an interview (transcript, day 157, page 56).

199. The Board's decision not to suspend BR26 was notified to the Ministers (transcript, day 149, page 60). Mrs Madden recalled that NIO expressed its disappointment and surprise with the Board's decision which in its view disregarded the considered advice of the experts in the field, and undermined clear principles of child protection (transcript day 149, page 98).

200. It is worthy of note that the conclusion reached by the Board, that it would disregard the advice and would refuse to suspend, was in stark contrast to the practice in place in institutions such as Rathgael where staff were placed on precautionary suspension if they were the subject of police investigation in relation to matters relating to their conduct towards children.

201. Mrs Madden explained that the NIO would have continued to monitor the police investigation and could at any time have given consideration to going back to the Management Board to see what more could be done. (Day 149, page 98). The Panel will be aware that no prosecution was directed against BR26.

202. It is submitted that the NIO's approach to this matter demonstrates the primacy which was given to child protection at the heart of Government. The Department acted promptly and effectively, it commissioned the necessary expert advice and delivered a clear message to the Management Board that the protection of children was more important than institutional or personal reputations, or even the effectiveness of a police investigation. The NIO did all that it could practically have done to secure BR26's suspension having regard to the constraints of its relationship with the Board of Management.

203. Fr Timothy Bartlett, in his Statement to the Inquiry, did not disagree factually with Mrs Madden's version of events. His justification for the actions taken by the Management Board was as follows:

"In terms of how the particular allegations against BR26 were handled, it is important to acknowledge that this situation arose in the period before the Church and indeed the State had in place the comprehensive protocols and policies that now govern such allegations being received. In this particular instance, the findings of the police investigation subsequently proved the judgement of the Bishop and the Board to have been consistent with the final outcome. The damage to the reputation of BR26 had he been suspended, even if subsequently vindicated, could have been enormous. The decision not to suspend has to be considered in the light of the knowledge and understanding of child-safeguarding principles at that time and the information the parties had available to them." (SPT-3015)

204. The Department disagrees with Fr Bartlett's view. Firstly, it is clear that in 1993 it was recognised that for child protection purposes those who faced serious allegations of misconduct should be removed from positions of responsibility for children. This was the expert advice of SSI which, it is submitted, would have properly reflected the "*knowledge and understanding of child-safeguarding principles at that time*".

205. Secondly, it is only with the benefit of hindsight that Fr Bartlett can state that the Board took the correct choice not to suspend BR26.

206. Thirdly, and most importantly, child protection must take primacy over the reputation of a member of staff or the institution.

207. Regrettably, the Department is bound to suggest that the approach taken by the Management Board in this instance contained the same flaw that infected the actions of those at St Patrick's who had knowledge of Bernard Teggart's abduction, and the behaviour of DL137. In each case, steps should have been taken which would have prioritised the protection of children within the school, but for reasons which have not been adequately explained, those steps were not taken.

Absconding

208. It is recognised that absconding was an issue at the training schools, Rathgael and St Patrick's in particular. One incidence of absconding was noted in an inspection report on St Patrick's as far back as 1950 (SPT-10440). The civil unrest in Northern Ireland during the Troubles made the issue of absconding from St. Patrick's all the more concerning because of its location in West Belfast. In contrast to Rathgael where absconding pupils invariably went into Bangor town centre and visited the arcades, children from St Patrick's were more likely to become involved in the anti-social and dangerous behaviour of joy-riding which, because of the security situation placed them in grave danger.

209. All training schools were required to provide absconding statistics to the Department. However, it is submitted that the responsibility for monitoring and managing absconding was for the senior management and Management Boards of the schools, with the help of APRU and input from NIO if required, in terms of funding and policy advice.

210. The APRU, commissioned by the NIO with the agreement of the Chair of the Board of Management and Director, carried out a review of absconding at Rathgael and produced a report in 1991. It contained 11 recommendations and there were follow up reviews in 1992 and 1993 to monitor the effectiveness of the recommendations they had made in 1991.

211. It appears that the 1991 report was not shared with staff at the other training schools – this meant that the steps which were identified to help reduce absconding in Rathgael, were not considered for implementation elsewhere. The Department is surprised that the report and learning from it was not shared with the other training schools, not least because the role of APRU brought its staff into direct contact with all of the schools. Mrs Madden in her evidence to the Inquiry on day 149 (pages 70

- 71) was of the view that although the report may not have been disseminated formally there were various mechanisms by which the report could have been shared.

212. The Department accepts that NIO ought to have taken the initiative to check to ensure that the report was shared with relevant staff across all training schools and that its findings were considered for application in each institution.

213. It would only be speculation to suggest that the practitioners in APRU did not see a direct relevance between the Rathgael situation and the St. Patrick's situation.

214. The Department recognises that absconding was a particular problem in St. Patrick's as well as Rathgael and regrets that it proved impossible to bring it fully under control at either location. However, the training school system was a deliberately open system so that an inevitable side effect of it was the risk of absconding, despite the various initiatives which went into trying to improve supervision of children.

215. As the Inquiry is aware, SPT 81 [redacted] died on [redacted] in a joy-riding incident during an absconding episode from St Patrick's. The Inquiry is referred to Mary Madden's statement to the Inquiry (SPT-2678) which provides information in relation to his death. This particular incident brought the issue of absconding at St Patrick's into focus. Unsatisfactory reports arising from reviews into the death of SPT 81 [redacted] by the Western Board and St Patrick's resulted in the NIO commissioning SSI to conduct its own review.

216. Both Dr McCoy (SPT-2003) and Mr McElfatrick (SPT-2008) have stated that the relationship between SSI, training schools and NIO was generally good at all levels. However, they made reference in their statements to a strain being put on the relationship with the NIO as a result of a discussion between Mrs Madden and Mr McElfatrick on the SSI report in relation to the death of SPT 81 [redacted] (SPT-12906). This meeting prompted Mr McElfatrick to write a memo to Dr McCoy on 3rd May 1995 (SPT-12712) in which he described the meeting as *"rather difficult*" and suggested that "*NIO are uncomfortable with the idea of our independent role and …… they would like to have been able to influence the content of our report*." Mr McElfatrick's memo also suggested that the NIO had hoped the SSI report into the

death of SPT 81 would provide information that could be used against St Patrick's.

217. This was denied by Mrs Madden in her evidence to the Inquiry (transcript, day 149, pages 78 - 87). Although she did not recollect the particular meeting with Mr McElfatrick, the papers which she referred to in her evidence indicated that she had been of the view that the report should have addressed the role of the Management Board in tackling the issue of absconding. She pointed out that SSI had explained their position by asserting that the terms of reference for their review did not allow them to address the role of the Management Board. Mrs Madden pointed out that it was in fact SSI who had advised the NIO on the terms of reference following their own observations and concerns, on foot of St Patrick's earlier report, suggesting that there was a failure to tackle that issue at senior and Management Board level. While accepting that the terms of reference did not expressly include an examination of the role of the Management Board she did not believe that the terms precluded such an examination either.

218. Mrs Madden also stressed that she had not asked for the report and its findings to be diluted or altered in any way but, on the contrary, her view was that it was not robust enough. The report was silent on the role of the senior staff and the Board of Management in that it failed to identify inaction at that level to address the culture of absconding and the increased levels which the SSI inspectors had found existed in the school at that time. There was no evidence that these matters had been brought to the formal meetings of the Board and a discussion on what action could be taken to address the growing problem.

219. Acknowledging the close working relationship that existed between the Department and the SSI, Mrs Madden stated that she expected SSI to challenge the Department if they found any inadequacies on its part - to do so not only fulfilled their independent role but also gave Ministers the assurance that Government was acting properly. If Mr McElfatrick seriously believed that she was challenging that independence she would have expected that to have been raised at the highest level, perhaps even Ministerial levels recognising that the Secretary of State who had overall responsibility was just as easily approached by all concerned. Mrs Madden confirmed to the Inquiry that she was never made aware of Mr McElfatrick's concerns until his note was produced for the Inquiry. Mrs Madden also

highlighted documents to the Inquiry (SPT-12759 and 12880 to 12881) that demonstrate that concerns existed at senior and Ministerial levels in relation to absconding and wider issues.

220. The regrettable death of SPT 81 highlighted the need to address absconding at St. Patrick's. At no time did NIO try to use the failings exposed by his death to unfairly attack the management of the school, or to attempt to compromise the independence of SSI. Mrs. Madden confirmed to the Inquiry that there was no agenda to close St. Patrick's rather, with legislative changes being brought forward whereby 'justice' and 'care' children would be sent to separate establishments, St. Patrick's had to be 'fit for purpose' as a 'care' facility.

Summary

221. The Department submits that whilst it afforded St. Patrick's significant autonomy, it did so whilst applying a strong regulatory framework. The Training School Rules established a baseline and inspections were regular, detailed and effective, improving in their rigour over time in line with societal expectation and changes in policy. The Department provided St. Patrick's with resources, funding and support to the extent necessary to carry out its functions.

222. Complaints made by those who have come forward to the Inquiry are comparatively small in number relative to the numbers who attended the school. With the exception of DL137, no member of staff has been convicted of any offences relating to the abuse of boys at the school.

223. The Department has the highest regard for the excellent work carried out by those who served on the staff at St. Patrick's, both lay and religious, during some extremely difficult and challenging times. However, the Department has reached the view that the school's handling of the issues arising out of the cases of Bernard Teggart, DL137 and BR26, demonstrates that there was a regrettable failure to take adequate steps to safeguard the needs of children.

Section 3: The Rathgael Centre

Background

224. The Inquiry is referred to the detailed statements and the oral evidence of Mr. Campbell Whyte (RGL 1714 - 1776, and day 164) and Mr. Lindsay Conway (RGL 5089 - 5116, and day 163). These men have a combined experience of almost 60 years of service to Rathgael. They have an unrivalled knowledge of the school having occupied a variety of roles during their career before progressing to the position of Director.

225. Both men exhibited an obvious pride in the work which was carried on in Rathgael during their time there. It was a pride shared by other former staff members who gave evidence to the Inquiry. When he concluded his evidence to the Inquiry on day162, RG 20 said the following:

I just feel my experience in Rathgael has been next to none. The practice, the young people, my experiences have been excellent. Supervision and support were very good and I got -- through the lengths of it I have learnt a lot. I just feel Rathgael could possibly get hit with a lot of criticism. In the care section where I worked I can only speak highly enough of it, and that was reflected latterly through inspection reports by RPIA and SSI. Life is not easy in residential. It's a calling. I think on reflection now probably ten years is a long enough -- I was in it twenty and I think ten years is long enough, but positive, positive. (transcript, day 162, page 56)

226. As RG 20 has suggested, the prospect that Rathgael might be criticised has had a disturbing effect on some former members of staff. Their positive experience and sense of pride in a job well has apparently been rocked by the allegations that have emerged.

227. However, as with the other institutions under consideration in Module 7, the complaints made against Rathgael to the Inquiry are extremely small in number (17) relative to the several thousand children (minimum estimate 4211) who passed through Rathgael’s doors over a period of 40 years.

228. The complaints do not paint a picture of widespread abuse. They suggest, at worst, that a small number of individuals behaved abusively towards a small number of children, in defiance of the rules of the system and whilst working amongst

colleagues who were otherwise focussed on doing their very best to meet the needs of many challenging children.

229. Nevertheless, the Department recognises that some of the complaints which have been made by the applicants to the Inquiry, while small in number, are in some cases extremely serious and merit very close attention.

230. Children whose difficult family or social backgrounds caused them to be placed in the training school setting were vulnerable and in need of care. They were entitled to expect that their human rights and their proper feelings of dignity and respect would be safeguarded by the staff who were entrusted with their care.

231. The Department accepts that some of the staff who were employed at Rathgael to fulfil these key roles did not always behave as they should have. The Inquiry has heard evidence that some staff used physical violence towards children and that on occasions such incidents were not appropriately investigated or dealt with.

232. Many of the allegations which have been made against former care workers at Rathgael have, however, been denied. A significant number of staff have come forward to refute the allegations made against them and to give their own versions of events. In circumstances where an allegation is contested the Department considers that it would be inappropriate to comment on the matter except in the most general of terms.

233. The evidence of Mr. Whyte and Mr. Conway suggests that much of the work undertaken at Rathgael by its dedicated staff was extremely positive and constructive. It is submitted that if abuse did occur in Rathgael it occurred at the hands of a minority of staff working outside the systems, guidelines and ethos of the organisation.

Inspection of Rathgael

234. Rathgael was an accessible place. It conducted its business in the heart of the community, and was open to visitors from all backgrounds. There were systems in place which ensured that its daily operations and the work of the staff were the subject of supervision and monitoring. It's openness suggests that it was not a place in which abuse could easily flourish. If abuse was widespread it would have been easily detected.

235. The Inquiry might consider the records for November and December 1985 at RGL 23593. Over the space of a 6 week period Rathagel was visited by an academic on behalf of a magazine, members of the Probation Board, representatives from Barnardo's, a representative from the Voluntary Service Bureau, a community workshop, a major sporting personality, a group of lay Magistrates, and a number of University students.

236. The Chairman of this Inquiry may remember his visit to the Rathgael Centre, in the company of Sir Robert Porter, and Mr. Justice Nicholson (as he then was) on the 3 September 1986 (23595).

237. Many of these visitors provided positive feedback in relation to what they saw of the working life of Rathgael.

238. On a more formal level of course, Rathgael was the subject of the regulatory system applied by the State. The inspection arrangements which were implemented by the MoHA / NIO, by adopting the expertise of SWAG/SSI, the changing role played by these Inspectors over time, and how they conducted their work, has been the subject of analysis elsewhere in these submissions.

239. Some witnesses have created the impression that the inspection arrangements under SWAG did not challenge the work of the schools. These submissions have already examined what Dr. Harrison thought of that. In the context of Rathgael, the perspective afforded by Mr. Conway is particularly interesting. He was asked by Inquiry Counsel whether the approach adopted by SWAG Inspectors was more relaxed and informal and less independent compared to his experience of the SSI approach. He rejected that characterisation:

"Not really. I mean, as a younger -- much younger social worker in those days, SWAG would have still had the same -- you know, the same reputation of you were being -- you were being inspected. The relationship definitely was different. The old Social Work Advisory Group journeyed with you through developments. So from that point of view if you were being innovative, if you wanted to introduce something new, they journeyed with you, advising you every step of the way." (transcript, day 162, page 16-17)

240. Regrettably, there is little documentary trace of the work undertaken by SWAG in Rathgael, and the reports available in respect of SSI's inspection work at the Centre

are limited to just two reports. It is probable, that as was the case with Lisnevin, more inspections of Rathgael took place than are reflected in the available inspection reports.

241. The first SSI inspection of Rathgael concluded on the 2 October 1987. The report of the Inspectors can be found at RGL - 2326 - 23752 although the Inquiry will note that there is a further composite report reflecting the findings of SSI inspectors following inspections in 1987-88 at all four training schools. This report can be found at SPT 16222, but for the purposes of these submissions it is proposed to refer only to the Rathgael specific report located at RGL 2326.

242. The inspection of Rathgael in September/October 1987 was a characteristically thorough inspection, involving a team of four Inspectors working in the Centre for a period of more than 2 weeks, including visits at the weekends. The young people at the Centre were active participants in the inspection: they were observed at close quarters by the inspectors and their opinions were actively canvassed and considered. They fully co-operated with the inspection (RGL - 23628).

243. In the conclusions to their report, the Inspectors reflected upon the substantial structural challenges which had been met by the staff of Rathgael in the previous four years: girls had been successfully integrated into the school, and a split campus provision had been adopted for Care and Youth Treatment.

244. The SSI concluded that while the changes were not without difficulties, it was to the credit of senior management that they "sought to bring a new dynamic, encourage new thinking and attempted to change many of the institutional practices that were a feature of life in the old training school system" (RGL - 23732, at 19.4).

245. While the report made a number of recommendations (74) in order to reinforce the change of emphasis and enhance the quality of care delivered at the Centre, the inspectors were satisfied with the standards of care being delivered at the Centre, notwithstanding the challenging environment in which staff found themselves. Inspectors highlighted the following facets of the work undertaken at Rathgael:

[19.5] The Inspectors were impressed with many features in the Centre. There is a substantial programme of diversion located in Sort-Term Care, with some 85% of admissions being placed in alternative settings. Of the three Adolescent Care Units, one has been totally integrated with considerable success, after much effort in

bringing together boys and girls in a setting that, ten years ago would have been totally unheard of in the training school system. Youth Treatment are absorbing many elements of good practice and it is hoped that under the present leadership will continue to improve. The Eastside Project, under the supervision of the community care team has attracted national recognition as an innovative and effective method of supporting young people upon their return to the community." (RGL - 23732, 23733)

246. Only 4 of the 74 recommendations put forward by SSI for consideration were not accepted by Board of Management, and some 55% of the recommendations were put into effect immediately or within a short period of time (23755).

Visits by Board of Management

247. In their report following the 1987 inspection, the SSI highlighted that the Board of Management complied with the requirements of the Rule 10 duty, for one of their number to visit the Centre at least once per month. The Inspectors noted that a report of visits by Board members was being maintained (RGL - 23721, para 13.2). The inspectors expressed the belief that a "formal system of monitoring" might be a preferable approach, and indicated that they would be prepared to formulate guidelines to assist Management Board members carry out their duties under Rule 10. Such guidelines were subsequently developed to assist Board members to focus on a number of key safeguarding issues during their visits.

248. Board visits were an essential part of the apparatus, enshrined within the Rules, for the purposes of protecting children, ensuring the achievement of high standards and effecting a challenge function. Documents available to the Inquiry demonstrate that SSI Inspectors were keenly aware of the importance of Board visits, and the role which they played in ensuring good governance within a training school.

249. It can be seen, for example, that Mr. Donnell spoke to the Rathgael Management Board on the 1 March 1989 to remind members of their responsibilities. He highlighted that on their monthly visits members of the Board should focus on the "*needs of the young people in the Centre, record of admissions and discharges, events of importance, menus, record of sanctions and the record of fire drill*." It was "*stressed*" that members were obliged "*to have regard to the quality of social and emotional care*," as well as "*the quality of physical care*." Members were

encouraged to probe "*the relationship between the young people and the care staff, methods of control and discipline and sanctions imposed*" (RGL - 23597).

250. It is submitted that this kind of activity on the part of SSI Inspectors, working with Board members to remind them of their duties, provides a powerful example of the regulatory system in action. The Training School Rules contained a number of key working principles, but the Rules were of little value unless steps were taken to ensure their observance.

