Career History

1. I was employed at Lisnevin Training School from its opening in 1973 until 1983. During that time I was a psychologist providing services to both the assessment unit and the special unit in Lisnevin. Much of the field work for my doctorate (1982) was at Lisnevin where some of the young people in the special unit were subjects. I did not have direct experience of the system or regime at Lisnevin from 1983 to 1995.

2. When I left the training school system in 1983 I joined the Extern Organisation and subsequently became its Chief Executive. I then became Chief Executive of the Youth Justice Agency NI in 2003 and a senior civil servant within the NIO; as such I was a member of the Criminal Justice Board for Northern Ireland. I remained in the position until my semi-retirement in 2010. Since that time I have worked part-time as a forensic psychologist. I currently hold appointments as an independent chairman for Serious Case Reviews conducted by the Safeguarding Board NI. I am also the Deputy Chairman of the National Review Panel (NRP) in the Republic of Ireland. The NRP undertakes reviews of deaths and other serious incidents relating to children in the care system. Prior to that I was appointed by the Minister for Children in the Republic as a child care expert on the Special Residential Services Board/Children’s Act Advisory Board and was appointed by the Secretary of State in Northern Ireland to be an independent member of the Criminal Justice Review, which reviewed, inter alia, the youth justice system in Northern Ireland.
Part ONE: History of Lisnevin

Background of Lisnevin in Newtownards

3. In October 1973, the then Ministry of Home Affairs (MoHA) (later to become the Northern Ireland Office (NIO) and now the Department of Justice (DOJ)) opened a training school, known as Lisnevin Training School, on the outskirts of Newtownards, at the bottom of Bradshaw’s Brae (in an area known as Kiltonga), then the main thoroughfare from Belfast to Newtownards. The name Lisnevin was a term of historical connection to Newtownards and was believed to be one of the old names by which the town was known. Until that time there had been four existing training schools in Northern Ireland: one each for Roman Catholic Boys, Non-Roman Catholic boys, Roman Catholic girls and Non-Roman Catholic girls. Each catered for children aged 10-17 inclusive, who were sent to them under a court order. The four schools were provided and maintained under provisions contained in the Children and Young Persons Act (Northern Ireland) 1968, and were the equivalent to the former “approved schools” in England and Wales.

4. Lisnevin, which catered for boys between the ages of 10-17 years, was the first integrated training school, in that it was non-denominational and had both Catholic and non-Catholic boys. It was established in response to the need for additional facilities to serve the needs of the Juvenile Courts and the existing training schools. At that time it had two separate functions which were catered for by two separate units – a) an Assessment Unit for 20 boys whom the courts considered might be in need of residential training and b) a Special Unit for 20 boys who did not respond to the “open” non-secure environment of the existing training schools (many of these boys would have had an extensive record of absconding from the existing schools; although some were there by virtue of violent or very disturbed behaviour). The annual throughput of the Special Unit was quite small with most boys remaining there for around 15 months. It was normally running at full capacity of 20 boys. The throughput of the Assessment Unit was quite steady. Again it ran at full capacity and I would estimate that it had a throughput of more than 100 boys per year.

5. Lisnevin was built around a refurbished nineteenth century mansion house (which I think had been known as Kiltonga House). It was situated within its own extensive grounds of probably around 5 acres. It had a long driveway from the main road. An 8 foot wire fence had been built around the perimeter of the gardens. This fence was alarmed so that a bell would ring within the main

---

1 Exhibit 1 – MoHA – Development of Lisnevin at Kiltonga - Operational Policy August 1972
2 SPT-100587
3 Exhibit 2 - Lisnevin Training School – SSI Inspection Report 1988, pp??
4 Exhibit 3 – Admissions – An analysis of admission to Lisnevin remand Unit 1985-92
5 Exhibit 4 - Map of Lisnevin
building when anyone touched or tried to climb over the fence. At the entrance
gate there was a sectional building which housed the principal’s office, the
finance/administrative office and a security man, who controlled entrance and exit
to the site through locked gates. To the right of the administrative building was a
separate wooden gymnasium, which was big enough to play 5 aside football in.
Beside this was a purpose built football pitch which had its own perimeter fence.
At the side of the main building was a fenced around tennis court. The gardens
were extensive and well maintained, with a number of specimen shrubs and
trees. There was a large 30x12 heated greenhouse where the boys were taught
horticulture.

6. The main house was three stories high and had been extensively refurbished to
meet the needs of the training school. Living accommodation was on the ground
floor. This had a large common room for the Assessment Unit boys and a similar
sized common room for the Special Unit. There was a staff office adjacent to both
common rooms and a tuck shop across the hall. In addition there was a large
domestic style kitchen which the staff could use for making supper and so on,
plus a sewing room/laundry. On this floor there was a small domestic style
bathroom with a bath in it. This could be used by staff. Opposite was a purpose
built shower/changing room. This had a bank of about 6 open showers and a very
large circular-style wash hand basin at which 6 boys could wash simultaneously.
There were also toilets/urinals and each boy had a wooden locker to store his
day clothes in this area. All boys were expected to shower in this area before
getting changed into their pyjamas in preparation for going to bed. A similar
routine happened in the morning when they would wash and change into their
day clothes. All activities in this shower/changing area were normally supervised
by 3-4 care staff.