251. The SSI Inspectors were at the coalface of bringing the Rules to life. Not only were they responsible for conducting thorough inspections, but they used their influence to ensure that other key participants, such as Board members, realised the importance of their own roles and exercised the powers available to them.

252. The Inquiry has received a number of reports written by members of Board of Management following their Rule 10 visits to the Centre. These documents illustrate that Board members took their responsibilities extremely seriously. They followed and applied the guidance given by the SSI. They were a frequent, questioning presence in all areas of the school to ensure that the school was delivering care to the children in a manner consistent with the Rules and good practice.

253. Some Board members, having observed the work of staff at close quarters, used their report to praise the commitment of carers:

"I take my hat off to the Rathgael staff from the least among them to the Director, especially as they must get many disappointments and knocks, yet they persevere many times above and beyond the call of duty." (RGL-23769).

254. In another report completed later that same year (1991), a Board member remarked upon the fact that when she was talking and eating lunch with four young people and two staff members in House 2, the young people talked freely about their school work and leisure activities, and seemed "*very relaxed in adult company*" (RGL- 23775). She noted that the staff appeared to have a good relationship with the young people.

255. In May 1992, two Board members visited the Youth Treatment Unit and found "*an easy informal rapport between boys and staff in residence, evident by the banter as they washed up the supper dishes*" (RGL - 23834)."

256. A Board member who visited the Shamrock Unit in February 1993 remarked that the children he spoke to were "*open and forthcoming*" and he stated that he "*was impressed at the friendly atmosphere between children and staff*" (RGL -23845).

257. Another Board member visited a Unit on the Care Side in April 1993. He noted a "*general bond*" between children and the staff. When he took some time to speak to the children in the absence of staff, to give them an opportunity to freely criticise or make complaints, the most significant issue noted was that bed time was too early (RGL -23848).

258. A visit to Shamrock by a Board member in October 1993 produced the following observation:

"The overriding impression was one of care and vigilance in a very stressful situation. It was noticeable that a member of staff remained in each of the main rooms with the child/children in that room" (RGL - 238854).

259. The open nature of the visiting arrangements for members of the Board of Management was amply illustrated during a visit which took place to Houses 1 and 3 in November 1993. The member commented:

'RG 14 *took the opportunity of introducing one of the young people in each house to me. He asked them to show me around the unit and introduce me to the others. This worked very well, it proved a natural way of meeting and talking to the young people." (RGL - 23857).*

A Dedicated and Professional Staff

260. The reports of Board of Management visits provides the Inquiry with clear evidence that the staff of Rathgael were regarded as dedicated and professional. The observations of Board members suggested that staff had largely succeeded in developing close bonds with the children under their care, and that an easy respect had been established.

261. It is accepted, of course, that not every child - staff relationship was as straightforward as the reports of Management visits might suggest. The challenges provided by some children often brought tensions to the Units which had to be worked through and managed by the staff.

262. The reports of the SSI inspections suggest that while Rathgael was not without some staffing issues, a key asset of the school was the staff that it had in post. In the SSI report following the 1987 inspection a number of features were acknowledged. Firstly, SSI reflected upon the very low staff turnover, with 54% of staff having more than 6 years service. The Inspectors remarked that this feature would have a tendency to "*provide stability for the Centre and security for the young people living there*" (RGL 23638, para 3.14).

263. Secondly, the Inspectors noted that the staff was largely professionalised - "*almost 60% of the staff hold relevant qualifications and this must be commended*" (RGL - 23638, para 3.15). It was also noted that where vacancies arose, the Centre had a policy of recruiting only trained staff, whereas those who remained in the workforce without qualifications were "*encouraged*" down the route of obtaining them, with the option that they could be "*seconded to full time training courses*" (RGL - 23642, para 3.24).

264. Thirdly, in service training, utilising the services available from external providers such as the Health Boards and the Universities, or purchased from training organisations, was also a notable feature. The Inspectors found that "*every opportunity*" was taken to place residential care staff on short training courses. SSI noted that in the 12 months leading up to their 1987 inspection, the following training courses were convened within the Rathgael Centre and attended by relevant groups of staff: Sexuality in a Child Care Setting; Developing a Child Care Role in the Rathgael Centre; Child Sexual Abuse; Staff Supervision (RGL - 23643, para 3.25).

265. Fourthly, the Inspectors were also impressed with the gender mix amongst the staff. While there was a preponderance of female staff on the Care side of the Centre by contrast with the majority male staff on the Youth Treatment side, there was an almost even number of women and men working on the professional side of the residential social work task, and there were male and female staff working in each house Unit within Youth Treatment (RGL - 23638, paras 3.16, 3.17). Men and women were represented in the senior management group.

266. It is acknowledged that SSI identified a number of staffing issues including the absence of formal staff supervision (RGL - 23642, para 3.23), and some resistance on the part of some staff to accept new policies and innovative practice (RGL

23644, para 3.32). Against that, Inspectors were clearly impressed by the volume and content of staff meetings at both management and Unit level (RGL - 236643, paras 3.26 and 3.27) and they commented that overall they "*were impressed by the staff's professionalism and commitment to their work*" (RGL - 23644, para 3.32).

267. Some staffing groups were singled out for particularly high praise. For example, within house 2 (long term adolescent care), it was said that "*everything possible was being done to create a homely atmosphere for the children*" (RGL 23669, para 6.16). This in turn contributed to what was described as "*a pleasant relaxed atmosphere when staff and children were togethe*r" (RGL 23669, para 6.17). It was remarked upon that the fact that few incident reports were ever filed was characteristic "*of the skilled and tolerant approach by staff to difficult situations*" (RGL 23669, para 6.18). The staff were prepared to use the services available to them, including psychological and psychiatric advice, but they were also "*prepared to undertake therapeutic interventions themselves"* (again at 6.18).

268. That the staff were providing an excellent service was reflected in the views of the young people who engaged with the SSI Inspectors. With regard to the short term care / assessment unit (Houses 9 & 9A), the Inspectors reported:

"[5.36] The Inspectors met most of the children in the unit at some time during their time in the Centre….Their views were wide-ranging but a consistent theme emerging was their high regard of the Centre. Generally, they were content with the treatment they received and their only main complaint was about the food." (RGL - 23655)

269. Within the Youth Treatment wing of the Centre, the inspectors were also impressed with the composition of the staff:

"[7.8] The staff present as a competent, committed group, who have had to adapt to new practices and procedures during the course of the past two years. Although there was some evidence of traditional, institutional thinking, in the main the staff appeared to work well together and would see the needs of young people as being of paramount importance." (RGL - 23683)

270. In turn, the young people with whom the inspectors communicated, clearly had a high regard for the staff and for the work being undertaken in the Centre:

"In general a good rapport exists between staff and boys in the units. There are many instances of good practice and the boys appear to be content and well cared for. The question of the quality and quantity of the food came up in all of the units and was the subject of ongoing debate throughout the inspection" (RGL 23692, para 7.32).

271. The quality and professionalism of the staff attracted further positive comment when SSI returned to Rathgael to conduct a thematic inspection of Shamrock House in 1992. The report of that inspection can be found at RGL - 23798 - 23833. [It should be noted that while the report refers to an inspection in relation to Shamrock House, the close supervision unit on the care side of the Centre, at that time the children were actually housed in Fox Lodge because the accommodation in Shamrock House was the subject of substantial modifications (RGL - 23806)].

272. The staff in Shamrock clearly impressed the inspectors:

"Only one staff member was without a relevant qualification. There is a good blend of youth and experience and the staff group impressed as a committed, well integrated team who work well together and adopt a professional approach to their task" (at 6.30).

273. The thematic inspection was triggered because of the concerns which emerged nationally in relation to the operation of children's homes in Staffordshire, following the publication of the "Pindown Report." The report was commissioned by the NIO which was concerned, in particular, to ensure that,

"no child, being cared for in a secure unit within the training school system, was being subjected to any practice that was punitive, degrading, placing unnecessary pressure on them to conform to rules and regulations, locking them up in isolation rooms for lengthy periods or depriving them from regular contact with care staff." (RGL -23801)

274. The inspection of Shamrock was conducted by three inspectors over a period of two days in January 1992. The fieldwork conducted by the inspectors included visiting the Unit during the day as well as at night time, and included informal discussions with the children, as well as meetings with staff at all levels.

275. The Inspectors described "*a friendly atmosphere in the unit*" and a positive, respectful relationship between staff and children (RGL - 23820, para 9.2):

"Residential social workers and children appear to share an open and constructive relationship. Staff have to exercise close supervision and keep a careful watch for situations which could give rise to aggressive behaviour. They appear to have found a balance between care and control which is not always easy to achieve. Also they have managed to create a caring attitude towards the young people in the unit."

276. At the time of the 1997 inspection, the Inspectors scrutinised the methodologies which staff applied when working with young people at Rathgael. They commented approvingly in relation to the approach adopted in the Short Term Care Unit (Assessment), describing it as involving a "*comprehensive*" assessment, which made use of "*appropriate interdisciplinary resources*," including medical, educational, psychological, psychiatric and social work inputs. The inspectors recognised that this helped to facilitate "*the most effective intervention*" (RGL - 23661, para 5.70).

277. Staff working in the adolescent care units had adopted an individualised approach to the young people in their care - engaging them with individual counselling, group work and behaviour modification programmes through contracts and a marks system. Efforts were made following the initial assessment, to allocate a young person to a key worker "*taking into consideration the personality and needs of the [child]*" (RGL - 23669, para 6.14).

278. The full details of the approach adopted when working with children are beyond the remit of this submission, but are summarised here to emphasise the fact that upon inspection of the work, SSI considered that staff were addressing the needs of the children appropriately. The report of the SSI inspection provides further details of the methods deployed.

279. Mr. Conway described the work of the school as "*child centred*" long before "*child centred practice*" entered the social work mainstream (RGL5094, para 16). The message conveyed in some of the applicants' evidence had a tendency to suggest that staff did not care about them or their problems. It is submitted that such complaints should be disregarded.

280. Taking all of this evidence into account, the Department submits that it is clear across two SSI inspections which were separated by a time span of five years, and during many visits to the school by members of the Board of Management, the staff of Rathgael were not found wanting in terms of their professionalism and commitment to the children under their care. They displayed no little skill and had succeeded in building up close respectful relationships with the children.

281. Consideration of the evidence gathered by SSI in particular would tend to suggest that if staff were behaving abusively towards children in Rathgael during this period, they were acting in a manner which departed from the high standards of the majority of their colleagues.

Health Care

282. Not only were the children who were resident at Rathgael well served by a team of committed and professional carers, but they had access to a range of facilities and services which were found to be of a high standard.

283. The health of the children was regarded as an important concern. At the time of the 1987 SSI inspection the following health care arrangements were in place: two local general practitioners had been appointed by the Board of Management to satisfy the terms of Rule 50 of the Training School Rules; the GPs attended two mornings per week to provide a surgery; a dentist attended two mornings per week to provide a surgery; qualified nursing staff provided for the day to day oversight of the children's health by operating daily clinics with appointments, and they were on duty from 8.00am - 6.00pm on weekdays, with a reduced service at weekends. (See SSI report on health care arrangements commencing at RGL - 23716).

284. In addition, three psychologists from the Adolescent Psychological Research Unit ('APRU') provided a service to Rathgael on 5.5 days each week. The Inquiry has received the opinion of Dr. Lockhart that the arrangements under APRU were less effective than those which operated when a dedicated psychological service was located in each facility (transcript day 161, page 51). Dr. Lockhart is an experienced practitioner but it will be recalled that his work in the training schools ceased in 1983. Perhaps, he was not in post long enough to experience the benefits which came with the APRU approach and which others came to appreciate. Certainly, his

views were not those reflected in, for example, the report of the SSI Inspectors who examined psychological provision in Rathgael in 1987. They reported:

"[15.1] The psychologists provide a diverse range of forensic, educational and clinical skills in the assessment of the child and his/her family as to (1) assessment of optimal placement; and (2) treatment or intervention. The psychologists also perform roles of research, training, management consultancy and staff support/development. As well as involvement with children and young persons, the psychologists contribute professional advice and support to each of the Care and Youth Treatment Units and have a direct role in evaluating potential admissions to the secure units."

285. The Inspectors went on to find (referring to the psychologists of APRU) that, "*Their professional independence makes a valuable contribution to the various models of inter-disciplinary assessment in the Centre as well as providing an independent sounding board for staff and management…"*

286. The advantage of bringing psychologists together to form an expert Unit, rather than continuing with the model of stand alone psychological services in each institution, lay in the opportunity which was created to share information, solutions and best practice between institutions. It provided a "*joined up*" approach to psychological services and enabled the Unit to provide services which the stand alone approach could not facilitate.

287. In 1988, for example, APRU conducted a survey on incidence and nature of self harm in three training schools, Lisnevin, Rathgael and Middletown (LSN - 14086). The report recommended "*as a matter of professional urgency that each centre adopt a continuous monitor of self injury [by designing] a pro-forma self injury record sheet to be completed by staff attending each act of self injury*." APRU ensured that St. Patrick's were made aware of the findings of the survey report and its recommendations, although for reasons which are not explained, incidents of self harm at St. Patrick's were not considered as part of the survey (LSN - 14091).

288. APRU engaged in follow up work to ensure that teachers and night staff were aware of the need to record self injury and how this was to be done. All of the residential establishments agreed to participate in the arrangements for recording self injury (LSN - 14098). Schools were then required to make periodic self injury returns to

the Criminal Justices Division of the NIO, who then supplied them to APRU for consideration (LSN - 14101).

289. The Inquiry may wish to consider a sample of self injury report forms (for each of the schools) which appear on the Inquiry bundle at LSN 14103. These show that in each institution a self injury monitoring group was formed. Each group had responsibility to compile a record of self injurious incidents, and to evaluate the results.

290. The system of monitoring brought about useful analysis. For example, in a series of reports on the data gathered on the monitoring forms, staff at Rathgael were able to establish some common features. In November 1994, one report noted, "*an overall trend continues to show that sexually abused youngsters are at high risk of self injury. It is also evident that a high number of incidents occur between 8.00pm and 11.00pm*" (LSN - 14194). Other reports took the opportunity to highlight clusters of self injurious behaviour at particular residential locations (LSN - 14196).

291. A number of complainants have indicated to the Inquiry that they self harmed when resident in Rathgael: see the statements of HIA 172, 182, 231, 386, 389 and 488. The records available to the Inquiry show that staff at the Centre took the issue of self harm extremely seriously. Efforts were made to intervene to prevent self harm, and steps were taken to address the causes of it.

292. It is appropriate to consider an example of the kind of steps which were taken. For example, the documents before the Inquiry show that HIA 198 had an extremely tousled history. She was referred to the Shamrock House Secure Unit for 6 months from the [redacted] because of the risk self harm and over dosing (RGL - 40794, 40765), and to try to work through the causes of her behaviour. Staff spoke to her about her problems and endeavoured to counsel her, but ultimately it was decided that Shamrock was the best placement for her, in the interests of keeping her safe (RGL - 40794).

293. A plan was developed to work with HIA 198 in Shamrock - "*it is hoped that during [her] stay in Shamrock House that work will centre around several important issues ie. her history of abuse and subsequent recovery work; her feelings of self worth; her attitude to protecting herself from over dosing and constantly absconding…."* (RGL - 40766)

294. Review meetings were held to discuss her progress and at one it was noted that her "*attitude to self harm hasn't changed as she is unable/unwilling to fully open up and explore her feelings*" (RGL - 40766).

295. It is clear that RGL 198 made substantial progress during her time in the secure facility. Towards the end of her time there it was remarked that HIA 198 "continued to do very well in the unit and displayed a very mature, sensitive attitude towards the other children" (RGL - 40768).

296. Mr. Whyte has discussed in his statement how the self injury monitoring group which he helped to establish at Rathgael, and which received input from psychologists and nursing staff, was proactive if they became aware of any particular child at risk:

"Where we were concerned about particular individuals or a group we would make the staff aware and place the child or children under closer supervision or assign extra staff to a particular unit." (RGL 1726, para 67).

297. It was also noted by Inspectors at the time of their 1987 inspection, that the APRU psychologists were instrumental in providing inter-agency contact, and in terms of accessing the specialist resources which exist within these agencies (RGL - 23726, para 15.1), and it was recognised that they were key to the professionalisation within the Centre inherent in the use of individual client profiling.

298. The Inspectors also reported upon the availability to the Rathgael staff of a psychiatrist who attended the Centre once per fortnight, and who operated an "*on call*" service. His work was described as "*much valued by the staff*" because "*his support and guidance [was] a crucial element in dealing with disordered adolescents*" (RGL - 23726, para 15.4).

299. The Inquiry has heard complaints from some applicants that they were dissatisfied with the health care provided at Rathgael: see in particular the statements of HIA 198, 386, 438 and 503.

300. It is submitted that the records of each of these applicants demonstrate that they were provided with access to medical facilities as required, and for some of them they attended the Medical Unit on numerous occasions. It is submitted that they were all properly treated and that the centre's Medical Unit worked extremely well.

301. It will be convenient for the Inquiry to consider the supplementary response statements provided by DOJ in respect of the applicants who have complained about their medical treatment. These statements reference their attendance at the Centre's Medical Unit: for HIA 198 see RGL 4210 at paragraph 5; for HIA 386 see RGL 4229 at paragraph 5; for HIA 438 see RGL 4233 at paragraph; for HIA 503 see RGL 4240 at paragraph 3.

302. It is appropriate to consider one such complaint. At paragraph 4 of her statement at RGL - 119, HIA 438 has complained about the level of attention she was given when she was suffering abdominal pain. She is concerned that her condition was not regarded with sufficient seriousness or urgency by the staff on duty.

303. However, the records demonstrate (RGL - 1028) that she was seen by the locum doctor who provided medical advice to the staff at the Centre, which was acted upon. Further advice was sought when the symptoms continued, and she was ultimately admitted to hospital for treatment. It is submitted that the records show that a watchful eye was maintained on the condition of HIA 438, and that appropriate medical advice was taken and complied with.

304. The Department takes the view that the medical, dental and psychological support and facilities which were available at Rathgael were of an extremely high standard, and enhanced the quality of life of the children there.

Education

305. Regrettably, many complainants to the Inquiry have criticised the educational provision at Rathgael: see the statements of HIA 172, HIA 198, HIA 200, HIA 386, HIA 389, HIA 429, HIA 438 and HIA 503.

306. In their report following their 1987 inspection SSI provided a more positive analysis of educational provision. They referred to a school programme which was designed to meet the individual needs of each boy or girl. In the approach to delivery it was recognised that there was a need for assessment, followed by basic, remedial or vocational education, depending upon interest or ability (RGL - 23709, para 9.2).

307. The inspectors went on to describe a "*varied support curriculum*" (RGL 23709, para 9.3), and recognised that the school block, which included a gymnasium, games room and swimming pool was "*well equipped*" (RGL 23709, para 9.4).

308. However, the Department recognises that the educational arrangements at Rathgael were not perfect. A report from the Education and Training Inspectorate following an inspection of Rathgael in 1991 pinpointed problems around the management and organisation of the school and the curriculum (RGL 23778 - 23797).

309. Nevertheless, the inspectors recorded that "*teaching at Rathgael is characterised by good relationships and an ability to handle difficult children sympathetically*" (RGL 23789). They went on to record that teaching was satisfactory and that the children "*were generally co-operative and displayed few behavioural excesses*."

310. It is important, therefore, not to over exaggerate the extent of the problem. In his evidence to the Inquiry Mr. Conway expressed a degree of puzzlement at the criticism which some children directed towards the educational arrangements (RGL 5095, paras 19-21).

311. He noted that HIA 172 complained in his statement that he left Rathgael unable to read or write (RGL 010, para 42). Mr. Conway was sceptical about this. HIA 172 only arrived at Rathgael at the age of [redacted] by which stage he should have had at least basic English and Maths. During his time in Rathgael HIA 172 was transferred to [redacted]. Mr. Conway cannot comprehend how HIA 172 could have returned from there unable to read or write.

312. HIA198 complained that her experience of school when in Shamrock was a constant play time: she coloured in pictures, completed crosswords and played games (RGL - 033, para 32). Mr. Conway has stated that HIA 198's recollection of Shamrock does not align with his experience of a facility which enjoyed high staff to pupil ratios, and in which individual teaching plans were developed and followed.

313. Mr. Conway also recalled that those with high ability would have attended local schools in the Bangor area "*to allow them to continue mainstream education and obtain qualifications*" (RGL 5095, para 20). It was his impression "*that Rathgael introduced many to a positive education experience for the first time, introducing them to a school routine and afforded them an opportunity to progress with their own personal development"* (RGL 5095, para 21).

314. Mr. Conway noted that some who attended Rathgael proceeded to obtain qualifications such as City and Guilds, eg. HIA 400. In his evidence to the Inquiry,

HIA 200 spoke positively of his educational experience in Rathgael, recalling that he moved from a C or D class through to an A class (transcript day 152, page 34).

Amenities

315. The report of the SSI inspection of the Rathgael Centre resonates with descriptions of the excellent facilities and services which were available to young persons there. The school itself was equipped with classrooms, domestic science room, library and an art/craft centre (RGL - 23646, para 4.5).

316. There was also a large swimming pool, serviced with showers and changing rooms, as well as a gymnasium which was furnished with a stage in order to host concerts and other forms of entertainment (RGL 23646, para 4.6).

Recreation

317. Staff arranged an array of activities for the children at Rathgael. Mr. Whyte has provided the Inquiry with a snapshot of what was available:

"[30] Evening activities included classes in photography, art and typing. Alternatively, the young people could play pool, do hairdressing or watch television. They also had opportunities to participate in specific projects. For example, in 1976, the young people, under supervision, converted an old Ulsterbus into a play bus, which was used by the Voluntary Service Bureau in the community for children to play in. This involved the young people using the metalwork, painting and motor engineering skills they had learnt in class. The play bus formed part of the Community Service Programme referred to above and provided an opportunity for a young person to act as an Assistant Playbus leader in support of the two ladies who were in charge. For this project it was normal practice for the volunteer to have come from one of the estates it operated in and was the only project in which a volunteer travelled unsupervised to and from the project.

[31] The school also ran a number of sporting competitions, mostly for football, pool and gymnastics. In fact, there was a Rathgael Gymnastics Club, which consisted of boys mainly and would put on shows. The Bangor Rotary Club would arrange for residents from nursing homes to come into the school so that young people could put on a show for them." (RGL 1720 - 1721)

318. There was also an opportunity for children to use the Runkerry facility on the North Antrim coast. The SSI Inspectors remarked, "*the specialist resource available at the Runkerry Centre, [had] much to offer and recommend[ed] that every effort should be made to maximise its use*" (RGL 23711, para 9.9).

319. It is submitted that the evidence before the Inquiry indicates that every effort was made to provide the children with well resourced facilities and that the staff at Rathgael, many of whom gave up of their free time, used those facilities in a manner which provided stimulating and constructive activities for the children.

Food

320. A number of applicants have complained to the Inquiry about the quality of food which was on offer to them during their time at Rathgael: HIA 83, HIA 172, HIA 198, HIA 386 and 503. Some of the applicants have suggested that the food was inedible at times.

321. At chapter 10 of their report following the 1987 inspection (starting at RGL - 23712), the SSI described a range of problems with regard to food provision, including the quantity of food which was allocated to boys and an issue relating to keeping food hot.

322. In his statement to the Inquiry, Mr. Whyte acknowledged that food at Rathgael was substandard at various times in the 1970s and 1980s but he indicated that "steps were taken to improve the standard of food provided and the chef was replaced" (RGL 1721, para 34).

323. HIA 429 recalled that the food was of a good standard. He has told the Inquiry that he loved the food and regularly asked for second helpings (RGL 106, para 17).

324. The Department recognises that for a time the food available to the children was inadequate and of poor quality, and regrets that this was the case.

After-Care

325. Some of the applicants who gave evidence to the Inquiry bemoaned what they described as a lack of effort to help them to settle back into the community. For example, HIA 503 stated in her witness statement that after being discharged from Rathgael she telephoned back to say that she had nowhere to stay and that she

could not get a job. She claims that she was told that she was not their problem any more (RGL 126, para 50).

326. Others would appear to have enjoyed a much more positive experience. HIA 248 gave evidence that a job was arranged for him through Rathgael (RGL - 059, para 8). HIA 200 told the Inquiry that after his discharge his family was helped on what appeared to be a voluntary basis by RG 19, whereas Mr. Conway followed up on his progress in his official capacity and even attended court with him when he got into trouble with the law (transcript, day 152, page 44).

327. Moreover, the Inquiry is asked to reflect upon the excellent work carried out by the Rathgael After Care Team under the leadership of Mr. Conway, as described in his statement at RGL 5110 at paragraphs 71-78. As appears from his description of the work of that team, Rathgael took seriously its responsibility to comply with the "*placing out and aftercare*" provisions contained in Rules 44-49 of the Training School Rules.

328. Mr. Conway and others took an innovative approach to their responsibilities under the Rules. For example, they developed the ground breaking Eastside Project as a practical and innovative way to support former residents in their return to living in the community. The work of the Eastside Project was described by the SSI as "*one of the most promising developments in the juvenile justice system*" at that time (RGL 23707, para 8.42).

Amalgamation with Whiteabbey

329. The closure of the Whiteabbey Training School and the movement of girls into Rathgael has engaged the attention of the Inquiry. As the report of the 1987 SSI inspection remarked, the amalgamation of Rathgael with Whiteabbey was implemented for very good reasons:

"1.3 The amalgamation was based on a more effective use of existing resources and in pursuit of the concept of normalisation by enabling boys and girls to share the same facilities and to take part in co-education" (RGL - 23629)

330. There can be no doubt that the transfer of girls into what was formerly an all male domain (at least in terms of the pupils) caused some initial teething problems, despite the high degree of pre-planning which Mr. Conway described.

331. This may not have been helped by the fact that a fire at Whiteabbey forced the amalgamation to happen a little earlier than had been anticipated. With the benefit of hindsight it could be argued that some form of training should have been provided to staff who had no experience of working with girls (or boys as the case may be) and some greater thought might have been given to housing all of the girls in one unit.

332. However, as Mr. Conway has explained both in his statement and in his oral evidence, the initial teething problems were soon overcome. He has explained the position in the following way:

"[31] Unfortunately a fire in March 1985 accelerated this process thus preventing us following our agreed transition strategy. As a result girls and staff were moved on mass from Whiteabbey to Rathgael shortly after. This resulted in a nervousness that translated into resentment amongst some Rathgael and Whiteabbey staff. It also meant that we were not as well prepared for taking girls as we had hoped to be. However, Whiteabbey staff transferred to Rathgael at the same time as the girls so there was no deficit of knowledge, skills or experience. Over time, however, any issues that did exist were resolved as staff and girls settled and the male young people adjusted to the changes girls brought with them." (RGL - 5099)

333. Ultimately, the creation of a mixed gender training school was viewed as a positive development. It is respectfully suggested that the the degree of difficulty which the move prompted has been a little exaggerated. There were some initial problems but with a degree of pragmatism the staff coped and the training school survived.

Absconding

334. The Inquiry is aware that absconding was a problem at Rathgael. According to the APRU report (see further below) there were 256 recorded abscondings in the period between 1 January and 31 August 1991.

335. However, it is also quite clear that absconding was a problem which the management of Rathgael worked stridently to resolve. Mr. Whyte explained during his oral evidence, that he ensured that every absconding was reported to police and he travelled to other centres and sought advice widely in an effort to come up with solutions to the problem (Day 164, transcript unavailable).

336. The Inquiry is by now familiar with the study carried out by APRU which focussed on the absconding behaviours of young people at the Rathgael Centre (RGL 5125). In his oral evidence Mr. Whyte explained that while the report may have been commissioned by NIO the determination to have such a study carried out came from him and his staff at Lisnevin.

337. The outcome of the APRU study was the introduction of robust arrangements for monitoring absconding, including the formation of a Monitoring Group. Mr. Conway reported in his statement to the Inquiry that an evaluation of the work undertaken in Rathgael concluded in 1992 that the number of absconders had reduced by 37% and the number of abscondings had reduced by some 60%. These successes were attributed to what is described as "*the strategic management approach implemented by Senior Management*" (RGL 5100, para 35).

338. Any notion of a strategic management approach would have been unheard of during the 1970s. A number of applicants to the Inquiry who were resident during that period have complained that in order to try to prevent them from absconding staff would dress them in short trousers (see the statements of HIA 83, HIA 200 and HIA 248).

339. While others who have given evidence have suggested that they thought this tactic unlikely (eg. RG 20 when he gave evidence on Day 162) and that in any event the school uniform of the day involved the wearing of shorts, there is a consistency about the allegation which affords it the ring of truth.

340. The Department suggests that what appears to have been at play here was a somewhat unsophisticated attempt to prevent absconding. The dangers inherent in absconding were such that staff probably considered that this was a proportionate response to the problem. It is unlikely that any boy suffered any adverse consequences as a result of this strategy, although it may have caused some embarrassment at the time.

Sexual Abuse

341. A number of female applicants (HIA 198, HIA 231, HIA 236, HIA 389, HIA 438) and one male applicant (HIA 83) to the Inquiry have alleged that they were the subject of sexual abuse whilst resident at Rathgael.

342. For the avoidance of doubt the Department fully accepts that sexual relationships between a care worker and a pupil of a school could just as appropriately be categorised as sexual abuse, but the two complaints which fall into this category are separately analysed below under the heading "*inappropriate relationships*".

343. HIA 231 and HIA 236 have each made allegations of sexual abuse against RG 48. He has responded to those allegations in two witness statements and has emphatically denied the allegations (RGL - 4816, 4863).

344. HIA 389 has alleged that RG 20 sexually abused her. HIA 198 has alleged that RG 20 touched her inappropriately on the chest area. He has responded to those allegations (and the allegations made by others who are not applicants to this Inquiry) in a witness statement at RGL - 4793. He denies the allegations and he maintained that stance when he gave evidence to the Inquiry on Day 162.

345. HIA 438 has alleged that she was sexually abused by RG 82 who has responded with a statement denying her allegations (RGL 4788). He maintained that stance when he gave evidence to the Inquiry on Day 159

346. HIA 83 gave evidence that he was abused by RG 31. RG31 is deceased and the allegations of HIA 83 were never put to him while he was alive so far as can be determined. It is known that he was compelled to resign from his post at Rathgael approximately 10 years after he might have had contact with HIA 83, having permitted an absconding resident to overnight at his home.

347. The Department does not propose to say anything in relation to the particular allegations that have been raised, or the responses that have been made to them. The allegations have never been tested in court and no doubt this Inquiry will handle them with a high degree of care.

348. If the allegations had been made contemporaneously to Rathgael, the Department feels sure that effective steps would have been taken to ensure that they were investigated. Various allegations have been raised over the years in relation to staff behaviour with pupils, and they have always been handled with care by senior management of Rathgael. The default position has been to report matters to police so that they can undertake the necessary investigations. That has been the approach adopted in most cases.

349. In this regard the Inquiry is referred to the statements of Mr. Whyte (RGL 1714), Mr. Wardrop (RGL 1801), as well as the joint DOJ / DHSSPS supplementary statement (RGL 1608). These statements, in part, explain the responses that were taken by Rathgael (and other training schools) when allegations of abuse have been raised. In addition Mr. Whyte prepared and submitted to the Inquiry a second statement (RGL - 5393) in which he explained that he was the person who placed RG 48 on precautionary suspension when he was the subject of allegations in the mid [redacted]s.

350. The Department wishes to clearly state that any care worker who may have abused his position of trust to interfere in a sexual manner with a vulnerable child is entitled to the severest condemnation. Such conduct betrays the child centred ethos of a training school and betrays the high standards which the majority of care workers strive to comply with. Any child who suffered in this way during their time in a training school is entitled to a profound and since apology.

Inappropriate Relationships

351. Two applicants have alleged that male members of staff at Rathgael engaged in relationships with them whilst they were resident there.

352. [redacted]

353. [redacted]

354. HIA 236 did not give oral evidence to the Inquiry and her allegations have never been tested in court.

355. The Department can only make the general observation that staff members at Rathgael would have been keenly aware that relationships with pupils of the school

were unacceptable and those transgressing that rule would be liable to severe disciplinary action. [redacted]

356. [redacted] It suffices to say that if a member of Rathgael staff failed to pass on a concern or a suspicion that a colleague was engaged in an inappropriate relationship with a pupil, that would be an extremely grave manner.

357. It is accepted that training schools such as Rathgael ought to have had systems of supervision in place so that inappropriate relationships could be prevented or detected. However, it is plain that even the best systems may be incapable of prevention or detection. The success of any system largely depends upon members of staff reporting their suspicions or the suspicions of others.

358. HIA 268 gave evidence that whilst at Rathgael she engaged in a relationship with a teacher, RG27 (see her statement at RGL - 070, para 19). She gave evidence on Day 154, and from what she said to the Inquiry it is clear that she believed that her relationship with RG27 was an open secret amongst the staff since she was rarely out of his company and would often be seen going on errands alone with him (transcript, day 154, page 35).

359. RG27 is deceased, and deprived of his version of events there can be no certainty in relation to the claims made by HIA 268. However, it is known that RG27 was identified on licensed premises with HIA 268 and was suspended and made the subject of disciplinary action (RGL - 28515). He was given a "*final warning - in the strongest possible terms*" (RGL -22971).

360. It appears from the questions set out in the documents at RGL 28515 and 28516 that the person charged with investigating RG27's conduct was interested to discover whether the relationship with HIA 268 had deeper roots than an isolated visit to the pub. The thoroughness of his investigation is unclear and there is no documentary evidence to indicate how RG27 responded to the questions he was asked.

361. The Department takes the view that it is commendable that Rathgael took steps to investigate this matter, and to bring disciplinary proceedings. It would appear, however, that there was insufficient evidence at that time to suggest that RG27 was engaged in any form of abusive or inappropriate relationship with the girl, such as would have led to stronger disciplinary action or a report to the police.

362. It also has to be said with the benefit of hindsight, that at that time (July 1987) there was a flaw in the systems in place at Rathgael if they permitted a male member of staff to spend so much time alone with a female pupil, as was suggested by HIA 268 in her evidence.

Physical Abuse and Bullying by Staff

363. A number of applicants have complained that some staff at Rathgael adopted an excessively physical approach in their dealings with them, and would on occasions punch, slap or otherwise assault them. The Inquiry is referred to the complaints of HIA 83, HIA 172, HIA 182, HIA 198, HIA 200, HIA 248, HIA 267, HIA 268, HIA 386, HIA 389, HIA 429 and HIA 503.

364. Having heard the evidence and observed the demeanour of some of the applicants to this Inquiry, the Department is concerned that some staff may have used a slap or a punch to enforce discipline when such behaviour was clearly unacceptable.

365. There may have been a time when it was considered culturally acceptable to provide a child with a cuff around the ear. The Department wishes to state unequivocally that such conduct had no place in the Rathgael of the era with which the Inquiry is concerned, and it offers its apologies to any child who suffered any act of violence during their time there.

366. Elsewhere in these submissions we have described the violence and aggression which was often delivered upon staff in the training school environment. It is right to acknowledge that all staff were entitled to take reasonable steps to defend themselves or others from harm.

367. It is also right to offer words of sympathy to any member of staff in any training school who was injured in the line of their duty, working with difficult and aggressive children. Very many members of staff have exercised a high degree of courage,

fortitude and self control when working with such children and some have suffered for it. They deserve are gratitude and respect.

368. There are related complaints before the Inquiry that staff used restraint measures when it was not necessary to do so, or that an inappropriate restraint technique was applied, or was roughly applied - see the complaints of HIA 172, HIA 198, HIA 231, HIA 434 and HIA 438.

369. A number of female complainants recall that when they were placed into a restraint position no respect was afforded to them and private parts of their body would be exposed - see the complaints of HIA 396, HIA 389 and HIA 503.

370. The Department accepts that appropriate training for control and restraint was probably not delivered until May 1995 at Rathgael, although certain former members of staff who gave evidence have referred to their knowledge of restraint techniques apparently in advance of that date.

371. The Department regrets any unnecessarily rough treatment which was suffered by any child. It accepts that a deficit in training and guidelines could have caused restraint to be applied inappropriately. Likewise, the Department regrets any use of restraint which led to any girl to be treated immodestly, or without proper respect for her dignity.