7. To the rear of the ground floor building, in what I believe was a single story
return, and approached by a dark corridor, was a bank of 4 (I believe) single
rooms. Each room was no bigger than 6 feet by 8 feet and may have been
smaller. They were sparsely furnished with only a mattress and bedding and had
a narrow reinforced glass strip window, some four foot long by 8 inches wide.
These rooms were used for isolating boys as a form of punishment. They could
be used for as short as a few hours, or for as long as 4 days depending on the
circumstances. If a boy was particularly disruptive in the dormitories he could be
made to sleep in one on his own for a period of time in an isolation room. These
isolation rooms were in a very quiet part of the building and away from any
normal thoroughfare.

8. On the first floor of the main building were the dormitories of the Special Unit. I
think that there were four dormitories of varying sizes to accommodate the 20
boys – probably two six bed and two four bed. These were also sparsely

6 Exhibit 5 - Analysis of removals from class and teachers perceptions of problem behaviours – a paper
produced by APRU 1991 and references to use of separation as a sanction - extracted from board minutes
furnished and had only beds in them. The beds were of a solid wooden construction and mounted on the floor so that they could not be moved. On this floor there was also a staff bedroom. The care and teaching staff took it in turns to staff a rota of “sleeping in”\textsuperscript{7}, for which they were paid an additional fee\textsuperscript{8}. These staff were only woken by the night staff if there was a disruption or emergency. The night staff would have been on duty from 22:00 until 07:30 the next morning and would have stayed awake all night. There would have been at least one night staff member on each bedroom floor, and one on the ground floor. They would have taken it in turns to relieve each other.

9. The top floor had a similar arrangements and layout to the first floor, but had more of an attic feel to it. It provided bedrooms for the Assessment Unit boys. In both cases the bedrooms were only accessed for sleeping purposes and were not in use during the day.

10. There was a large, wide staircase leading to the upper floors. It was “netted” to prevent any of the boys jumping over it. In my memory there were no suicide attempts during the time Lisnevin was in Newtownards.

11. Apart from having reinforced glass windows and the netting on the staircase, the main building had the feel of a large domestic building. There were then two separate wings, made of temporary sectional buildings. The first housed the school with a series of small classrooms and workshops plus some offices for the senior staff. Classes were rarely larger than three or four boys and a full range of subjects were available, including woodwork, metalwork, art, and PE. A highly individualised curriculum based on the needs of each boy was in operation.

12. The second wing housed the dining room and kitchens. On this corridor, but after descending a flight of stairs, was another corridor which housed the nurses/medical room, purpose built dental surgery, social worker and psychologists offices and a large case conference room.

13. Later there were two additional sectional classrooms which were placed outside on their own at the back of the main building. These classrooms were for general subjects.

**Services provided at Lisnevin**

14. The reasons for referral of the boys to Lisnevin differed according to the unit they were admitted to. The Special Unit was designed to cope with those boys, who because of court appearances, for reasons such as non-attendance at school, being in need of care protection and control, and juvenile offending, were already in the care of the existing training schools but who were regarded as being in

\textsuperscript{7} Exhibit 6 – Night staff operational procedures

\textsuperscript{8} Exhibit 7 – National Joint Council for Local Authorities’ Administrative, Professional, Technical and Clerical Services; Scheme of Conditions f Service (8\textsuperscript{th} Edition) 1975
need of more secure conditions. The decision to transfer to secure conditions was an administrative arrangement and agreed by the respective managements of the schools and was not a court decision. Some of the boys had no record of criminal offending before being transferred to Lisnevin.

15. It was a medium to long term facility with boys living in the unit for between nine months to three years, with a median of around 15 months. As I explained in my 1982 thesis by far the most common reason for transfer to the Special Unit was persistent absconding from the open schools (69 per cent), with need of care protection and control the next most common (18 percent) and beyond control (5 percent); other reasons included need of intensive care, special educational facilities and no progress being made in the open school or a combination of these reasons.

16. The opening of the Special Unit met a need which had been apparent since the passing of the 1969 Children and Young Persons Act in England and Wales. This Act abolished the Approved School Order and replaced it with a Care Order under which the young person became subject to the care of the local authority rather than the Home Office. This meant that because of the new legislation it was no longer possible to have “problem” boys removed from training schools in Northern Ireland to the “closed” facilities in England. In the past it had been possible to have a small number of boys, perceived as difficult, transferred to the Special Units at Kingswood in Bristol, Redhill in Surrey and Red Bank in Lancashire. The increase in civil unrest in Northern Ireland since 1969, which had been coupled with an increase in serious juvenile crime, also indicated a need for Northern Ireland to have its own Special Unit.

17. The Assessment Unit catered for a different range of boys. All were remanded by the juvenile courts for assessment after a finding of guilt or a case proven. The reason for the assessment was to assist the courts in deciding on an appropriate disposal. A small number of boys would also have been remanded because of their need for care, protection and control. The main legislation in use was the Children and Young Person’s Act 1968.

18. This time was very rarely extended but did happen on occasion when a young person was charged with a very serious offence, such as murder. A significant number of the boys remanded for assessment were charged with “scheduled” offences relating to the Troubles. Some were charged with paramilitary activity and some with offences, such as riotous behaviour. Around 50 percent were charged with “ordinary” juvenile crime, such as theft, burglary and criminal damage, although some were still there for not attending school or being out of control in a children’s home. Most had already pleaded or been found guilty of an offence and the court was trying to decide on a suitable sentence.