372. However, the Department does not accept that restraint of children was a widespread technique. It was rarely used.

373. In its report following the 1987 inspection, the SSI discussed the approach which staff adopted when tensions developed in the secure Unit:

"[6.37] The staff of Shamrock are aware that the young people there can find the environment oppressive and this can exacerbate their problematic behaviour. They have taken steps to relieve this situation in co-operation with the teachers who work within the unit, through skilfully handling situations when they arise and by the introduction of some useful procedures. For example the residential staff try to anticipate difficulties and will intervene early to divert the young people from a possible collision course. Primary workers provide individual counselling sessions for the boys and girls twice weekly and if there is concern about a young person staff will make a check on him or her at 15 minute intervals during the day and

overnight. Another general procedure which has been introduced by the staff team is to hold a full meeting within 48 hours of any major incident involving the residents to examine its antecedents and consequences." (RGL -23674)

374. While the inspectors noted that the approach to supervising the young people was more relaxed in the adolescent care units (Houses 1, 2 and 3) than it was in Shamrock, there was nevertheless a general determination on the part of staff members to "*control the behaviour of young people using personal influence and by working through problems with them as they arise*" (RGL 23679, para 6.54). That this was the general approach of staff is reflected in the fact that so few complaints have been made about staff behaviours.

375. The Department has also noted the complaint that some staff engaged in bullying or intimidatory behaviour with their words or actions - see the complaints of HIA 200, 386, 389. Such behaviour ought to be anathema to a care worker in a training school environment and where it has occurred it is repudiated by the Department.

376. Mr. Whyte gave evidence to the Inquiry to explain that he had occasion to report complaints of abusive behaviour by staff to police throughout his time in a senior management role, and to suspend staff on a precautionary basis to facilitate a full investigation. This was the proper approach and the approach commended by the Department in order to safeguard the rights of children and to protect them and others against the risk of further abuse.

377. Inquiry Counsel identified for Mr. Whyte certain complaints of ill treatment which were registered with other Rathgael managers, and which were not apparently reported to police or otherwise investigated. He was referred to other incidents where the child withdrew his complaint despite holding to the view that he had been abused. In these cases a withdrawal of the complaint seemed to prompt a decision that no further action was necessary. The Department would eschew such approaches and regrets that on some occasions former members of staff may not have been held to account for their behaviour.

Peer Bullying

378. It has been suggested in some of the oral evidence received by the Inquiry, that staff at Rathgael did nothing to prevent bullying, or failed to address its consequences: see for example the complaints of HIA 172, HIA 200, HIA 389, and

HIA 503. The account given by HIA 400 is a particularly graphic description of unrestrained bullying.

379. In this context, the Inquiry will recall the evidence of Mr. Conway who explained that so far as he could recall, bullying only became a recognised issue at Rathgael in the mid-eighties. He remembered that staff were trained to detect and challenge such behaviour (transcript for day 163, page 37).

380. The report of the 1987 SSI inspection suggests that by that time at least, staff had begun to acquire the techniques necessary to address bullying amongst the children.

381. For example, it was reported that within House 7 (on the Youth Treatment side) three boys had been transferred to House 6, because of prolonged incidents of bullying directed at younger boys (RGL- 23688, para 7.21).

382. A similar approach was taken with a boy referred to by the inspectors as [redacted]. It was reported that following complaints of bullying from a number of boys in House [redacted], [redacted] was transferred to House 6 "*where he would be with boys his own age*" (RGL 23687, para 7.20).

383. The Department regrets any injury suffered by any child as a result of bullying in Rathgael. It is clear, however, by the 1980s this was an issue which was being strongly tackled by the staff working with children in the Units.

Use of Sanctions

384. At the time of their inspection in 1987, the SSI Inspectors found that with regard to the Assessment Unit, "*staff try to be consistent in their approach to discipline*," using the withdrawal of privileges to punish indiscipline. More serious offences, such as wilful damage, was addressed by making a deduction from pocket money (RGL-23654, para 5.28). The inspectors suggested that consideration should be given to a scheme which would expressly reward good behaviour.

385. In the adolescent care units and in Shamrock there was a marks system in place which sought to reward positive attitudes and behaviour by awarding marks to individuals and groups, based around compliance with targets which had been agreed and set. The SSI inspectors commended the system and described it as "*progressive*" (RGL 23679, para 6.55).

386. In the Youth Treatment side, it was recorded that boys came to the unit having established patterns of behaviour which demonstrated that "discipline was non-existent or inconsistent" (RGL 23695, para 7.41). This required staff to maintain discipline by the use of "*close supervision*" and by clearly defining the "*boundaries of acceptable behaviour*." In circumstances where those boundaries were crossed the inspectors noted that sanctions took the form of "*extra work, both in class and in the units, cancellation of outings, deprivation of television, early bed and in exceptional circumstances deprivation of leave"* (at 7.41). As in the Assessment Unit on the care side, damage to school property was met with the imposition of fines. The inspectors noted that senior staff oversaw the imposition of sanctions to ensure that they were proportionate.

Separation

387. The Inquiry has heard that standard mechanisms (such as the system of rewards and sanctions) to regulate behaviours are not always appropriate. On occasion staff have to resort to separation to bring control to a situation, or to try to bring an end to frequent absconding.

388. A number of complaints have been advanced to the Inquiry about the use of separation in general, and in relation to what has been described as the "D" Room in Shamrock. For example, the following applicants have referred to or complained about their experience of the use of separation: HIA 386, HIA 389, HIA 434, HIA 438 AND HIA 503.

389. The policy for use of separation in Shamrock Close Supervision Unit (Care) in Rathgael stipulated, amongst other things, that children should be kept in separation for the least time possible and no more than an aggregate of 72 hours within a 28 day period. All periods of separation were to be recorded, those which exceeded 15 minutes required approval of a senior member of staff, and children in sedation were to be closely monitored (RGL - 31991).

390. The use of separation (or "time out" as it was sometimes called) was the subject of close scrutiny by the SSI inspectors in 1992. They did not express any concern about the use of separation in Shamrock, which they found was appropriate and proportionate, or the care provided (RGL 23824, para 10.3). Their main concern at that time was in relation to the recording of "time out" incidents:

"[10.3] The recording of "time out" i.e.. when a young person is removed from the group, needs to be examined by management. The Inspectors have no concerns about the quality of care provided and the methods of separation used but there does seem to be a variation in the methods of recording." (RGL - 23824)

391. They also noted with some concern at paragraph 10.4 that an individual had been the subject of separation on three occasions during one shift and that the approval of senior management had not been sought until the third occasion (RGL - 23824).

392. Following the inspection, an internal progress report dated 15th September 1992 (RGL - 23796) recorded that full guidance had by then been introduced and that a record-keeping methodology was in the process of being agreed which would be used throughout the training school system in Northern Ireland.

393. Mr. Conway explained in his statement to the Inquiry that all rooms which were used for the purposes of separation were necessarily sparsely furnished and equipped in order to reduce the risk of self-harm. Special safety mattresses were used and blankets, as opposed to sheets, were provided as there was less chance of them being used as a ligature. Clothing and toiletries would be checked and those items regarded as high risk were prohibited.

394. In his oral evidence (transcript day 159, page 8 and 24) RG 82, [redacted] in Rathgael, confirmed that children could be placed in separation for as short a time as 10-15 minutes, but in his experience it could extend to an overnight stay depending on the nature of the conduct. He could recall only one boy ever being held in separation overnight. He stated that children who were held in separation had to be checked every 15 minutes.

395. It is the Department's view, that the available evidence suggests that separation was not used for abusive purposes, but represented the sanction of last resort on many occasions in order to regulate the behaviour of a challenging or violent child.

396. It may assist the Inquiry to explore a small sample of examples of where separation has been used in Rathgael.

397. In her statement to the Inquiry HIA 438 has complained that she was put into isolation for absconding and then moved to Shamrock when she repeated her behaviour (RGL 119, para 7-9).

398. The records relating to HIA 438 (RGL 46160 – 46261) include many incident reports and associated isolation report sheets. These cover occasions when she was placed in her own room in order to calm down and to prevent escalation, for minor issues such as being verbally nasty to another child (RGL 46160, 46185 and 46220), and others when, for more serious misbehaviour such as physically attacking staff and for destruction of property, in order to protect herself and others, she was placed in the designated isolation room (RGL 46166 and 46254).

399. Periods of time spent in isolation ranged from 30 minutes to a few hours. On a few occasions, because of the seriousness of the incidents, she was kept in isolation overnight or for longer (RGL 46183 and 46254). In all cases the records show that staff checked on her at 15 minute intervals. On the occasions when she was in isolation for longer periods the records show that staff spent some time with her in the isolation room (RGL 46183).

400. HIA 389 recalled in her statement to the Inquiry (RGL 87, para 12) that she was sent to the D room once a month. She complained about the absence of any furnishings or a window, and that she had to use a buzzer to notify a staff member of her need to use the toilet.

401. The available records for HIA 389 (RGL 44949 – 44965) include incident reports to record when she was placed in isolation. They reveal that she was sometimes sent to her own room (RGL 44949 and 44957) and on other occasions for more serious misdemeanours, such as physical violence, she was sent to Shamrock overnight (RGL 44952,44963 and 44965). The weekly record sheet at RGL 44830 refers to spending time out in Shamrock and although details of duration are not recorded it would seem to be for short periods of time.

402. HIA 231 has not registered a complaint in her statement about the use of separation. The document at RGL 41264 describes a particularly violent incident when she assaulted staff. She was removed to her room but she refused to stay and assaulted staff again. This incident led to police being notified. RGL-41265 highlights that HIA 231 was removed from House [redacted] to House 4 (a secure unit) for her ‘accumulative bad behaviour’

403. HIA 386 has complained that she was often locked in D room for up to 72 hours for a range of offences including glue sniffing, self harming, cursing, or being cheeky or aggressive to staff (RGL 080, para 12).

404. The documents available in respect of HIA 386 support the fact that she was separated from the group because of her disruptive behaviour although there is no indication that her separation ever lasted for as long as 72 hours.

405. RGL-44214 records that HIA 386 was removed from the classroom because of her disruptive behaviour and had to go to her room on several occasions as she had ignored staff's directions. She was also offensive and nasty but after the short 'time-outs' she made a more conscious effort to adapt a more agreeable attitude. RGL-44215 describes how HIA 386 was so disruptive in class that her cumulative abusive behaviour resulted in her being placed in Shamrock. She returned to her unit mid-evening and was more agreeable. On another occasion whilst on a bus outing, she tried to open the back door, she kicked a member of staff in the stomach and was placed in Shamrock on her return to the centre. It is unclear how long this detention lasted.

406. The Department submits that the use of separation facilities was, in extreme situations, both a necessary and proportionate means to regulate behaviour, restore calm or protect others from harm. Those who have complained about its use have not apparently factored into their criticisms the behaviour that rendered the use of separation necessary in the first place.

Smoking

407. The Inquiry appeared interested during the oral hearings in receiving evidence in relation to attitudes to smoking within the Rathgael Centre, and elsewhere. The report of the 1987 SSI inspection noted the following (RGL 23654, para 5.30) in connection with the assessment unit:

"Pocket money often goes on cigarettes although smoking is not allowed under the age of 16 unless parental permission has been given. Cigarettes are handed over to the staff and children request a cigarette. A maximum of seven per day is allowed and there are sensible no-smoking rules in bedrooms and the dining room. The policy over smoking is under constant review. Perhaps a policy of incentives for non-smoking could be considered."

408. A similar approach to smoking was adopted on the adolescent care side. It was noted that many residents arrived at Rathgael "*with an already established smoking habit*." It was recognised by the Inspectors that restricting cigarettes to seven per person per day was preferable to giving children unrestricted access to cigarettes. Nevertheless, the inspectors counselled that management should consider introducing a policy which would incentivise non-smoking (RGL 23680, para 6.60).

409. In today's more health conscious times the idea of giving cigarettes to young people is anathema. Even in 1987 it was recognised that steps should be taken to incentivise non-smoking.

410. However, Rathgael as with the other training schools was in something of a bind if it wanted to discourage smoking. Young people were generally arriving in the training school with a nicotine addiction. They relied on their access to cigarettes. To prohibit cigarettes would have caused much upheaval and would probably would have led to disturbances.

411. In his oral evidence Mr. Whyte reflected on the fact that the provision of a cigarette had a tendency to have a pacifying effect on some of the young people. He recalled an incident when two girls were creating a disturbance on the roof of the Centre. He was able to bring the incident to an end with the provision of their cigarettes. He went on to suggest that at a later date steps were taken to prohibit the smoking of cigarettes at least in the Units.

412. At the time of writing there is no transcript available in respect of Mr. Whyte's evidence to enable the page reference to be given, but he gave his evidence on day 164.

413. It is submitted, that as the Inspectors suggested, the most sensible policy was to try to regulate consumption.

Summary

414. The work of the majority of staff at Rathgael deserves the highest commendation. The record suggests that they were highly attuned and committed to the needs of the young people in their care and worked fastidiously to make improvements to their lives.

415. A number of serious allegations of physical and sexual abuse have been registered against a small number of staff. The Department is anxious that any question of misconduct is resolved, although this is rendered more difficult with the absence of contemporaneous complaints or records and the passage of time.

416. The Department unreservedly condemns any abuse which may have occurred.

Section 4: Lisnevin Training School

Background

417. When Lisnevin opened at the Kiltonga site in October 1973 it answered a demand for two key services which were necessary to enable the Northern Ireland juvenile justice system to fully function: a Special Unit to house those boys who would not settle within the environs of the existing open/non-secure training schools and an Assessment Unit to assist the courts in determining the suitability of boys for residential training.

418. In his considered statement, Dr. Lockhart charts the history of the Lisnevin establishment and allows the Inquiry an insight into the life of Lisnevin, particularly in its early years before he left the service in 1983 (LS 1227 - 1675 - and see also his oral evidence on day 161).

419. LN 25 also provided the Inquiry with the benefit of his experience of working at Lisnevin (LSN 1224-1226, and see also the transcript for day 162). He had worked in Kiltonga for 3 years before leaving the service and then returning to work at the Millisle site from 1983 until his retirement in 2007. He had extensive experience of working with children at first hand, and of managing staff on the ground.

420. It was plain from Dr. Lockhart's evidence that he had concerns about certain aspects of the Lisnevin approach, particularly (but not exclusively) after the move to Millisle in September 1980. However, he did not consider that he worked in an institution which was routinely abusive. This was also the experience of LN25.

421. Abuse can and does occur behind closed doors and behind peoples backs, in defiance of the ethos of the organisation and its clear rules. The Department notes that only nine people have felt sufficiently strong enough about their experiences in Lisnevin to come to the Inquiry to register complaints. This of itself suggests that if abuse occurred at all, it was relatively isolated, and would have represented a departure from the benchmark of the high standards that had been established at Lisnevin.

Inspection of Lisnevin

422. The documents before the Inquiry demonstrate that an effective system of regulation was in place at Lisnevin. NIO officials, including inspectors from

SWAG/SSI worked closely with Lisnevin to advise on a range of issues, including the training needs of staff, April 1979 (LSN - 12839), and on issues such as absconding, March 1990 (LSN -12827).

423. Additionally, Lisnevin was also the subject of a number of intensive SSI inspections. It is submitted that the inspection reports, prepared as they were by independent experts in the field, provide the Inquiry with an invaluable source of evidence and a clear insight into the life of the school at the time they were produced.

424. While the inspections identified areas for improvement and made recommendations that changes were required in some areas - itself a strong indication that the regulatory system was focussed and functioning - the reports provide an acknowledgement that Lisnevin had developed strong systems of management and conducted its business in a proper manner.

425. The first such inspection took place over an 11 day period in April 1988, when a team of three inspectors visited the school. Their report can be found at LSN 13714 - 13779. The inspection was followed up with a visit from Mr. Donnell to discuss the implementation of the report's recommendations (LSN - 13712). The inspection regime did not settle for merely making recommendations; those recommendations were followed up and plans for implementation were developed.

426. In the 1988 report the Inspectors referred to the uniqueness of the Lisnevin facility in that it was "*the sole inter-denominational training school facility and the only one [providing] treatment in total security*" (LSN -13764, para 16.1). They opined that the Lisnevin site at Millisle, since it was formerly the premises of the secure borstal and built along penal lines, "*was in many ways unsuitable for use as a special unit for adolescent boys where the philosophy was based based upon child care considerations…*" It will be recalled that this was a point which was also raised by Dr. Lockhart in his evidence to the Inquiry (LSN 1238, at para 45).

427. The Department must accept this criticism. However, the records show that the original Lisnevin site at Kiltonga, whilst arguably more suitable for a training school enterprise, became unsustainable after a public enquiry refused to approve its continued use in the face of local objections.

428. Furthermore, the choice of Millisle was undoubtedly driven by public expenditure considerations, given the availability at that location of a vacant facility containing many of the amenities necessary for a training school.

429. The need to improve the Millisle facility was obvious to management and the Inspectors noted at the time of their visit that "*a major programme of refurbishing [had] brought about considerable improvements to the building*" although it was recognised that some problems still remained with the physical provision (LSN - 13726).

430. The Inspectors reflected on the various challenges which the school had encountered in its short history, including the movement from Kiltonga to Millisle and the opening of the Special Remand Unit within the school (LSN - 13764, para 16.2). The Inspectors commented that since the opening of the Remand Unit "*life has not been without its problems,"* and identified "*disturbances, barricades, damage, fire, assaults on staff and acute problems of control of very difficult behaviour"* as features of the Lisnevin environment.

431. Nevertheless, the school had many successes. The inspectors paid tribute to the Director and his team for the fact that "*so much has already been achieved and that the operation [of the Remand Unit] continues despite all the problems*" (LSN - 13747, para 7.20).

432. Having spoken with and observed the boys in the Remand Unit the Inspectors felt able to say, "*They had no complaints about the way they were treated…staff provide a good standard of care*." (LSN - 13744, para 7.8). The Inspectors did identify some concerns about the use of separation (discussed further below) but overall, in relation to the whole school, the Inspectors were satisfied with the standards of care being delivered to the young people at Lisnevin (LSN - 13764, para 16.2).

433. In 1992, SSI carried out a thematic inspection of Lisnevin's Secure Unit in light of the concerns expressed following the publication of the Pindown Report. The report of the thematic inspection can be found at LSN 13809 - 13849. The Inspectors reported on the progress which had made since the 1988 inspection in relation to the practice of separation (see further below), and the use of early bedtimes. The

Inspectors commented that "*the present situation is acceptable to the Inspectorate*" (LSN - 13812, at para 1.5). Overall the findings of the inspection were very positive:

"[1.7] The group of young people were well cared for and the systems that are in place ensure that no child is locked up unnecessarily or for any lengthy period of time. The facility to register complaints exists; regular visits by Board Members and the existence of an Independent Representation scheme are all elements which ensure the safety and well being of the young people. The Inspectors are satisfied with the quality of care provided and commend the Senior Management Team for their diligent style of management and clear involvement in the process." (LSN - 13812, para 1.7)

434. At the time of thIS 1992 inspection, the Inspectors were clearly visible to boys, but only one boy raised a complaint. He alleged that he was being bullied by other boys and that staff did not listen to him. The boy was invited to meet with the Director but during this meeting he declined to make any complaint, and at a further meeting with the Inspectors he described an "*excellent"* relationship with staff (LSN - 13840, para 13.7).