9 SPT-100587
10 Exhibit 8 – Controlled study into the effectiveness of individual client-centred counselling for young offenders in residential care. Chapter 1. Thesis submitted for Doctor of Philosophy by B Lockhart 1982
11 SPT-100587
Assessment on arrival

19. On arrival, a fairly comprehensive assessment process began. This included developing a social profile of the young person and their family. The main responsibility for this fell to a senior social worker, seconded from one of the local Health and Social Services Boards. There was then an educational assessment carried out by the teachers and a fairly detailed psychological assessment carried out by the psychologists. These various reports were then collated and discussed at a multi-disciplinary case conference. From this a final recommendation was made to the courts. Anecdotal evidence suggests that the courts found these reports very helpful. One finding to emerge was that after several years of operation, the Assessment Unit at Lisnevin was recommending that some 80 percent of the boys should receive a community disposal on return to court. This was in stark contrast to the reception units at both Rathgael and St Patrick’s who, after conducting their assessments, recommended that around 80 per cent of boys should receive a Training School Order. This finding ultimately led the NIO to close the Assessment Unit at Lisnevin and set up a day assessment unit at Whitefield House in Belfast. The Assessment Unit staff at Lisnevin moved to Whitefield, leaving Lisnevin operating for a period as solely a Special Unit for approximately two years.

Medical and dental care

20. Lisnevin had a fully equipped medical room of three nurses, and usually at least one was on duty between the hours of 9am and 9pm each day. They could deal with minor medical complaints and ailments. They would have also inspected all boys on arrival and after they returned from weekend or other leave. They would have noted any bruises or other evidence of injury on any part of the body. In addition, a local GP acted as medical officer. He would have visited at least once per week or otherwise on demand. Boys would have had full medicals, especially on arrival. In emergency situations, boys would have been taken to the Accident and Emergency Unit in Ards Hospital.\(^\text{12}\)

21. There was also a full dental room. An outside dentist visited on a weekly basis.\(^\text{13}\) All boys admitted to Lisnevin would have a dental inspection and were given treatment, as required, when there. I remember it being noted that many boys’ teeth were in a poor state when they arrived but in a much better state when they left.

Food and clothing

22. All boys were provided with clothing on arrival by the institution. This was of quite good quality. It consisted of jeans, checked shirt, pullover, suede boots, etc. and

\(^\text{12}\) Exhibit 9 - Incident report - William Turkington taken to hospital for an x-ray on 1974
\(^\text{13}\) Exhibit 10 - Examples of Medical & Psychiatric Care
would not have looked too much out of place in the wider community. All toiletries were provided.

23. Most food was eaten in a dining room. Usually three boys sat at a table with one member of staff. They were served at a table by a member of the kitchen staff. Special diets, could and were catered for. Food was of good quality and nutritious. It was plentiful with extras available on request. Supper and snack meals would have been eaten in the common rooms.

Staff training

24. All staff received induction training on arrival\textsuperscript{14}. There was ongoing staff training \textsuperscript{15} but nothing like the ongoing professional development training available today. There was no training on crisis management or restraint methods during my time in Lisnevin\textsuperscript{16}. Child protection training would have been rudimentary, but was in keeping with that available generally at that time in schools and other services working with children.

Rewards and disciplinary systems

25. For boys in the special unit there was, at first, a weekly points system\textsuperscript{17} which was based on good behaviour or otherwise. The boys could move through different levels, which carried with them increasing levels of reward and privilege. This could include pocket money, trips out and the biggest incentive was weekend leave. Poor behaviour could result in demotion and loss of privilege. Later I introduced a “token system” designed to give more immediate reinforcement of behaviour. The boys carried a card with them which was used after each educational class or recreational activity. The teacher or care worker awarded points after each session. These points could be exchanged for rewards as well as giving the basis for an overall weekly grade, which determined rewards, such as weekend leave.

26. The above was the main behavioural management system\textsuperscript{18}. However, this could be overridden in the event that a boy engaged in more serious behaviour. This included physical violence, absconding, failure to return from leave, smoking illegally and so on. On these occasions, physical separation in an isolation room\textsuperscript{19} could be and was used. This ranged from periods of one or two hours, up to four days. Such sanctions needed to be approved by a member of senior management – senior assistant or above. I cannot envisage any situation where the more prolonged isolations of a day or more were not approved by the Deputy

\textsuperscript{14} Exhibit 11 - Induction procedures 1988
\textsuperscript{15} Exhibit 12 – Staff training and development 1974 - 1996
\textsuperscript{16} Exhibit 13 – Chronology of the development and implementation of control and restraint training
\textsuperscript{17} Exhibit 14 – Control & discipline (1988) Marks system and pocket money; sanctions
\textsuperscript{18} Exhibit 15 - Guidance on the management of situations involving disruption, aggressive behaviour, violence and the exercise of physical restraint as a last resort
\textsuperscript{19} Exhibit 14 - Control & discipline (1988) Marks system and pocket money; sanctions
Headmaster or above. Any sanctions would have been in accordance with the 1952 Training School Rules\textsuperscript{20} in force at that time.

**Corporal punishment\textsuperscript{21}**

27. Physical punishment was allowed, but I cannot remember it ever being used in the Special Unit. Very occasionally it was used in the Assessment Unit, though sanctions such as loss of leave were not available there because of the short length of stay. Fighting or violence could result in caning – this was normally administered by a bamboo cane to the hand by the Head Master of each Unit or, in his absence, his deputy. Any use of corporal punishment was recorded in a “punishment” book. Any other form of physical punishment was not allowed and would not have been approved by senior management.