435. An unannounced inspection took place at the Lisnevin Secure Unit on 13 January 1993. The report of the inspection can be found at LSN 13873 - 13879. The inspector commented that his presence and purpose was known to the young people in the unit, but no complaints were made to him (LSN - 13875). The inspector observed a "*healthy buzz*" of conversation and activity in the unit.

436. A regulatory inspection was conducted in February 1993. The report of the inspection can be found at LSN 13850 - 13872. The inspector made a number of recommendations, including the need to review the use of a sanctions tariff because the approach contained a risk that separation could be used inappropriately (this is further discussed below). Overall the report was positive, however. The inspector interviewed a number of young people and he remarked that although they *"fully realised the purpose of the visit and although provided with the opportunity to do so, no complaints were raised about their care in Lisnevin."* (LSN - 13872, para 28)

437. A further regulatory inspection took place in January 1994. It reported (LSN 13896 - 13904) that there were ongoing staffing problems at the school, particularly a

reduction in senior staff and the continuing use of casual staff. It was noted that an already depleted senior management team had to cope with the uncertainty associated with the former Director's lengthy illness. However, despite these problems it was recorded that "*the school has continued to function well*" (LSN - 13904).

438. There then followed an unannounced inspection in June 1994 which focussed on the Special Unit (LSN 13905 - 13911). The Inspectors received no complaints from the boys whom they spoke to, and they noted a "*relaxed attitude*" between the boys and the staff. The inspectors "*sensed a very positive attitude towards the unit, with new ideas and strategies being considered*" (LSN - 13908). They reported that the IR scheme had been extended to cover boys in the Remand Unit, and that the scheme overall was "*working well*" (LSN - 13909).

Dealing with Complaints in Lisnevin

439. Upon committal to Lisnevin, boys were given an information sheet containing details of the rules of the school, their rights as well as their responsibilities. A similar document was also prepared for remand boys. The sheet for committed boys (dated October 1986) provided the following explanation of the complaints process:

"IMPORTANT

While at Lisnevin you may feel that you are being treated unjustly or that your rights are not being protected. Should you feel this to be the case you should bring your complaint to your key worker who will discuss it with you. Should such discussions fail to resolve the matter to your satisfaction, you may then ask to see the person in charge of the Unit. Your final appeal may be to Dep. Director (Care) or Dep. Director (Education). Should this contact fail to satisfy you, you may then refer the matter to the Management Board, through the Director." (LSN - 12360)

440. In his statement LN 25 recalled that during his time spent working in Lisnevin there was a functioning and "*effective*" complaints procedure. He explained that it was the role of a senior member of staff to examine any complaints made by a resident against a member of staff (LSN - 1225, at para 9).

441. Such was the care taken by Board of Management to ensure that pupils did not suffer ill treatment that it was determined in September 1991, following the Pindown Report, that there would be a review of pupil complaints:

"Following the publicity surrounding "Pindown" and related matters Senior Management re-examined incidents involving allegations against staff during the preceding twelve months and spoke to staff involved. Management was satisfied that the existence of senior staff inspections, constant supervision, independent representations and Board inspections should ensure that rights of children are protected." (LSN - 19971)

442. It would appear that this step was taken independently of the SSI decision to conduct a thematic inspection of the Secure Unit, referred to above.

443. The records of a Board of Management meeting from November 1992 document that a former remand pupil had made an allegation that he had been assaulted during his time in Lisnevin. This allegation concerned LN 25, who referred to it in his oral evidence to the Inquiry. This issue attracted the attention of NIACRO. It is clear that the Board adopted an open approach, and were prepared to engage with NIACRO officials to discuss the matter. Records show that in September 1993 the acting Director met with NIACRO and was able to explain that the incident had been reported to police who had carried out an investigation. The matter had also been the subject of an internal investigation. Each investigation concluded that "*nothing was found to substantiate the boy's claim*" (LSN - 12975 - 12976). Nevertheless, it was determined that the matter should be revisited. Ultimately the matter was considered by the DPP who directed "*no prosecution*" (LSN - 12986).

444. It was noted that there had been a failure by management to report the complaint concerning LN 25 to the NIO at the outset, and the Board took the opportunity to clarify the appropriate procedures when a complaint is made of physical abuse by staff:

"(a) All serious incidents or incidents which could bring the Centre into disrepute will be reported to the NIO within 24 hours.

(b) The Lisnevin Disciplinary Procedures be reviewed and in this respect the advice of the NIO be sought.

(c) In the event of a boy making an allegation of assault by a member of staff and where there is some evidence to support the allegation, the RUC will be invited in to investigate the matter. In such circumstances the management will request an examination by a police doctor.

…." (LSN - 12977).

445. In 1993, a written procedure was issued, reminding staff of the steps to be taken when a complaint was made against a member of staff, and indicating that consideration should be given to suspension pending investigation, and stating that the complainant would be given immediate access to his solicitor and Independent Representative. (LSN - 12633).

446. It can be seen from the records that allegations against staff featured on the agenda of the Board of Management, so that the Board could give oversight to the issues. In 1988, the school received a complaint from a former Lisnevin boy that he had been sexually abused whilst a resident of the school. The alleged abuser was by that time deceased. Nevertheless, the Chairman of the Board unhesitatingly decided that this was a matter which had to be referred to the police (LSN - 12693).

447. It is also clear that staff were prepared to report on colleagues if they compromised the rights of pupils. Hence, in November 1990, a team leader reported that three members of staff had "*acted unprofessionally in relation to a client's right to privacy*." Disciplinary action was instigated and formal warnings followed (LSN - 12967).

448. It is also to be noted that even when an allegation from a boy was withdrawn, the matter not only continued to be the subject of investigation by the police, but also internally (LSN - 12979). On another occasion the boy withdrew a complaint after speaking to his solicitor, but nevertheless the Board indicated that "written reports" would be sought from all concerned (LSN - 12981).

449. That said, while there was an emphasis in the adopted procedures on the need to report complaints from boys to police, the Department accepts that this approach was not followed in every case. In a report which was disseminated in June 2000 (but dealing with events from 1994, and therefore within the Inquiry's reference period), NIACRO remarked upon the "*continued cases of alleged physical abuse of young people in Lisnevin*" (LSN - 14385). It also expressed its misgivings about the

handling of complaints reported to NIACRO through the IR Scheme in the period between 1994 and 1997, stating, "*Despite the serious nature of the complaints they were all dealt with internally by Lisnevin [and] none were referred to either social services or the police"* (LSN - 14396).

450. The Inquiry may be interested to consider the cataloguing of the complaints considered by NIACRO in the period from 8 August 1994 and the end of 1995, of which there appear to have been 14 (LSN - 14379). It is unclear whether the incidents logged by NIACRO in the document at LSN - 14379 represent the total number of complaints made against staff at Lisnevin during that 1994-95 period, or whether they simply represent the complaints brought to NIACRO's attention. The complaints did not simply relate to alleged assaults by staff. Some of the complaints concerned peer bullying and self injury, while others related to privacy in the shower area where staff would normally be present for supervision purposes. There is a deeper analysis of some of those complaints at LSN - 14413 - 14414, when it is clear that they were being discussed as part of a review in 2000. The findings of that review were that a number of cases that had been referred under the IR scheme "*did not seem to have been properly concluded"* (LSN - 14462).

451. Nevertheless, it can be said that the available evidence supports the submission that boys in Lisnevin were told of their right to complain, and formal procedures existed to allow those complaints to prosecuted. The existence of those procedures, and the fact that children were told about them and told how to use them, is an example of good practice, and it suggests that protecting children from abuse and giving them the means to do something about their grievances was taken seriously by the Board of Management at Lisnevin.

452. The Department regrets that in some cases identified by NIACRO there were some procedural failings, but it is submitted that overall the picture is one of an institution which endeavoured to disseminate the clear message that abuse, where it occurred, was unacceptable and should be challenged.

Complaints to the Inquiry About Lisnevin

453. The small number of complaints which have been presented to the Inquiry in relation to Lisnevin from a total population in excess of 1600 residents suggests that there was never a significant problem of abusive behaviour by staff.

454. It is understood that the Inquiry works on the basis that there are 9 applicants which are relevant to its work in relation to Lisnevin. It is not the case, however, that there have been 9 complaints to the Inquiry about Lisnevin. HIA 294 is catalogued as an applicant in relation to Lisnevin but it is understood that he has not produced a statement of complaint in relation to his time there. On the other hand, HIA 253 has produced a statement (at LSN 056 - 061) in relation to his time in Lisnevin in [redacted]-[redacted]. However, he is clear that he has no complaint to make about the institution.

455. In his witness statement he recalls a positive experience at Lisnevin:

"[12] The regime in Lisnevin was a complete sea change to what I had experienced at St. Patrick's. The members of staff were friendly and not really strict. They had a good range of education choices which I really enjoyed…" (LSN - 059, para 4)

456. HIA 253 repeated this description of Lisnevin in his oral evidence before the Inquiry (see transcript for day 142, pages 19-21).

457. The main complaints which have emerged from the applicants to the Inquiry with regard to Lisnevin have concerned the following issues: sectarianism; peer physical abuse; assaults and bullying by staff; excessive use of separation. These complaints will now be explored.

Sectarianism

458. In his statement HIA 418 raises an allegation that sectarianism was rife amongst staff and residents, and that he was singled out for sectarian treatment:

"[3] During the entire time I spent in Lisnevin I received sectarian abuse from the other residents and staff due to my name, which would easily have identified me as a Catholic." (LSN - 025, para 3).

459. HIA 418 went on to claim that all staff members were Protestant, and that one member of staff came to work in a [redacted] football jersey (LSN - 027, para 10). He alleged that LN 25 would tell the boys "*not to play shots known as crosses*" whilst playing snooker. He suggested that this was a reference to his Roman Catholic faith (LSN - 027, at para 12).

460. In his statement HIA 138 referred to the fact that he had [redacted]

[redacted]. He has suggested that at least 12 members of staff would verbally abuse him in this manner, although he only identifies one member of staff by name, LN 28. There is no response statement from LN 28, although it was indicated by Inquiry Counsel that he refuted the allegations which have been made about him by HIA 138 (see transcript, day 156, page 5).

461. In his statement LN 25 explained that in Lisnevin there was no religious segregation within the Units; "*boys were simply placed into units on the basis of availability irrespective of age or background*" (LSN - 1224, at para 3). He went on to reject HIA 418's suggestion that there was something inherently sinister and sectarian about his use of the phrase "*cross shot*." It was merely a term used when playing snooker to describe a particular technique. (LSN - 1226, at para 10).

462. In his oral evidence to the Inquiry LN 25 explained that so far as he was aware there was no culture of sectarianism at Lisnevin. He told the Inquiry that he made it clear to the boys that he would not tolerate that kind of thing (transcript day 162, page 102).

463. In his statement to the Inquiry, Dr. Lockhart reflected that upon its opening, Lisnevin became the first integrated training school in Northern Ireland (LSN - 1228, at para 4). He went on to comment:

"One factor, which many would have predicted as likely to cause problems was the inter-denominational character of the school, but this in fact did not cause problems. There were examples of friendships formed between young people in Lisnevin that would otherwise have been highly unlikely." (LSN - 1235, at para 32).

464. Dr. Lockhart referred the Inquiry to his research paper which examined the issue of integration at Lisnevin (transcript for day 161, page 56-58).

465. The reported experiences of HIA 138 and HIA 418 were not shared by the applicant HIA 253 who was also from the Catholic community. HIA 253 was transferred to Lisnevin from St. Patrick's. In his oral evidence he indicated that he had "*read something about sectarian stuff and all, but I never seen anything, to be honest, and I got on well with people from the other side of the divide*" (transcript day 142, page 19).

466. Another witness, HIA 434, recalled sectarian name calling but this was limited to rival boys. He stated in clear terms that it was his experience that staff took no part in sectarianism. In his witness statement HIA 434 recalled that "*there were fights on an almost daily basis between Catholic and Protestant inmates at Lisnevin*," but staff intervened to break them up (LSN - 039, para 12). In his oral evidence HIA 434 addressed the allegation of sectarianism amongst the staff:

"To me I had never seen the staff at all whether you want to call it sectarian or you want to call them being bullies or anything like that there. The staff were very, very fair and very, very good, so they were." (Day 153, page 122, line 1).

467. It will be noted that HIA 434 was a resident of Lisnevin in [redacted], a year or so before HIA 138 was sent there, and three years before HIA 418 was sent there.

468. It is the case that only on one recorded occasion (assuming that our searches of Inquiry documents are accurate) did a boy make a complaint to management about sectarian behaviour by staff. The Inquiry will see this documented at LSN - 12987. On that occasion, recorded on the [redacted], it was stated that "*a member of staff made sectarian comments to him*." An investigation was directed, albeit that the boy withdrew his allegation. The Director expressed the view that he was "*concerned about the sudden retraction*" and it was agreed that this was a matter which "*would have to be monitored very closely."*

469. Plainly, the Director was anxious to get to the bottom of this issue, concerned that there had been a retraction of the complaint, and determined to keep the issue under review. His decision-making on this matter, and the views which he expressed, indicates that management gave a strong lead on the issue, and that staff should have been in no doubt that sectarianism was anathema to the organisation.

470. A further indication of how staff at Lisnevin dealt with sectarian behaviour on the part of residents can be examined by reference to a document contained at Exhibit 9 of Dr. Lockhart's statement at LSN - 1538.

471. On the [redacted] a boy (LN 113) engaged in singing and whistling loyalist songs. Staff tried to prevail upon him to desist from this behaviour but he refused to do so. He was told to go to his room when he refused to stop, and when he reacted aggressively to this instruction it became necessary to ask the other occupants of

the room to go to another area. The boy's aggression eventually led to him being restrained and during this process the boy and a member of staff unfortunately suffered injuries.

472. The effort of staff on this occasion to deter sectarian behaviour by a resident is consistent with the recollection of LN 25. He was not so naive as to suggest that sectarian name calling, for example, did not occur out of his ear shot or that of his colleagues. However, LN 25's stance, that he would not stand for sectarianism in the school, is reflected in the approach of his colleagues to this incident (see transcript for day 162, page 102).

473. It is submitted that the allegations of HIA 418 have the ring of exaggeration about them. His suggestion that the staff were all Protestant is undoubtedly inaccurate. The Catholic community was always represented on the Board of Management, with Canon McCann a long time member and Chairman of the Board. It is hardly likely that he would have tolerated any suggestion of anti-Catholic bias from the staff towards the boys. The suggestion by HIA 418 that the reference to a "cross shot" was a sectarian taunt is simply a ludicrous contrivance and should be treated as such by the Inquiry.

474. Nevertheless, the Department accepts that there undoubtedly was some element of sectarian behaviour amongst the boys in Lisnevin. It would be naive to suggest that Lisnevin could have absorbed itself from what was a pervasive feature of Northern Ireland of that time. The position may be little better today.

475. The Department also accepts that [redacted]. Staff members were expected to behave professionally at all times, and to treat those in their care with dignity and respect.

476. The Department has no hesitation in condemning any acts of sectarianism on the part of staff, which may have occurred. However, the evidence to suggest that staff behaved in this way is limited, and certainly there is no indication that such behaviour was widespread. It is submitted that the weight of the evidence suggests

that staff members were intolerant of sectarian behaviour and took steps to clamp down on such behaviour on the part of residents.

Peer Physical Abuse

477. During his evidence LN 25 was asked to comment on a document at LSN 21195, which concerned a complaint made by HIA 418 that he was being bullied by another boy in his class and wanted to be moved to another class (Day 162, page 99-101).

478. The Inquiry will note that it is HIA 418's complaint that he was intimidated and bullied by other boys and that staff took no action (LSN - 026, para 4).

479. The document at LSN 21195 indicates that HIA 418 felt able to draw his experience of bullying to the attention of a staff member (in this instance LN 25), who he is otherwise critical of. As LN 25 explained in his oral evidence, he took the complaint forward by writing it up in the diary (which served as a log or occurrence book). This is the document at LSN 21195.

480. While LN 25 had no specific recollection of the complaint, he surmised that if he wrote it up in the diary this indicated that he had gone to the manager's office to report the problem and to ask for something to be done about it (transcript for day 162, page 99). The entry in the diary indicates that LN 25 asked his colleagues "*to keep an eye on the situation*." LN 25 went on to explain to the Inquiry that he did not know whether HIA 418 obtained a transfer to another class, although that decision would have been one for the Education Department to make (transcript for day 162, page 101).

481. LN 25 challenged HIA 418's claim that when boys were being intimidated by other boys, staff just stood by and failed to intervene. LN 25 expressed surprise if this was the case. He explained that it was the duty of staff to "*make sure that the place you were working in was in a calm and fair environment*" (Day 162, page 117, line 15).

482. As noted above, HIA 434 was positive in his recollection that staff did intervene to break up fights or resolve tensions (RGL - 115 - at para 12).

483. The Department accepts that bullying was undoubtedly a feature of life at Lisnevin just as it would have been at any school, although complaints of this nature to this Inquiry are limited to that of HIA 418.

484. The Department agrees with the analysis of LN 25, that it was indeed the duty of staff members to intervene and to try to put an end to intimidation or bullying where it occurred. It would have been an unacceptable dereliction of duty if staff had failed to exercise their authority by intervening. It is reasonable to suggest that staff had a duty to be sensitive to where bullying might be occurring, and to report and monitor behaviours which were suggestive of bullying.

485. The Department would be critical of any member of staff who did not comply with those duties. However, there is no evidence before the Inquiry that staff routinely ignored instances of bullying. The complaint of HIA 418 is an isolated one, and in his case there is clear, contemporaneous documentary evidence that steps were taken by a concerned member of staff to address his complaint.

Assaults and Bullying by Staff

486. The Department's position is unambiguous: any unlawful assault perpetrated against a child resident of the juvenile justice system would have been unacceptable then, just as it would be now.

487. Staff at Lisnevin were the subject of a detailed induction process, during which Lisnevin policy and philosophy was explained to them (LSN - 12361). Staff were bound to know that to assault or bully a child would constitute a disciplinary offence, and would most likely be a breach of the criminal law as well.

488. The Inquiry will note that allegations of assault and/or bullying by staff at Lisnevin are contained in the witness statements of the following complainants: HIA 94 at LSN - 009, at para 4; HIA 275 at LSN - 014, para 13; HIA 418 at LSN - 026, para 5, 8 and 9; and HIA 138 at LSN - 030, para 5, 6, 7, 8.