**Complaints**

28. I cannot remember any official complaints system being in place when Lisnevin was in Newtownards. That is not to say that boys did not make complaints and in my experience they were normally listened to and their complaints acted upon, if appropriate. I remember taking up several complaints on behalf of boys. If warranted, they usually received satisfaction.

29. In Newtownards there was no independent advocacy or visiting system in place. Although not formalized, the young people could have complained to certain people, such as parents, social workers, teachers, solicitors or chaplains.

**Uncertainty and tension in relation to the site in Newtownards**

30. Before it opened in October 1973, Lisnevin had been subject to a Public Inquiry because of the strong objections of the local residents to the siting of a training school in their neighbourhood. The Inquiry decided that the school could open in Newtownards on a temporary basis, pending the building of a purpose built unit at Rathgael in Bangor some five miles away. However, because of changes in the nature of the school, namely the moving of the Assessment Unit to Whitefield House\textsuperscript{22} and the establishment of a Junior Remand Wing (for mainly those charged with scheduled offences) at Crumlin Road Prison, which provided a guarantee that no young terrorist offenders would be housed in Lisnevin, an attempt was made to have the school sited permanently at Lisnevin. I recall that in the first year of its opening there was, in fact, an attempt to free a boy charged with terrorist offences from Lisnevin\textsuperscript{23}. Armed men entered the building, held staff at gun point, relieved them of the keys and locked them in an office and made off with the boy. They were soon apprehended at a police roadblock set up at

\textsuperscript{20} SPT-80063 – SPT-80073
\textsuperscript{21} Exhibit 16 – Corporal punishment in Lisnevin – references found in Management Board minutes
\textsuperscript{22} Exhibit 17 – Newspaper cutting - 1987
\textsuperscript{23} Exhibit 18 – 1973 Board Minutes, para 9
Dundonald, as they omitted to take the keys from one of the staff members and the alarm was quickly raised.

31. At the second Public Inquiry in November 1978, the neighbours maintained their objections concerning threats of having a training school for difficult offenders sited in a residential area. As a result, the report of the Inquiry recommended that as the role of the school had not changed substantially and it still had its share of “dangerous and thoroughly aggressive boys” it should be discontinued at its present site. It was recognised in the report that the need for a secure training school or similar unit still existed in Northern Ireland.

32. It should be noted from the above that Lisnevin at Newtownards always functioned under a degree of stress and uncertainty. The temporary nature of some of the buildings were far from ideal. The feelings of pressure on the staff and boys because of the uncertain nature of the school were at times almost tangible and were certainly detrimental to the smooth running and emotional security of those in the school. 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 otherwise would have been highly unlikely. Certainly compared with later frictions when Lisnevin moved to Millisle, this period could be described as “nirvana”. My memory of it was of a happy place where staff and young people got on well. On many occasions I have met boys in later years who were in Lisnevin in Newtownards and their memories were mainly positive.

Philosophy under which Lisnevin in Newtownards operated

33. The philosophy under which Lisnevin operated is described in an unpublished staff handbook, which was made available to staff during training before the Special Unit opened. It made it clear that the aim of Special Unit was treatment rather than punishment. A quotation from this handbook under the question: What is a Special Unit? stated as follows:

The Unit is special in so far as the treatment we offer is special and we are dealing with children whose needs are both special and individual with the result that our staff have special qualities required to understand, treat, and relieve the pressures which are causing their severe maladjustment.

The building itself is special in that it is unobtrusively secure, relieving the worries of absconding both from our children and staff. Security is in this sense a positive factor which affords the staff the opportunity to operate the full treatment programme without the additional worries of absconding and affords the children the opportunity to receive treatment for the first time, without the temptation of absconding because of fear or sheer habit. In this sense we are special and thus need special staff with ability to give all and expect little in return.
The document goes on:

Our primary aim would appear to be the establishment of a relationship with each individual which will be meaningful and based on friendship, respect and kindness on both sides...

Once our primary aim is achieved we must then encourage our children to establish relationships with each other and invisibly guide them towards eventually helping their fellows. Through these delicate manoeuvres we can therefore hope to readjust our children towards a society dependent on such relationships so that one day he can become an adult who can give a security and love to his children, family and friends which he probably never received.

34. The clear assumption from the above was that the primary aim was one of establishing relationships so that children with a deficit in forming relationships would learn to develop these skills through modelling by staff.

Staffing, recruitment and organisational structure

35. There was a publicly advertised recruitment process for the new staff in Lisnevin. This meant that many of the staff in Lisnevin were new to residential care. This had a number of positive aspects. While many of the care staff were unqualified they were open to training and new methods. Most of the teaching staff recruited would have come from mainstream schools, and few, would have had a background in special education. However, some staff were recruited from the existing training schools. At least five came from St Patrick’s Training School. Three of these were teachers/craft instructors and were appointed to the management team in Lisnevin: (Headmaster of the Special Unit); Denis O’Brien (Deputy Headmaster of the Assessment Unit); and Pat Barry (Senior Assistant/team leader in the Special Unit). Of the five, three had been brothers in a religious order but had since left it. My understanding was that in each case it was the De La Salle Brothers who ran Kircubbin and St Patrick’s.

36. Similarly a number of staff had worked in Rathgael. The Principal had been a senior manager and teacher in Rathgael. The Headmaster of the Assessment Unit had been a teacher in Rathgael and the Deputy Headmaster of the Special Unit was a psychology graduate and care worker in Rathgael. The senior management team was made up almost exclusively of teachers, although Dennis O’ Brien was seconded to go off to do a residential social work qualification in England. He left some years later to join the Social Work Advisory Group (SWAG) in the Department of Health and Social Services.