489. In the nature of things it is impossible for the Department to challenge the factual assertions made by the complainants. The majority of the complaints have been made against unnamed individuals. Accordingly, there is no factual basis upon which to contest the allegations.

490. In his statement to the Inquiry LN 25 addressed HIA 418's allegation (at paragraph 7 of his statement) that he was bound to have been aware that staff behaved in a physically abusive or intimidatory manner:

"…during my time in the Centre I occupied a general supervisory role over different units and can attest that I never witnessed nor was party to any instance or culture of bullying or intimidation within the Centre created or carried out by either myself or other members of staff." (LSN - 1224, at para 3).

491. Elsewhere in these submissions a number of violent assaults on Lisnevin staff have been recorded and referenced. It is reasonable to infer that staff were bound to resort to physical intervention to defend themselves or to protect others from physical harm in those situations.

492. Likewise it is probably reasonable to assume that aggressive boys who were determined to barricade themselves in a room and to destroy the contents of that room, or to burn it or flood it, were unlikely to react peaceably when directed to desist. It is inevitable that staff in situations such as this would have had to respond with physical intervention.

493. However, staff were expected to treat every situation on its merits and to react appropriately to the given situation. It is clear that staff did not automatically respond to unruly or aggressive conduct on the part of children by taking an aggressive approach.

494. In his oral evidence LN 25 acknowledged that he developed a rapport with the boys he had contact with, and while he had occasion to have resort to restraint techniques to calm or control a situation, he was often able to use that rapport to talk the child back into line (see transcript, day 162 at page 98). He accepted that other members of staff may not have had that rapport with the children and may have had their own techniques for dealing with situations, but he emphatically denied the accusation that restraint techniques were used to intimidate, bully or assault residents.

495. The Board of Management minutes for 28 February 1983 refer to a serious incident in the school when five boys barricaded themselves into a common room and caused considerable damage. The initial strategy was to adopt "a watching brief" and to endeavour to talk to the boys using the internal telephone system. It was

only when a possible fire risk was identified that a decision was made to summon the police, and to force entry into the room. It was noted that the incident was resolved without any boy suffering injury "*or even being manhandled*" (LSN - 12942).

496. Despite the flexibility and calming approach which many staff will have deployed in dealing with difficult situations at Lisnevin, the Department readily accepts that even the best trained and most professional staff can overreact or lose their temper in moments of stress or when provoked. Nevertheless, loss of control by any staff member for whatever reason and whatever the provocation would be regarded by the Department as worthy of criticism.

497. However, the allegations contained in the statements of HIA 138, HIA 275 and HIA 418 are of a more worrying character. They speak of gratuitous and unprovoked violence on the part of staff towards children under their care. The Department is obliged to make the point that such complaints do not represent the experience of the vast majority of those who were resident of Lisnevin. However, if such abuse was visited upon these complainants it cannot be condoned. Those who perpetrated it would have known that they were acting in manner which was inconsistent with their obligations.

498. The Inquiry will note that HIA 275 has made a complaint that he suffered a perforated ear drum as a result of an assault by staff. He claims that he was not provided with medical attention (see statement at LSN - 011, para 13). The Inquiry is invited to consider this applicant's medical notes at LSN - 2000. It indicates that he first complained about a sore left ear on the 6 May [redacted] "*since he slept on it*." The doctor diagnosed otitis eczema and prescribed medication. HIA 275 went on to make further complaints, including on the 7 July that both ears were sore. The complaints continued into [redacted] On many of his visits to the doctor he recorded, "NAD" (no appreciable disease). Clearly, there was no complaint to the doctor that he had been assaulted by a staff member, and no diagnosis of a perforated ear drum. There was no failure to provide him with medical treatment on request.

499. HIA 138 has raised allegations that he was provoked by staff and then physically abused when he reacted to that provocation (paras 5-7 of his statement). Such behaviour would be equally unacceptable if it occurred, although the Inquiry will appreciate from the submissions set out in the section below, that HIA 138 was

undoubtedly an aggressive and disruptive presence in Lisnevin during his short time there and caused many difficulties for staff.

500. HIA 138 has also complained that the method used to restrain him, involving the bending of his limbs, caused pain and distress. He also claims to have been beaten when under restraint (para 7). The Department has acknowledged elsewhere in these submissions that formal training for staff in the application of appropriate restraint measures was too long delayed. It is accepted that inappropriate techniques could have been used by some staff. However, even in the absence of such training, staff would have been well aware that to beat a boy when taking him to the punishment block was unacceptable and would have resulted in disciplinary action had any such abuse been detected.

Separation Unit ("Punishment Block")

501. A number of complainants have told the Inquiry that whilst resident at Lisnevin they were abusively treated in connection with the use of the separation unit, or punishment block as it was known.

502. The SSI referred to the use of the "punishment block" in their 1988 inspection report. They noted that placing boys in the punishment block was integral to the sanctions policy of the school. Sanctions were set at 4 levels, the most severe being level 4. A boy who incurred a level 4 sanction, which was applicable to serious offences such as attempting to start a riot or a fire, or assaults on staff, could be removed to the punishment block for a minimum period of 96 hours (LSN - 13739, para 6.21).

503. However, they also found that while minor misdemeanours such as giving cheek to staff and non-co-operation would attract a loss of marks, the failure to comply with warnings leading to a repeat of such behaviour could lead to 24 hours separation in the child's own room, or the use of the punishment block if he failed to settle. Level 3 offences, such as fighting or bullying, leaving a classroom or activity without permission, attempted theft or destruction of property, possession of cigarettes/matches and excessive bad language, cheek or bullying, would lead to immediate removal to a child's own room for up to 48 hours.

504. The SSI Inspectors expressed concern about the use of the punishment block particularly in the Special Unit at Lisnevin and suggested that in drawing up the

behavioural guidelines management had appeared to overlook the requirements of Rule 39 of the Training School Rules.

505. It will be recalled from the discussion elsewhere in these submissions that Rule 39 provided that separation from other pupils could be used as a punishment in "exceptional cases" but provided that where it was to be continued for more than 24 hours, the written consent of a member of Board of Management would be obtained and the circumstances reported to the Department.

506. The Inspectors noted in 1988 that separation of boys for more than 24 hours occurred *"frequently*" and therefore they recommended that management should review the behavioural guidelines relating to the use of separation to take account of the Training School Rules (LSN - 13739, para 6.22).

507. The Inquiry will note that having received the recommendation to review practices regarding the use of the punishment block, the Director of Lisnevin wrote to SSI in December 1989 to indicate the progress which had been made:

"17.6 Lock up periods have been reduced by 50% and the situation is being reviewed by management with a view to further reduction. All separations are recorded" (LSN - 13792).

508. During their 1992 thematic inspection of the Secure Unit at Lisnevin the Inspectors commented on the progress that had been made in the area of separation since its earlier report:

"[12.5] All instances of removal from the group have to be authorised by the senior residential social worker or Unit Administrator. The records are clearly and regularly scrutinised by the Deputy Director. All incidents of removal clearly show the time in, the length of stay and the reasons for the removal. Such records are cross referenced in the log book. The inspectors were satisfied that the reasons for removal were justified and were pleased to note a reduction in the incidence of removal, particularly in the Remand Unit." (LSN - 13837).

509. These observations would tend to suggest that while the use of separation was clearly a concern at the time of the first SSI inspection in 1988, considerable progress was made in the years after that. The fact that senior management at Deputy Director level were involved in scrutinising the use of separation impressed

the SSI. This was viewed as an important procedural safeguard. Furthermore, the documented reasons given for removal and separation from the group clearly satisfied the Inspectors at a substantive level; the sanction was being applied when it was appropriate to do so.

510. The Department acknowledges that it is disappointing, therefore, that during the regulatory inspection in 1993 the Inspector had occasion to revisit the issue of separation (LSN - 13869). By that time what was described as "*a tariff system of standard sanctions*" was in force, a consequence of which was that "various breaches of discipline could lead to a boy being removed from the group for up to a maximum of 4 hours and in cases of severe misconduct for up to 24 hours" (LSN - 13869, para 21). While this represented progress on what had been observed at the time of the 1988 inspection when separations in excess of 24 hours were not infrequent, the tariff approach raised presented a new concern for the Inspectors.

511. The issue of the tariff was first flagged up during an unannounced inspection in January 1993 (LSN - 13876 - 13877), when the Inspector recognised that the tariff approach seemed to have been initiated to enable the system to cope with the behaviour of a large group of delinquent youth in circumstances where the desired strength of staffing in the Units simply was not available. The Inspector recognised the problem of control posed for the school in such circumstances, and acknowledged that the measures did not contravene Rule 38 of the Training School Rules. However, he expressed the following reservation: "*Although no boy is left alone for lengthy periods and counselling is provided during the period of removal, the use of standard sanctions, which can be automatically applied at Unit level, possibly on the recommendation of inexperienced staff, is a worrying development."* (LSN - 13870, para 23). The inspector considered that this was an issue which should be discussed between management, SSI and NIO.

512. The issue remained unresolved at the time of the next regulatory inspection in January 1994. It was noted that "*sanctions such as removal from the group seem to be used as the main means of controlling unacceptable behaviour*" (LSN - 13903, para 27). The Inspector expressed the view that while management had made efforts "*to bring about improvements in practice within the school, in relation to removals, sanctions etc., unless the fundamental problem of staffing is tackled such efforts are likely to have limited success*" (LSN - 13899, para 8).

513. An unannounced inspection took place 6 months later, in June 1994, which focussed on the special unit. The inspectors spoke to LN 25, who was the unit manager at that time (LSN - 13908, para 6). They also spoke to the senior residential social worker who reported that there had been a reduction in the use of separation as a sanction (LSN - 13908, para 5). It is not clear from the available documentation whether the SSI continued to be concerned about the use of separation at Lisnevin.

514. The Department accepts that what emerges from the SSI reports is that separation has not always been used appropriately at Lisnevin. It is acknowledged that at the time of the 1988 inspection, separation was used somewhat excessively, with insufficient regard for the conditions set out in the Training School Rules. It is regrettable that on some occasions separation was used for up to 96 hours, although this extended use of the procedure appears to have been relatively uncommon and only used "*where behaviour has been exceptional*" (LSN - 13744, para 7.10).

515. While management at Lisnevin were able to reform and improve the arrangements associated with the use of separation following publication of the 1988 inspection report, the introduction of a tariff system several years later and the concomitant reduction in managerial involvement and oversight, was naturally a cause for concern. While SSI accepted that separation was operated within the terms of the Training School Rules, and that the tariff approach was a pragmatic and convenient solution to addressing volatile behaviour on the part of young persons in the face of staffing and supervision problems, it properly pointed out that such measures carried a risk that the sanction could be used inappropriately in certain circumstances.

516. The Department accepts the burden of these criticisms. It is perhaps understandable that administrative convenience brought about the tariff approach so that control and order could be maintained against a backdrop of staffing issues, but it is acknowledged that such issues should have been capable of resolution. At this remove it is not possible to fully explain why those staffing issues were not more speedily addressed.

517. The complaints which are before the Inquiry in relation to the use of the separation unit, mainly relate to the period from 1988. There are three complainants who

express concerns about the use of separation from that time: HIA 138 ( ); HIA 275 ( ); and HIA 418 (and .

518. Only HIA 94 has complained to the Inquiry about the use of separation at an earlier time. He was resident in Lisnevin at Kiltonga in the period 1 . He has complained that he was kept in a secure cell every night and sometimes during the day for 20 months (LSN - 005, para 23).

519. It is clear from the evidence given to the Inquiry by Dr. Lockhart, that HIA 94 was a special case. In his statement Dr. Lockhart, who was very familiar with HIA 94, recalled that he was often required to sleep in a single room on his own because he got into lots of fights with the other boys (LSN 1227-1675, para 70). In his oral evidence, Dr. Lockhart recalled the position in more vivid terms. Referring to the decision to place HIA 94 in his own room at night, he stated:

"[HIA 94] …The dormitories -- the smallest dormitory would have had four young people and he was quite a dangerous person in those situations. That was my memory of him and I would have known him quite well. So it was a planned strategy as opposed to a reaction.

….

I think the fears were that if he was in a dormitory, then there was a danger of significant violence usually against somebody else rather than to him." (transcript, day 161, pages 76-77)

520. In order to compensate for the need to separate him from the group at night time, Dr. Lockhart recalled that HIA 94 was given paint so that he could decorate and personalise his room, and he benefitted from a certain leeway when it came to the time at which he was required to go to bed (transcript, day 161, page 77).

521. In his statement Dr. Lockhart also referred the Inquiry to the documents identified at paragraph 3 of Karen Pearson's response statement concerning HIA 94 (at LSN - 1196) which explain how his challenging behaviours were managed at times other than at night time.

522. Those documents show that it was necessary to place HIA 94 into the punishment unit, or to require him to take "time out" in his bedroom, in response to particular behaviours. Careful consideration of the documents referred to by Ms Pearson

indicate that HIA 94 was confined to the “single room” for up to a day, usually for no more than a few hours at a time with the shortest recorded confinement being for 10 minutes.

523. The Department accepts that the evidence shows that HIA 94 spent a considerable period of time separated from his peers, particularly at night. However, for the reasons articulated by Dr. Lockhart, this was a clear and deliberate strategy, designed to protect other boys from the threat which HIA 94 frequently posed. The treatment of HIA 94 was entirely justified. He appears not to realise or be prepared to admit that he posed a significant problem of control and management for the staff at that time, and represented a danger to his fellow residents.

524. It is clear that another of the applicants who has complained about the use of the punishment block, also posed significant control issues for the staff at Lisnevin. HIA 138 has suggested that he was always brought to the punishment block when he misbehaved, and that on most (90%) of the occasions when he was brought there he was beaten by staff en route (LSN-031, para 7). In his oral evidence on day 156 he explained that he was always left bleeding when placed in the punishment unit, and that the use of restraint left him in some pain (transcript, day 156, pages 12-13).

525. Records show that after 2 months in Lisnevin HIA 138 was viewed by staff as “troublesome and disruptive” (LSN - 20788). Shortly after being admitted to Lisnevin he threatened a member of staff with a piece of wood, and was removed to his bedroom (LSN - 21437). On the 17 April [redacted] night supervision reported that he had been removed to the separation unit for disruptive behaviour and for flooding his room. A decision was made, following discussion between senior staff, that HIA 138 should “*remain off the floor [that day]”* (LSN - 21442). A week later HIA 138 was given an early night and placed on report (LSN - 21443), a sanction which was repeated on the 5 May (LSN - 21448) and on the 8 May (LSN - 21449). The record for the 27 April suggests that a decision was made that HIA 138 would be given a punishment of three early nights (LSN - 21446). An entry for the 11 May [redacted] suggests that HIA 138 was removed to the separation unit, having assaulted a fellow resident (LSN - 21541).

526. Numerous other incidents were recorded during May and early June [redacted] leading a member of staff to record on the 10 June that “*staff reported that [HIA] 138] is*

becoming unmanageable" (LSN - 21459). That night, HIA 138 barricaded himself into his room, and proceeded to destroy lighting and windows. He was placed in the punishment block (LSN - 21460) and was later charged with causing criminal damage (LSN - 20782). Given the difficulties that he was presenting, management in Lisnevin in conjunction with the NIO, refused an application made by his solicitor on his behalf to transfer him to St Patrick's (LSN - 20800).

527. The records available to the Inquiry demonstrate that HIA 138 was frequently aggressive, violent or disruptive. It would appear that different techniques were adopted to try to control his behaviour including talking to him (LSN - 21446), putting him on report, and putting him in his room or to bed early. On only four occasions was he placed in the separation unit or punishment block (LSN 21463 - 21466). There is no record of him sustaining any injury in association with his transfer to the punishment block. In his evidence HIA 138 indicated that he was never detained in the punishment block for long periods of time - he described it as "*short periods of time*" (transcript, day 156, page 23).

528. HIA 418 has complained that he was regularly placed in the punishment block during his time in Lisnevin. He asserted that he was placed there 10-15 times, and that during such times he would be given very little to eat or drink (LSN - 026, para 5 and 6).

529. The records available for HIA 418 are very comprehensive. There is a problem of interpretation because of the similarity between his name and that of another boy who was in Lisnevin at the time (LSN - 21186). However, upon our consideration of these records - and there are numerous entries and some problems of legibility - it appears to be the case that HIA 418 was the subject of separation on quite a few occasions. That said, none of the entries suggest that he was ever brought to the punishment block. The entries indicate that he was instead placed in his bedroom (see LSN - 21189, 21192, 21196, 21205, 21206). Other entries refer to him being required to go to bed early (LSN - 21190, 21232, 21239), or being removed from class (LSN - 21206). There is an ambiguous entry which refers to him being "*removed from group*" but the entry does not record that he was placed in the punishment block.

530. LN 25 explained to the Inquiry in his witness statement that Lisnevin had a separation unit which was known to the boys as "*the Block*." He went on to comment upon the circumstances in which "*the Block*" was used:

"The separation unit was used when a young person became so violently disruptive, disruptive and/or out of control as to represent a danger or disruption to staff members, fellow residents or himself. In those circumstances the offending resident would be sent to the separation unit to give him time and space to calm down. There was a very clear set of Regulations in place which staff members were required to follow when a young person was referred to the separation unit." (LSN 1224, at para 4).

531. It is notable that none of the incidents of misbehaviour recorded against HIA 418 would fall into the categories described by LN25, and this would support the suspicion that he is mistaken when suggesting that he was regularly placed in the punishment block.

532. LN 25 went on to refute the claim made by HIA 418 that those placed in the separation unit were deprived of food and drink. LN 25 has carefully explained that the same meal time routine was applied to those who were held in the separation unit, as was applied to the rest of the Lisnevin population: food was served in the separation unit at the same time, in the same quantities and to the same standard as applied to the rest of the school (LSN 1225, at para 5).

533. When he gave oral evidence LN 25 was asked to elaborate upon his experience of the separation unit. With regard to his experience at Kiltonga he said:

"Well, it was basically a time out area to get them away from all the other boys in the units that they were in and they were given time out specifically. It could be a couple of hours. It could be half a dozen hours. You just wouldn't know. It depended on the boy's behaviour." (transcript day 162, page 86, line 2).

534. LN 25 went on to explain that in his experience two days was the maximum detention period he had witnessed in Lisnevin, and it was more normally a period of some hours (transcript, day 162, at page 92). He accepted that the separation unit was probably used more often in Millisle than had been the case at Kiltonga (transcript day 162, at page 90). However, he disputed the suggestion made by Dr. Lockhart in his evidence (day 161) that a boy placed in the separation unit in Millisle

might have been left unmonitored, and might have had to continually press a buzzer to summon assistance to get to the toilet, for example, or could be ignored. That was not his experience, although it is fair to point out that LN 25 and Dr. Lockhart would have not worked for very long together at the Millisle site. Instead, LN 25 recalled that, *"…whoever was manager on the shift at the time had to allocate a member of staff to sit in the office, which was at the end of that separation unit."* (transcript day 162, at page 91, line 12).

535. LN 25 was invited through questions by the Chairman to expand upon his recollection of the procedures applicable to the use of the separation unit at Millisle:

"If two care staff or teaching staff, whatever, had to remove a young person at a particular point when he was out of control, they would have completed the removal, but they would have had to inform senior staff immediately of what had happened, and then the senior staff would have appointed somebody to be present in the office in that particular unit to look after the young person's needs." (Day 162, page 113, line 113).

536. LN 25 was not specifically asked to address the concerns raised by SSI in relation to the use of a tariff approach to separation in or about 1993.

537. LN 25 could not recall senior staff approving the use of the separation unit for a boy in advance of his removal there; the tendency was for a volatile incident to happen, leading care staff or teaching staff to decide that removal to the separation unit was appropriate, followed by a report to senior staff, and approval of the use of the separation unit, or not, as the case may be (Day 162, page 114).

538. LN 25 went on to give helpful estimations of the duration of stays in the separation unit. He explained that 70% of the removals to the separation unit would be for short periods, ranging from a matter of minutes and up to an hour. It was only in 30% of the cases that separation lasted for any longer and in these more extreme cases the boy might be separated for a morning or an afternoon, sometimes overnight and on rare occasions for up to two days (Day 162, pages 115-116).

539. LN 25 was referred to HIA 418's allegation that he had been placed in the separation unit up to 15 times. LN 25, who was familiar with HIA 418 at the relevant time, seemed to regard this as an exaggeration, and stated that in all his time in Lisnevin he could not recall any boy being removed that number of times, although

he recognised that some regarded it as badge of honour to be detained in the separation unit and that of course, some boys were more regularly disruptive and this may have required greater resort to the unit (transcript, day 162, at page 93).

540. HIA 275 has claimed that at Lisnevin he was placed in the punishment block regularly, sometimes for no reason at all (LSN - 011, para 14). However, in a report dated 18 August [redacted] it was recorded that staff found HIA 275 "*to be at least outwardly co-operative without proving a management problem*" (LSN - 20884 - 20885). It was said that he had "*successfully progressed within our system*."

541. It is always possible to fail to spot relevant entries even after detailed scrutiny of the records. Indeed DOJ in its supplementary response statement (LSN- 1199, para 5) has recorded that HIA 275 was sent to bed early on a number of occasions (LSN - 21035, 21042, 21055), but the statement failed to draw attention to the fact that the record at LSN-20137 shows that he was placed in the separation unit for 96 hours, having been found on the roof of workshops in the grounds of the school. A further record at LSN-21042 indicates that he was placed in his room for 24 hours for his behaviour at a recreational activity.

542. In response to the complaint made by HIA 275 that he was placed in the punishment block regularly and often for no reason, it can be said that the records which have been located only suggest that he was placed in the punishment block on one occasion. Moreover, the records show that there was good reason for doing so. The records also show that he was the subject of a separation punishment by being removed to his own room on several occasions, and again the documents indicate that there were good reasons for imposing such sanctions.

543. It is submitted that apart from the period effected by the "tariff system," the documents available to the Inquiry demonstrate that there was no automatic resort to the use of the separation unit. There was no one size fits all approach. Even what appear to have been relatively serious incidents did not necessarily lead to detention in the separation unit. For example, on the 4 April 1988 a Special Unit boy who used a fire extinguisher to smash several panels of glass was merely removed to his bedroom (LSN - 12984). The documented behaviour of HIA 138 was regularly the subject of adverse comment, although the records show that he was only detained in the separation unit on 4 occasions.

544. It has been acknowledged that SSI had concerns about the use of separation at various points in time. In the specific cases which have given rise to complaints to this Inquiry, in one (HIA 418) there is no record that the complainant was ever sent to the punishment block. Very detailed records were generally kept and these show in the cases of HIA 94, HIA 138 and HIA 275, that the Unit was used proportionately and as a means of addressing violent or disruptive behaviour, and that staff were required to comply with procedural requirements in order to justify its use. The Department accepts that if staff did behave in a violent fashion towards children when restraining them to bring them to the punishment block, as HIA 138 alleges, this would have been completely unacceptable.

Other Matters

545. HIA 434 has complained that having burnt his arm on a radiator pipe staff merely laughed his injury off, and failed to provide him with medical treatment (LSN - 035, at para 14). When he gave oral evidence to the Inquiry he refined his complaint and suggested that there was a delay in providing him with treatment until there was a change of shift amongst the staff by which stage his wound had started weeping (transcript day 153, page 123).

546. The Inquiry may have taken the opportunity to review a sample of medical records associated with residents of Lisnevin. The records are usually impressively detailed and reflect the fact that the medical attention available at Lisnevin was generally excellent. It is clear from the records that HIA 434 received treatment for a small burn on his arm on [redacted] and [redacted] (LSN - 21290, 21291).

547. The Department would accept that medical treatment should have been provided urgently if it was required. At this remove the Department cannot address the allegation that treatment was delayed. There may be many good explanations for delay. For instance, a view might have been taken initially, that the injury was minor and did not require treatment. Ultimately treatment was provided and HIA 434 suffered no adverse reaction.

548. There have been no allegations of sexual abuse made by any complainant to the Inquiry in relation to their time spent in Lisnevin. While HIA 374 has raised allegations of inappropriate touching, he has told the police during interview that he was not sure if there was anything sexual about it (LSN - 25566). Giving his

evidence to the Inquiry HIA 374 was even more firmly of the view that while he thought what happened to him was an inappropriate thing for someone to do, he was resolved there was nothing sexual to it (transcript, day 140, page 13).

Summary

549. It can be inferred from the relatively few complaints which have been received by the Inquiry that the systems which were in place at Lisnevin provided an effective bulwark against any tendency on the part of staff to abuse the rights of the children placed there.

550. The vast majority of staff were both caring and effective in trying to manage cases of difficult children towards making improvements in their lives.

Section 5: Hydebank Young Offenders Centre

Background

551. The Inquiry is referred to the statement of Max Murray, who was employed in Hydebank from 1984 to 1987 as Deputy Governor and then as Governor (HYD-469). He sets out in considerable detail the key features of the Hydebank facility when he worked there, how it was operated and managed, the regime which was applied to the young people there, and the protections which were in place to prevent abuse.

552. Hydebank has attracted a small number of complaints - only five in total. The Department has examined the evidence which has been given in support of those complaints and will use this section of the submissions to address the key issues of concern.

553. It is first necessary to say something about the arrangements which were in place at Hydebank to facilitate the making of complaints. It is notable that none of those who make complaints to the Inquiry about their time in Hydebank, used any of those complaints mechanisms.

Avenues of Complaint for Inmates

554. The Department submits that there were a number of avenues available to inmates at Hydebank had they wished to make a complaint. As Mr Murray makes clear in this statement (HYD-483):

"Upon committal, inmates were advised that they had the right to see a Governor on request, a member of the Visiting Committee or a visiting representative of the Secretary of State in compliance with Rule 42. Inmates received a copy of the 'Guidance to Prisoners on Committal' (HYD-483). [By virtue of] Para 42 of the YOC rules the Governor shall, at a convenient hour every day, other than Saturdays, Sundays and Public Holidays, see all inmates who had made a request to him.' [That was delegated to junior governor grades depending on their areas of responsibility.]

In addition to the management being visible throughout the Centre, other staff, including Chaplains, Probation or Teachers, Counsellors and Administration staff also had access throughout all areas of the centre."

555. Mr Murray added:

"Inmates could make a request to see a member of the Visiting Committee or an official of the Northern Ireland Office (NIO)at the next visit. [Those] would be made directly with the Class Officer, who would record the request and refer to the Visiting Committee Clerk, who would enter it into the Visiting Committee Journal. Any member of the Visiting Committee on their next visit would be required to see the inmate. Separately, inmates could directly approach members of the Visiting Committee who visited throughout the Centre without referral to prison staff.

All inmates were entitled to write a petition to the Northern Ireland Office, the content of which could not be censored by the establishment.

Inmates were [also] entitled to make direct representation to Members of Parliament."

556. Therefore, from their arrival at Hydebank, prisoners were advised of their rights and how to exercise them. The Inquiry will be aware that complaints would also be recorded in the Governor's daily journal. The example of Mr Murray's at HYD-495 to 498, shows allegations he recorded in 1986. It can be seen that allegations against staff members were recorded when made.

557. Mr Murray states that there was never an unwillingness on the part of people in Hydebank to complain:

"I can assure you if they had something to say, they had no reservations about saying it. I mean these were young people who had limited respect for authority, who were very much -- what is the word for it -- very disturbed in their own right, but also people who were very clearly individuals and people who very clearly had a view and if they had a comment to make, they had no hesitation in making it. They had no fear in speaking openly." (transcript day 159, Page 160)

558. The Secretary of State appointed the Visiting Committee, an independent body of individuals, who could visit at any time, but met at least once a month at the centre, and provided an annual report to the Secretary of State.

559. As Mr Murray stated above, inmates were made aware that they could complain to the Visiting Committee. They were also made aware of this fact on a frequent basis (HYD-12412), and were generally aware of their role (HYD-12442). Mr Murray

recalled in his evidence to the Inquiry that in the course of a week he would expect a member of the Visiting Committee, either as an individual or a group, to come into the prison unannounced at any time during the working week (transcript, day 159, page 156). They had the freedom to walk along wings and choose where they went. There was nowhere off limits to them. They would also routinely visit the punishment/segregation unit and the medical centre.

560. It is clear from the evidence received by the Inquiry that the Visiting Committee was very active in Hydebank. The available documentation reflects a high level of activity by the Committee. They had access to all areas of the institution, and spoke widely with the young offenders to receive complaints. As Mr Murray said during his evidence to the Inquiry:

"They would never have went on a conducted tour. They would never have been accompanied and they would have valued that significantly, their independence, and they made it very clear that they were independent and wouldn't be accompanied. They were extremely conscientious. … I would have attended … the monthly meeting to account for issues that they may have discovered during their unannounced visits or during their scheduled visits." (transcript day 159, page 155)

561. The minutes of the monthly meetings of the Visiting Committee demonstrate how allegations against staff were handled. At HYD-11653, there is mention of how an inmate had complained of assault by officers. During the Governor's inquiry into the incident, the inmate changed his story and said he injured himself. Despite this, the Governor called in the local police to investigate fully and suspended the 3 officers from duty.

562. HYD-12480 provides an example of an inmate specifically requesting that the Visiting Committee attend with him. In this case, he wanted to complain that his loss of remission was too severe and that he was not given full credit for his time on remand. These issues were then investigated by the Visiting Committee.

563. The minutes show that the Visiting Committee often made a point of visiting the prison hospital and also speaking to those in solitary confinement. At HYD-12945, it can be seen that the visiting members spoke with two inmates who were not afraid to complain to the Committee of victimisation by staff and their complaints were noted.

564. At HYD-12884, the Chair of the Visiting Committee enquired into an allegation of assault on an inmate. It was confirmed that the matter was in the hands of the police. It is submitted that this is another example of complaints being dealt with appropriately, and the rigour of the Visiting Committee in checking on their progress.

565. At the other extreme, the Visiting Committee received complaints about the supply of deodorant and disposable razors (HYD-12390) – an example of how prisoners were not afraid to speak to the Visiting Committee about even more mundane matters.

566. Mr Murray's Governor's Journal from 1986 provides further examples of how complaints were dealt with at Hydebank. These entries are summarised in Mr Murray's statement at HYD-469. These show that allegations of assault by officers were taken very seriously, leading to internal investigations involving the interviewing of staff and inmates and referrals to the RUC. NIO was also routinely informed.

567. In one particular instance, on 10th October [redacted] HB 21 was medically examined following allegations of an assault by officers. An inquiry followed the following week, during which prison officers, other inmates and HB 21's parents were interviewed. The findings of the inquiry were forwarded to NIO. HB 21 did not make a formal complaint on his allegation against staff and refused to participate fully in the subsequent investigation. Despite this, an investigation continued and as stated by Mr Murray: "*The requirement to carry out an investigation into any circumstance within the Centre remains the responsibility of the Governor irrespective of whether a member of staff or an inmate decides to co-operate."* (HYD-497)

568. These examples show not only that allegations were received from prisoners and properly investigated, but that management did not allow matters to rest simply because a prisoner retracted a complaint.

HM Chief Inspector of Prisons

569. Her Majesty's Chief Inspector of Prisons (HMICP) inspected Hydebank in 1982, providing a report in December 1983 (HYD-502). Mr Murray stated that visits by HMICP lasted almost a week and the inspectors could go as they wished and speak to whoever they wished. They were not accompanied.

570. In the general conclusions of the report, it was stated:

"*Our inspection of Hydebank Wood revealed an establishment of which the Northern Ireland Office can be justly proud. It fulfils its functions well, and while the regime is brisk and purposeful it is also caring. This is always a difficult balance to achieve, but especially so given the stresses that exist in Northern Ireland.*

In summary we concluded that the Governor and the staff had succeeded in establishing a humane new Centre with an imaginative and purposeful training regime in very difficult conditions. They are to be congratulated". (HYD-518)

571. A further inspection took place in 1994, with the report published in May 1995 (HYD-1595). The report stated:

"there was a clean, safe environment for inmates at Hydebank Wood. Individual appearance was smart, enhanced by the fact that inmates were allowed to wear their own clothing. Demeanour towards staff and visitors was invariably polite. Officers adopted a formal yet friendly approach. The ratio of staff to inmates was undoubtedly high but was used to good effect. The buildings allowed for good supervision, as each house had 4 landings containing 15 young men". (HYD-1649)

572. The report also stated that "*there was comparatively little bullying. We heard from an inmate who had experienced custodial life in both Ireland and England, that he preferred Hydebank Wood*". (HYD-1649)

Allegations Made by Complainants to the Inquiry

573. The Department is not in a position to comment directly on the actual circumstances which have given rise to the individual complaints before the Inquiry. However, it wishes to make the following general observations.

Reception Unit

574. HM Chief Inspector of Prisons found that the Reception Unit was *"housed in clean and airy premises where the staff carried out the reception procedures quickly and efficiently with due regard for the dignity of the inmates."* (HYD-11201). This is in contrast to the claims of abusive treatment raised by HIA 373.

575. HIA 373 has also alleged that he was forced into a cold shower. Mr Murray has indicated that this should not have been the case. He stated, "*The shower should*

have been hot water, given the boilers are in operation 24/7. I cannot explain why this would have been a cold shower." (HYD-490)

576. HB4 denies slapping HIA 373 (HYD-2870). In addition, Mr Murray described HB4 as a "*well-respected*" officer."

Clothing

577. HIA 373 complained about the clothing that was issued to him. He referred to being compelled to wear a red polo neck and "*paper jeans*" and suggested that this uniform was designed to mark him out. HIA 253 also mentioned a red jumper and flared jeans that were given to embarrass inmates.

578. The Inquiry is referred to HYD-1465 which is a note to prisoners from 1982 stating that "*all prisoners will be permitted to wear their own clothing at all times … Prisoners who are either unwilling or unable to prove clothing for their own use will be provided with official-issue clothing*".

579. Max Murray recalled that, "*At this time, inmates were permitted to wear their own clothing across the Northern Ireland Prison Service establishments*." (HYD-490)

580. HM Chief Inspector of Prisons found that, "*The inmates were issued with sweaters and jeans, which were popular, serviceable and well cared for*." (HYD-11201). Presumably, this was the clothing issued by the institution if the inmate did not wish to provide his own clothing.

581. The Department cannot confirm or deny the description of the clothing given by HIA 373 or HIA 253, but it is submitted that his opinion that the clothing marked him out and undermined him is entirely subjective and not in keeping with the findings of HMCIP.

Willow House

582. HIA 373 and HIA 275 have alleged that the regime was strict. HIA 434 explained that there was an emphasis on neatness and cleanliness.

583. The Department accepts that there was a focus on discipline at Hydebank, but Mr. Murray explained that it was not designed to break the spirit. It did, however, require inmates to conform to the institution's structure (HYD-491).

584. HIA 373's claims that HB5 assaulted him on a daily basis in Willow House are thought unlikely by Mr Murray who recalled that he was a "*professional*" officer who attracted no complaints about his performance (HYD-490).

Daily Life / Regime

585. The Chief Inspector of Prisons noted Hydebank's regime as "*a brisk regime with particular emphasis on education and training, physical and vocational, and to provide a staged system of progress through the house system to the pre-release unit."* (HYD-512)

586. HIA 373 stated that he was locked up for 16 hours a day, everyday. This was not the regime found by HM Inspectorate in their report.

587. HIA 373 also stated that cells were wrecked on a daily basis by staff. In addition HIA 253 mentioned staff wrecking cells if the cells were not clean and tidy.

588. However, this was not the experience of Mr. Murray (HYD-491). He recalled that there was an emphasis in the regime on tidiness and good order, but he had no experience of prison officers gratuitously upsetting the cells in the manner described by HIA 373 or HIA 253.

589. HIA 434 complained of having to shave every day despite his skin condition. Mr Murray explained that being clean-shaven was a requirement for inmates at Hydebank. The evidence shows that HIA 434 was, however, released from the obligation to shave every day, on medical advice (transcript day 153, pages 126-127). This suggests that the regime at Hydebank was flexible and sensitive particularly where medical conditions had to be taken into account.

Food

590. The Red Cross visit in 1989 found the quality of food to be good and the Chief Inspector of Prisoners found the standard of catering to be *"good with varied menus and consistently well-prepared and wholesome food*" (HYD-11202). These findings are again contrary to the claims of HIA 373 and HIA 434.

591. Mr. Murray stated that food was important to prisoners and that there were few, if any, complaints about food during his time in Hydebank. He asserted that if there had been any issues about food he would have known about them. He went on to

say, "…*there are two things prisoners value. One is his visits - the other is his food. Mess around with any of those and you're going to have problems…"* (transcript day 159, page 129).

592. It seems implausible that the prison authorities would have permitted the standard of food to deteriorate to the extent suggested by HIA 373 and HIA 434.