37. Many of the staff were recruited in the spring of 1973, some 6 months before Lisnevin opened. This afforded the opportunity to undergo staff training and most had placements in the existing training schools or other children’s homes.
38. There were quite a number of other staff employed in Lisnevin apart from teachers and residential social workers/ housemasters/ care workers. These included three qualified nurses, a visiting GP, a visiting Psychiatrist (at first Dr Ray Moffatt and then Dr. McAdam, based in DHSS), a visiting dentist, two resident psychologists, a seconded senior social worker from a Health Board, a cook, assistant cooks, a matron and assistant matron, cleaners, two gardener handymen, administrative staff, two gate men and a team of unqualified night staff.

39. An organisational structure and staff names in 1973 (to my memory) is contained in appendix 1. The SSI Inspection in 1988 provides information in relation to management and staffing levels then\(^{24}\). Extracts from Board minutes in relation to staffing are also provided\(^{25}\).

**Governance issues and relationship with NIO**

40. My memory was of a very good relationship with the Training School Branch in the Northern Ireland Office. They were helpful and supportive at the time, visited frequently and took a real interest. The Assistant Secretary was Ronnie Stirling and the Principal Officer was Brian Lorretto. Both were good men and very caring.

41. The Board of Lisnevin consisted of an independent chair (a Mr McReynolds and later Mary Clarke), appointed by the Secretary of State, and nominees from the other training schools. I would have had little confidence in the Board as members did not appear to act in the best interests of Lisnevin but appeared to see themselves as representing their respective training schools on the Lisnevin Board. There often appeared to be a sense of competition.

42. Lisnevin was also subject to both inspections and regular visits from the Social Work Advisory Group (SWAG) of DHSS. My memory is that inspections would not have been anything like they are today and were much more informal. A number of individuals from SWAG visited Lisnevin. It is my opinion that relationships were generally not as professional as they should have been to be truly objective, although some were an exception to this.

43. I also remember being supervised by a Psychologist called Smart from the Department of Education. He was an educational psychologist and visited several times per year. I believe he also had some sort of inspectorial function for education in Lisnevin, as he was part of the education inspectorate.

44. I have added appendix 1 about the staff management structure and daily timetable when Lisnevin was in Newtownards.


\(^{25}\) Exhibit 20 – Staffing issues from Board minutes 1973 - 1987
The background and history of Lisnevin in Millisle

45. The move to Millisle (September 1980) was to mark a major change in the culture and management of Lisnevin. As noted above, the original plan was to move to a purpose built site at Rathgael in Bangor. Why this change to Millisle happened I am not sure. It may simply have been that a vacant site became available when the Borstal closed in Millisle and the Young Offenders’ Centre opened in Hydebank. In any event, the building which had been designed as a Category C prison was totally unsuitable to house children. The environment changed completely and with it the culture.

46. From the outset staff were against the move. At this time there was a change in relationship with the Training School Branch in NIO. Wesley Pugh had become the Principal Officer of the Branch. His style was completely different than his predecessors. He visited the school frequently and it is my view that he took greater involvement in the running of the school than his predecessor.

47. The actual planning and implementation of the move from Newtownards to Millisle was, in my view, a disaster. I remember arriving down on the day of the move and finding the boys in a bare common room with no chairs, tables or television. I, personally, had to organise some of the care staff to go and look for the brand new chairs, which we found in a room above the gatehouse. We had to carry the chairs through the building to the common room. We found the television but it could not be connected to the outside aerial. I had to go down to an electrical shop in Millisle and buy a connecting lead to give the boys access to television.

48. There were many other problems with the move. When I was involved in the planning of the Juvenile Justice Centre at Rathgael to the newly built adjacent site around 2007 it was the subject of meticulous planning and change management. It took months to plan and involved almost all the staff in planning groups. By contrast, little planning appeared to have gone into the move of Lisnevin.

49. Another happening, which is scarcely credible, was that it took from September until the next May before the school resumed in Millisle. The teachers had decided that they would have to redesign the whole curriculum and took that time to do it. In the meantime a culture of the boys sitting watching television during the day emerged.

50. The move to Millisle was only about 10 miles but it might have been a million. Millisle was much more isolated from a public transport perspective. There were few direct buses from Belfast to Millisle and even fewer going on down the coast past Lisnevin. This made it very difficult for parents and families to visit the boys. It took much longer, was more expensive and often meant changes of bus and a walk of at least a mile outside Millisle. Similarly, it had a big impact on the number of home visits made by staff. Psychologically, Millisle seemed more isolated and being locked in the building had an adverse impact on staff.
51. At first, staff were not given keys to get out into the outdoor enclosed grounds and playing pitches. Only the senior assistant on duty had keys. This meant if the staff member wanted to take boys outside into the fresh air they had to wait until the senior assistant was ready to let them out. When they wanted in again they had to knock at doors and windows to attract attention. If the rain came on everyone got soaked. It could sometimes be as long as half an hour before entrance could be achieved. This put off both staff and boys from wanting to go outside for fresh air and exercise. The building had been designed for a large number of prison officers to control security and assist with exiting and entering the building. I remember being told that in borstal days it required 16 officers to be on security duty. This was replaced at Lisnevin with one gateman controlling the front entrance. There was a “glazed security hub” on each floor which was designed to be locked and staffed by prison officers. It had alarm systems and call bells from all the cells. In the Lisnevin days it was left unlocked and staffed by care staff, who often walked away to do other things. This meant that alarm bells and call bells were frequently left unanswered. This could be very frustrating to some of the young people when they rang the call bell from their single bedrooms. Many suffered from anxiety and poor emotional control.

52. I remember complaining about not having a key to the outside on several occasions. I found it very claustrophobic and was also worried that if a fire was to break out, I and others would not be able to get out of the building. Eventually it was agreed that all staff would be given keys to the outside secure grounds. This helped alleviate a lot of worries.

The nature of the building at Millisle

53. The building at Millisle was a fenced off site of several acres within what had been the open borstal estate at Woburn House. The site still housed a number of prison officer families and overall it was very secure. At first Lisnevin shared a common entrance to the site with the prison authorities. The front gate was staffed by prison officers. The level of security could be irritating to both staff and visitors. Some years later a separate entrance and driveway was built for Lisnevin using a side road. This allowed direct access to the Lisnevin carpark.

54. The Lisnevin site was enclosed by a high security fence – some 15 feet tall with razor wire on the top. In it were the main buildings, workshops and a number of full sized football pitches. Some years later a purpose built ropes course was built in the grounds. Very few outsiders came into the grounds for sporting activities, although I remember on occasion a church youth club was invited in to play football against the boys and were then invited to stay for super.

55. The main building housed the bedrooms, classrooms, common rooms, dining rooms and kitchen. It also had a good sized gymnasium attached to it. This could be used for playing 5 aside football and so on. The building was redbrick and had two floors which were largely identical. There were a lot of corridors in the building, which had barred gates at various intervals. This made it very prison
like, although most of these corridor doors remained unlocked when Lisnevin
took the building over. It was still a very secure building. Most windows were
narrow slits with bars and very few of the windows looked out to the outside
world. Most, in my memory, looked into internal courtyards. Toilets and ablutions
were very Spartan. They afforded little privacy, with toilet doors being only half
the normal height. The boys had separate single rooms in wings off the main
floors. At first Lisnevin used only the top floor of the building for sleeping,
education and recreational purposes. They did eat downstairs, where the kitchen
and main dining room was. There was a punishment block (sometimes referred
to as “Scrabo”), with, in my memory, 6 single cells and a small office. It was in a
very isolated part of the building on the ground floor. I choose to locate my office
in the punishment block because it was quiet. At first the punishment cells were
used solely for storage purposes. But within a year all the cells were brought
back into use for punishment and isolation purposes.

**Staffing issues at Millisle**

56. The bulk of the staff working in Newtownards made the move to Millisle. The
staffing complement remained much the same. One unusual feature of Lisnevin
was that each summer the bulk of the staff went on annual summer leave – this
applied particularly to the teachers who wanted normal teaching holidays. School
was thus suspended during July and August. Care staff also went on leave during
this period. This meant that instead of a staff of 8 care and teaching staff (plus
senior assistant in charge of team) only around two of the permanent staff were
on duty on each shift. The rest of the team was made up of temporary staff
employed for the summer. Most of these were students on holiday from their
courses but some were local people. They received no induction training. This
caused incredible disruption and could be a very unsettled period. Temporary
staff were expected to look after and amuse some of the most disturbed children
in Northern Ireland. It is my view that it did not work.

57. I remember one summer, soon after Lisnevin moved to Millisle, some of the boys
persuaded a young female student to take them out to play within the secure
grounds. They suggested playing hide and seek and she agreed. Within a few
minutes they had disappeared. They had climbed on to the roof of the main
building. They then made their way to the roof above the gatehouse. Fortunately,
the gate man heard noises on the roof and raised the alarm. The boys then
refused to come down. The Millisle site was shared with prison officers’ families.
They came over and became taunting observers. Some of them alerted
Downtown Radio as to what was going on. They sent a reporter and the whole
event started to have live radio coverage. The Principal, tried to
coax the boys down. Eventually he put a ladder against the wall and tried to climb
up to them. They let him get near the top and then pushed out the ladder –
leaving him stranded in a precarious position. The incident ended when the boys
became bored and agreed to come down.
58. I also remember [LN 56] Head Master of the Special Unit, hiring a guy to the summer team that he had given a lift to as he drove along the coast from Donaghadee to Millisle. In those days there was no such thing as Access NI. I am recounting these stories to indicate what a different climate we were living in then. Child protection and vetting of staff were in their infancy at that time.

Services and regime in Millisle

59. I worked for around two years as the psychologist assigned to Lisnevin in Millisle. I did spend approximately one day per week at Whitefield House, but most of my time was at Lisnevin. During the time I was given the task of developing a timetabled life skills programme for the boys. This involved most of the care staff in different aspects of the programme. They took workshops on tasks like cooking, decorating, simple electrical tasks and so on. I took two of the modules myself, one was parenting skills and the other was helping with job finding skills, undertaking mock interviews and so on. This programme was surprisingly popular with the boys.

60. Lisnevin in Millisle had a totally different character than the site at Newtownards. It was fundamentally a prison building and took on many of the characteristics of an institution. It became very inward looking and isolated. Sick leave was high in both the senior management and the other staff. The Principal [LN 6] took early retirement because of his health around 1984/85. There were an increasing number of riot style incidents, with some of the more vulnerable boys being held hostage on occasions²⁶.