Physical Abuse

593. HIA 373 and HIA 275 have claimed that they were the subject of multiple physical attacks from staff and were aware that other inmates were similarly treated. HIA 253 stated that inmates sometimes got slapped for indiscretions. HIA 373 categorised the physical abuse from officers as "*systemic*".

594. It is strongly denied by the Department that physical abuse from officers was "*systemic*" at Hydebank. It is submitted that this is simply not reflected in any way by the number of complaints actually received by the Inquiry, having regard to the numbers who would have passed through Hydebank.

595. The suggestion that Hydebank operated a brutalising regime is also inconsistent with the findings contained in the reports of the Red Cross or HM Prisons Inspectorate. It is of course clear that inmates made allegations of physical assault from time to time. The Department does not seek to suggest that no prison officer ever acted inappropriately in his dealings with prisoners, but it is also clear that any allegations or complaints of physical abuse were dealt with by management through investigation, referral to the police and in appropriate cases, suspension of staff.

596. Mr. Murray, is in his oral evidence to the Inquiry, stated:

"If there was the level of systemic violence that is perceived here or quoted here [by those complaining to the Inquiry], we would have been dealing with major riots and major concern of acts of indiscipline every day. The young people we were dealing with in Hydebank in those days would not have countenanced that type of behaviour … It would just be totally unacceptable." (transcript day 159, page 136)

597. HIA 373 stated that a prisoner who barricaded himself into his cell was beaten by prison staff with batons, trailed down a stairway so that his head bumped off the steps and hidden in the punishment block until he recovered from his beating. (transcript day 156, page 58)

598. It is worthy of comment that HIA 373 did not provide any pertinent detail to support this extremely serious allegation. He was unable to name the prisoner involved, the prison staff allegedly involved, when the incident took place, or where it took place. He provided no account to explain how he was able to see everything that allegedly occurred. It is submitted that his lack of detail casts doubt on his allegations. In this context it is significant that Mr Murray was able to explain that batons were not in service in Hydebank.

599. The Department submits that if the regime was truly as espoused by HIA 373 and some of the other complainants, then there would have been a multitude of complaints from those resident at Hydebank, if not to the Inquiry, then to other agencies. This was clearly not the case.

600. The Department recognises that, on occasion, physical restraint was required. The Inquiry is referred to the statement of David Dowds at HYD-1674 in which the history of control and restraint policies in Hydebank is discussed. It highlights that since the opening of Hydebank, the Prison Service has continued to review its polices and guidance on the use of control and restraint by staff. Staff training has developed as has record keeping associated with the use of control and restraint.

601. HMCIP found in 1994 that control and restraint techniques were being used sparingly (9 times in 10 months) and over 70 staff had been trained (HYD-2572). There is no documented evidence of direct complaints about the use of control and restraint in Hydebank relating to the period relevant to the Inquiry.

Medical Care

602. HIA 373 questioned the quality of medical treatment. Mr Murray stated that Hydebank had very high quality medical staff. This was reflected also in Red Cross inspections in 1989 and 1992. The Chief Inspector of Prisons in 1982 found that medical staff worked with "*dedication and enthusiasm* "*and that in all we considered that the standard of medical care provided to inmates was excellent*." (HYD-511)

Legal Advice

603. HIA 373 stated that he was advised by his solicitor that there was no point in lodging a complaint as "*That's Hydebank for you*". The Department submits that this does not seem credible, and that if the events claimed by HIA 373 were taking

place, he would have been advised to bring legal proceedings. Despite the complaints made by HIA 373 in his evidence to the Inquiry, he has never made any complaint to police, or pursued a civil claim against the Department.

Sectarianism

604. HIA 373 alleged that sectarianism from staff was a feature of the environment which he experienced in Hydebank. Mr Murray stated that he was not privy to or saw or otherwise was made aware of any type of sectarian type behaviour by staff to anyone, including the inmates (HYD-493).

Sexual Abuse

605. HIA 373 stated that a friend of his alleged that he had been sexually abused by a senior officer and that he knew of others who were sexually abused. He did not name any of these individuals other than one who is deceased. The Department is unaware of any direct evidence tending to suggest that any sexual abuse took place and Mr Murray was never made aware of any sexual allegations (HYD-493). No complainants have come forward to the Inquiry alleging that they were sexually abused during their time at Hydebank.

Education

606. HIA 373 stated that there was no system of education in Hydebank. The Department submits that this was simply not true and is not reflected by the Chief Inspector of Prisons' inspection of the institution:

"Education staff integrated into the life of the establishment, involved in several separate education schemes, day time education known as the Youth Ways programme, evening classes, both recreational and in support of vocational courses, a separate programme for boys in the remand unit and an innovative social skills programmes." (HYD-11204)

607. Furthermore, there were vocational training courses covering, amongst other things, bricklaying, hairdressing and catering. Inmates could acquire City & Guilds certificates. The Physical Education Department involved the inmates in the football team, adventure training in the Mourne Mountains and the Duke of Edinburgh Awards Scheme.

Bullying

608. HIA 373 alleged that bullying was a feature of Hydebank. Annual reports show that adjudications were given for bad behaviour, including bullying, which would tend to indicate that bullying behaviour would not have been tolerated by staff. The Inquiry is also referred to the HMICP report from 1995 referenced earlier that stated "*there was comparatively little bullying".* (HYD-1649)

Searches

609. HIA 373 complained that inmates were searched before and after visits and that this was unnecessary as not a single piece of contraband had ever been found. Mr Murray explained that this was standard operating procedure and continues today. He confirmed that contraband is found on searching (transcript, day 159, page 116).

610. The Department submits that searching in association with visiting time is a proportionate policy to prevent contraband entering the prison, as said contraband can have serious implications for the health and safety of inmates and staff alike.

Summary

611. The Department believes that it is significant that Hydebank was the subject of regular and rigorous scrutiny by multiple organisations, including the independent Visiting Committee, the International Committee of the Red Cross and HM Prisons Inspectorate. The reports of these organisations highlight that Hydebank was a well-run, disciplined but altogether humane institution.

612. The allegations raised by the few applicants who have complained about their experiences in Hydebank are not reflected in the findings reached by any of these distinguished bodies, and nor are they consistent with systemic abuse.

Section 6: Summary of Key Submissions on Behalf of the Department of Justice

Generally

The submissions summarised under this section are applicable to each of the four institutions with which we have been concerned in Module 7, namely, St Patrick's, Rathgael, Lisnevin and Hydebank,

- The passage of time, the destruction of documents per destruction schedules and the non-availability of witnesses has acted as an impediment to a full and accurate investigation of many events, practices and policies relevant to the institutions and the Department and which are of interest to the Inquiry.

- Only a very small proportion of those whose circumstances caused them to be placed into the care of the juvenile justice system institutions during the period relevant to this Inquiry have raised any complaint of abuse arising out of their experiences in that system, and a smaller number again have brought forward complaints to this Inquiry.

- Only a very small proportion of the very many people who have worked within the juvenile justice system have been implicated in the complaints which have been made, whether to the Inquiry or to other agencies.

- Many of the complaints which have arisen from those who have experienced the juvenile justice system do not allege direct abusive conduct on the part of staff employed within that system. Rather in some cases their complaints raise concerns about peer sexual or physical abuse, abuse by persons not employed in the juvenile justice system, or involve complaints about the application of policies, practices or procedures of the institution.

- The institutions furnished residents of the juvenile justice system with many vehicles by which they could have registered contemporaneous complaints about their treatment but there were very few such complaints.

- Where a complaint is made to the Inquiry for the first time, the absence of a contemporaneous report or complaint coupled with the passage of time is likely to impair the quality of the evidence available to the Inquiry when considering that

complaint. It may also have the effect of depriving the institution or the person(s) implicated in the complaint, of the evidential advantages which might have flowed from an earlier report.

- Very few of the complaints received and investigated by the Inquiry have ever been tested in a court of law, and some of the complaints received and considered by police have been viewed by the police with some scepticism and have not met the test for prosecution.

- The work of the overwhelming majority of staff who served within the juvenile justice system was targeted at ameliorating the difficulties faced by children within their care, who often presented with very challenging behaviours, and the work of the staff was generally characterised by a generosity of commitment and an abundance of care and skill.

- The services available to children within the various juvenile justice settings were regularly excellent, well-resourced and often innovative and ground breaking.

- The Department (MOHA and NIO) ensured that the juvenile justice institutions were the subject of frameworks of supervision and regulation, and that they had the benefit of professional systems of advice and assistance to inform improvements in practice.

- It is accepted that on occasions persons employed within the juvenile justice system departed from the high standards set for them and let down those children in their care. Regrettably, in a small number of cases abuses will have occurred.

- The entrenchment of the Training School Rules coupled with the advice and inspection arrangements from time to time in existence represented a robust regulatory system

St Patrick's Training School (SP)

- While the Department (MOHA and NIO) provided financial support, SP was afforded a high level of autonomy.

- St. Patrick's was adequately sourced by the State.

- The Department provided additional funding as and when required. The resources and facilities at St. Patrick's were regarded as very advanced when it opened on the Glen Road site, and in later years funding continued to be provided for refurbishment and additional services.

- While documentary records are not available for much of the period under consideration, it is clear that inspections were being carried out on a regular basis at St. Patrick's by the Ministry and later by the Social Work Advisory Group (SWAG) and the Social Services Inspectorate (SSI).

- There were few, if any, contemporaneous complaints. The inspection regime, social workers and other staff present did not raise any concern for the Department at this time. There is no independent corroboration for any of the complaints which have been advanced before the Inquiry. With the exception of DL 137 (see further below), no member of St. Patrick's staff has been convicted of any offences in relation to children cared for at St. Patrick's.

- The enactment of the Training School Rules set out the clear structures and standards to be followed by the management and staff of St. Patrick's in relation to the care of the children placed under their control, and this was supported by a system of inspection.

- Before an unspecified point in or about the mid-80s there was a failure to report suspicions of peer sexual activity

- Regrettably, persons in authority at St. Patrick's did not always act in the best interests of the children who had been placed under their care and control (note: this submission is connected to the following three incidents).

- When Bernard Teggart and his brother were abducted from the school premises by paramilitaries, there was a failure to raise the alarm by notifying the police or informing the Department. Bernard was interrogated by the IRA and murdered. The absence of documentation precludes a comprehensive analysis of the steps taken by the Department(s) in response to this incident.

- When complaints first emerged that DL 137 [redacted]) was attempting to sexually abuse children resident in the school, he was given a warning. Later, when complaints were made that he had engaged in acts of sexual

abuse on boys, he was compelled to resign from his employment. Astonishingly, the school provided him with a written reference, presumably to assist him to find new employment. Furthermore, the school failed to take effective action to address the concerns about him; it failed to notify the police or the Northern Ireland Office of their suspicion that a crime(s) had been committed. It is a matter of record that DL 137 went on to commit serious sexual offences in the community, and he was only much later convicted of offences relating to his activities in St Patrick's.

- When the NIO was notified by police that they were investigating sexual abuse allegations against Br 26, officials acted promptly to meet with the Chairman of the Board of Management (Bishop Farquhar). The Chairman was advised of the police investigation and was told that it was the view of SSI that in the interests of child protection, the Board should place BR 26 on precautionary suspension pending the conclusion of the investigation. It was a source of disappointment and concern to the NIO that the Board choose to disregard that advice and Br 26 was maintained in post. However, having regard to the nature of governance relationship with the Board of Management, the NIO had taken all of the steps that were within its limited power to take to ensure that child protection principles were given primacy. The NIO took all necessary steps which were within its power to take at that time.

Rathgael Centre

- The Rathgael Centre was well resourced and provided a generous array of services and amenities to the children placed there

- The use of a separation room or time out room to reduce tension between children or to allow children to calm down was an appropriate method of control and discipline and was not generally abused.

- Methods of physical control and restraint were used to mitigate the effects of volatile or aggressive behaviour from children, and were used as required to separate a child from the group when s/he refused to co-operate. Generally, these methods were used appropriately, although it is conceded that an unacceptable period of time passed before staff were provided with training in relation to control and restraint.

- The use of close supervision units (Shamrock and Fox Lodge) was an appropriate response to the behaviour of the most difficult children. A thematic inspection of

Shamrock carried out by SSI did not raise any concerns about how care was provided in that unit.

- It is accepted that a small number of staff adopted an unnecessarily physical approach with some children. However, some staff who have been accused of wrongdoing in this respect are quite likely to have been using appropriate physical intervention to restrain a child to prevent injuries to staff or other children. That said, the Department unreservedly condemns any member of staff who assaulted any child or who otherwise used unnecessary physical violence towards a child, or engaged in bullying, and the Department apologises to any person effected by this.

- There is evidence before the Inquiry that two members of staff engaged in inappropriate relationships with girls who were resident of Rathgael. [redacted] The Department would emphasise that such relationships, if they occurred, were not acceptable, would have constituted a clear breach of the standards to be expected of a staff member, and that staff members would have been aware of this.

- There is evidence before the Inquiry that some staff members engaged in acts of sexual abuse towards children in their care. It is noted that those who have been able to respond to such allegations before the Inquiry have denied any wrongdoing. The Department has no hesitation in condemning any act of sexual abuse of children where it occurred, and unreservedly apologises for any person effected by this.

- There is some evidence before the Inquiry of peer abuse. However, records show that where this was identified by staff, they were generally proactive in challenging the offender and assisting the victim.

- Management at Rathgael generally adopted a practice of reporting allegations of abuse by staff to police, the Northern Ireland Office and Management Board. In appropriate cases members of staff were the subject of precautionary suspension pending the conclusion of investigations. It is accepted that in a few cases identified by the Inquiry, this procedure was not followed. The Department takes the view that

all allegations of abuse by staff ought to have been reported to police and the other relevant authorities.

- The staff of Rathgael worked effectively to try to prevent absconding. All incidents of absconding were reported to police, and an important initiative was carried forward in conjunction with APRU to identify strategies to address the causes of absconding, with some success. The Department accepts that there was a failure to ensure that the learning which emerged from an APRU study of absconding in Rathgael was shared with the other training schools.

- The Department accepts that although a fire at the Whiteabbey premises had an unhelpful impact on the plans which were in place to move girls to Rathgael, valid concerns have been raised before the Inquiry about the absence of adequate support and training for staff to enable them to manage this change. With the benefit of hindsight it is possible that more could have been done to smooth this transition, but it is clear that staff worked constructively to solve initial teething problems and the mixed gender approach was ultimately viewed as a success.

- The staff at Rathgael were appropriately lauded in a number of reports for their professionalism and their commitment to their work. The Centre engaged in a variety of diversionary work with children, and offered them a range of valuable opportunities which would not have been available to them in the community. The relatively few complaints that have been received by the Inquiry is testament to the fact that this was a well run facility.

Lisnevin Training School

- There is some evidence before the Inquiry that staff too often resorted to use of a separation unit or punishment block and that boys were placed there for lengthy periods of time. There is other evidence that the facility was used appropriately and in a proportionate manner, and was subject to managerial overview. The Department would condemn any inappropriate use of the separation unit, but would submit that on balance the evidence supports the view that it was used to deal with aggressive, violent or destructive behaviour, and that the vast majority of boys who were sent there were detained for short periods of time before being reintegrated into the group.

- Methods of physical control and restraint were used to mitigate the effects of volatile or aggressive behaviour from children, and were used as required to separate a child from the group when he refused to co-operate. Generally, these methods were used appropriately, although it is conceded that an unacceptable period of time passed before staff were provided with training in relation to control and restraint.

- There is some evidence before the Inquiry that some members of staff adopted an unnecessarily confrontational and physical approach with some children, including inappropriate use of control and restraint. Those allegations were not accepted by the one former member of staff with “on the ground” experience, who gave oral evidence to the Inquiry. He explained that sometimes it was necessary to physically intervene to restrain a child in order to prevent harm to others. The Department unreservedly condemns any member of staff who assaulted any child or who otherwise used unnecessary physical violence towards a child, and would offer sincere apologies if any person suffered in this way.

- There is evidence from two complainants that staff engaged in sectarian conduct towards them. However, other evidence suggests that sectarianism was a limited problem in Lisnevin, and it only occurred in name calling between the boys, and that staff did not engage in such behaviour. Indeed one former resident suggested that staff were quick to clamp down on sectarianism between the boys, and there is documentation to suggest that this was their approach. The Department would unreservedly condemn any sectarian behaviour on the part of staff, if it occurred.

- There is some evidence before the Inquiry of peer abuse. However, there was some evidence before the Inquiry to show that where this was identified by staff, they were proactive in challenging the offender, monitoring the situation and assisting the victim.

- The Lisnevin facility provided the first non-denominational, secure training school in Northern Ireland. There is evidence before the Inquiry that some of its work, particularly in the early years was innovative, supported as it was by an enthusiastic and committed staff, and was well resourced. The Department accepts that valid concerns have been raised about the quality of planning that preceded the movement of the facility to the Rathgael site, and about the appropriateness of using a former Category C prison as a training school.

Hydebank YOC

- Management adopted an open and transparent approach, and welcomed inspections and visits from a range of organisations including the International Committee of the Red Cross and HM Prisons Inspectorate. In the main, they reported positively on what they found. The allegations made by the few complainants who have come forward to the Inquiry are not reflected in the reports of these organisations.

- The Visiting Committee was actively engaged with the Centre, and were generally afforded access to any area of the Centre, without notice. In their work, members of the Visiting Committee showed a preparedness to engage with prisoners, to take issues up on their behalf and to seek continuous improvement. They did not indicate that abusive behaviour by staff was a particular problem.

- There were multiple avenues by which prisoners at Hydebank could complain. There is evidence before the Inquiry that when prisoners made complaints that they were taken seriously, and that in appropriate cases, the police were notified.

- The complaints before the Inquiry suggest a harsh reformatory regime, in which the requirements of discipline and respect for authority were enforced with physical and mental/emotional abuse. It would be naive to suggest that every member of staff conducted themselves within the rules at all times. However, it is clear that some of the few complaints that have been made before the Inquiry are exaggerated, and the evidence before the Inquiry supports the view that this was a well run, progressive institution.

Concluding Remarks

As the Inquiry is aware, the Department continues to be responsible for the legislative and policy framework of the justice system in Northern Ireland, as well as the resourcing of that system.

How young people are cared for within that system is at the heart of its current and future activities. The Department, therefore, has a keen interest in examining the findings of this Inquiry

Practices in relation to the care of young people in state organisations have changed much over the last 20 years. The Department recognises and welcomes that the findings of this

Inquiry will ultimately provide an opportunity to learn lessons from the past, and that such findings may serve to further improve contemporary systems and policies.