Governance issues, APRU and relationship with NIO at Millisle

61. Around this time, circa 1981, Wesley Pugh in the Training School Branch decided to rationalise the four training school psychologists into one team. Prior to this each institution had basically one psychologist – although there were five training schools. I argued against this and said that I believed that Lisnevin needed its own full time psychologist who should be based there and could gain the trust of both the boys and staff but the decision had been made. I recount this because the message did not come from the Lisnevin Senior Management or Board but directly from Training Schools Branch in the NIO.

62. The amalgamation of the psychologists led to the setting up of the Adolescent Psychological and Research Unit (APRU). It is my opinion that it never really worked or delivered the services expected of it.

²⁶ Exhibit 21 - Incident report Barricading incident in 1986
Complaints Handling

63. Before 1995, complaints were investigated internally by the centre director, but new guidelines introduced in that year provided that internal investigation was no longer permitted. From then on all allegations of a child protection nature had to be referred to the police and social services.

64. A report by the Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) - a non-governmental organisation working in the field of criminal justice and community safety - details issues arising from the Independent Representation (IR) scheme in Lisnevin between 1994 and 1999. [vi]. The report documents a history of complaints from boys in Lisnevin and records 20 allegations made during this five year period ranging from extremely serious incidents of assault by staff to bullying by other boys. The report also reveals that the response of Lisnevin management to the allegations involved a mixture of flawed policies and procedures and poor practice.

Inspection reports and NI Human Rights Commission Report

65. Lisnevin in Millisle was subject to numerous reports. I have been unable to access any of the Social Service Inspectorate (SSI) reports, which had replaced the Social Advisory Group (SWAG) within the DHSS but I do know from the other reports listed below that they were critical of the regime at Lisnevin and its ability to adequately protect the children in its care.

66. I continued to have an interest in this area and am aware of a number of reports that were published in relation to Lisnevin that fall outside the temporal interest of the Inquiry. These are listed below:


   c. Written submission by the Northern Ireland Human Rights Commission (NIHRC) to the Assembly Health, Social Services and Public Safety Committee into Child Protection Services in Northern Ireland 2002.

Opening of Juvenile Remand Unit at Lisnevin

67. One issue that I have been unable to find much information on was the introduction of a new Juvenile Remand Unit into the ground floor of Lisnevin sometime in the 1980s. I remember there was talk of it before I left in 1983. It was introduced some time later and my memory was that it had many problems and was very difficult to manage.

27 Exhibit 22 - Complaints handling policy 1993 & 1994
Appendix 1 Management Chart when Lisnevin was established in October 1973

- Principal Teacher from Rathgael
- (Board Secretary and Administrative Officer)
- Donal Gordon
- (Deputy)
- New appointments plus admin staff

- (Headmaster Special Unit Teacher from St Patrick’s)
- (Deputy from Rathgael)

- Maurice Bunting & (new appointments)
- Each had a team made up of 4 teachers and 4 care workers

- (Headmaster Assessment Unit Teacher from Rathgael)

- Rathgael) and (new) Senior Assistants
- Each had a team of 4 teachers and 4 care workers

- Senior Social Worker,
- Senior Psychologist and psychologist,
- 3 nurses plus visiting dentist, GP and Psychiatrist
- Matron
- Ancillary staff including cooks, gardeners, night
### Names of persons from my memory who worked in Lisnevin Training School in Newtownards

<table>
<thead>
<tr>
<th>Special Unit</th>
<th>Job title</th>
<th>Assessment Unit</th>
<th>Job title</th>
<th>Other</th>
<th>Job title</th>
</tr>
</thead>
<tbody>
<tr>
<td>LN 8</td>
<td>Craft Teacher</td>
<td></td>
<td>General teacher</td>
<td>Donal Gordon</td>
<td>Dep admin officer</td>
</tr>
<tr>
<td>Pat Barry</td>
<td>Craft teacher</td>
<td>Mike Foster</td>
<td>General teacher</td>
<td>Paddy Curran</td>
<td>Gateman</td>
</tr>
<tr>
<td>Jill Trotter</td>
<td>General Teacher</td>
<td>Terry Andrews</td>
<td>General teacher</td>
<td>? Andrews</td>
<td>Gateman</td>
</tr>
<tr>
<td>LN 74</td>
<td>PE teacher</td>
<td>LN 16</td>
<td>Social Care</td>
<td>Sam</td>
<td>Handyman</td>
</tr>
<tr>
<td>Nel Calvert</td>
<td>Social care</td>
<td>Cavan Weir</td>
<td>Social Care</td>
<td>? Curran</td>
<td>Handyman</td>
</tr>
<tr>
<td>Tom Clarke</td>
<td>Social care</td>
<td>Thompson Best</td>
<td>Social Care</td>
<td>Jennifer Niblock</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Stanley Brown</td>
<td>Social care</td>
<td>Paul Nixey</td>
<td>Social Care</td>
<td>Sandy Carse</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Louise Ormsby</td>
<td>Social care</td>
<td>LN 25</td>
<td>Social Care</td>
<td>Ruth Elliott</td>
<td>Psychologist</td>
</tr>
<tr>
<td>LN 42</td>
<td>General teacher</td>
<td>Ards Footballer</td>
<td>Social care</td>
<td>Bill Lockhart</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Colin</td>
<td>General teacher</td>
<td>Kevin Miley</td>
<td>Social Care</td>
<td>Gerry Cunningham</td>
<td>Psychologist</td>
</tr>
<tr>
<td>Hutchinson</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gerry</td>
<td>General teacher</td>
<td>LN 59</td>
<td>Social Care</td>
<td>Jean Boucher</td>
<td>Nurse</td>
</tr>
<tr>
<td>McNamara</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Win Clarke</td>
<td>General teacher</td>
<td>Phelim Breene</td>
<td>Social Care</td>
<td>Doreen McVitty</td>
<td>Nurse</td>
</tr>
<tr>
<td>LN 61</td>
<td>Social Care</td>
<td></td>
<td></td>
<td>Farmer's wife</td>
<td>Nurse</td>
</tr>
<tr>
<td>LN 10</td>
<td>Social Care</td>
<td></td>
<td></td>
<td>Sandra Meeke</td>
<td>Social Worker</td>
</tr>
<tr>
<td>LN 5</td>
<td>Social Care</td>
<td></td>
<td></td>
<td>Andrew Logue</td>
<td>Social Worker</td>
</tr>
<tr>
<td>Seamus O'Hare</td>
<td>Craft teacher</td>
<td></td>
<td></td>
<td>Loraine Coburn</td>
<td>Social Worker</td>
</tr>
<tr>
<td>LN 3</td>
<td>General teacher</td>
<td></td>
<td></td>
<td>Tom Henry</td>
<td>Head Cook</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Phoebe Butler</td>
<td>Matron</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Mrs Robinson</td>
<td>Housekeeper</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Stanley Brown</td>
<td>Driver ( later social care)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Night staff</td>
</tr>
</tbody>
</table>
Appendix 2 An example of the Daily Timetable in Lisnevin

The Assessment Unit would have had a similar timetable but running 30 minutes in advance.

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7-30 am</td>
<td>Team arrives on duty</td>
</tr>
<tr>
<td>7-50 am</td>
<td>Senior Assistant refers to report book to see if any incidents have occurred during the night, and checks the number and if necessary the names of the boys present. The on-coming team of teachers and child care staff will be directed to supervise groups engaged in: toilet, bed-making, housework, etc.</td>
</tr>
<tr>
<td>8-10 am</td>
<td>Boys are taken downstairs to wash and dress. Night clothes to be stored and toilets etc. to be tidied. Any Special Unit boy in a single room downstairs will then be wakened.</td>
</tr>
<tr>
<td>8-25 am</td>
<td>Boys checked and taken to the dining room for breakfast. Utensils should be checked.</td>
</tr>
<tr>
<td>8-45 am</td>
<td>Common room, smokes supervised – preparation for school.</td>
</tr>
<tr>
<td>9-20 am</td>
<td>Assembly – Common Room – Worship – Conducted by Head or Deputy Head – other staff, under senior assistant to discuss school work, etc.</td>
</tr>
<tr>
<td>9-35 am</td>
<td>Sick bay attendance</td>
</tr>
<tr>
<td>9-40 am</td>
<td>Class with teacher or period with counsellor. Visits by doctor – boys to be supervised by staff under direction of Senior Assistant -</td>
</tr>
<tr>
<td>10-50 am</td>
<td>Boys are taken to the Common Room by the staff and whilst the boys have milk and a smoke under the supervision of the Head and Deputy and Senior Assistant the rest of the team have a coffee break.</td>
</tr>
<tr>
<td>11-05 am</td>
<td>Classes resume. The teacher collects boys in the Common Room.</td>
</tr>
<tr>
<td>1-05 pm</td>
<td>School finishes. Boys are escorted to lobby for handwash. Check.</td>
</tr>
<tr>
<td>1-15 pm</td>
<td>Lunch. Dining room routine</td>
</tr>
<tr>
<td>1-35 pm</td>
<td>Boys escorted to Common Room for recreational activity. Smoking is allowed, letters, the shop opened.</td>
</tr>
</tbody>
</table>

28 Exhibit 7 - Controlled study into the effectiveness of individual client-centred counselling for young offenders in residential care. Pp30-31 Thesis submitted for Doctor of Philosophy by B Lockhart 1982
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.00 pm</td>
<td>Staff changeover. Senior Assistant hands over to the opposite number and gives him any relevant information.</td>
</tr>
<tr>
<td>2-10 pm</td>
<td>Toilet routine. Preparation for school.</td>
</tr>
<tr>
<td>2-15 pm</td>
<td>Assemble in Common Room. Check.</td>
</tr>
<tr>
<td>2-20 pm</td>
<td>Afternoon school begins.</td>
</tr>
<tr>
<td>4-45 pm</td>
<td>School finishes. Assemble in Common Room. Check. Toilet routine. Smoking allowed in Common Room.</td>
</tr>
<tr>
<td>5.05 pm</td>
<td>Handwash. Assemble in lobby. Check.</td>
</tr>
<tr>
<td>5.15 pm</td>
<td>Dining room routine.</td>
</tr>
<tr>
<td>5.35 pm</td>
<td>Assemble in Common Room. Check. Smoking is allowed. The shop opened. Toilet routine. Sick bay attendance.</td>
</tr>
<tr>
<td>6-10 pm</td>
<td>Evening activities begin. These depend upon availability of rooms and special interests of staff. Either the gym or dining room will be available for more vigorous activities each evening. Other rooms will be allocated according to school timetable for the afternoon. Activities should be planned and arrangements for the provision of craft materials, games equipment etc made in good time. Television viewing should be programmed as part of evening activities and not relied upon as a time-filler. A routine for positive, enjoyable recreation should be aimed at which is not simply an extension of the school day.</td>
</tr>
<tr>
<td>8.05 pm</td>
<td>Supper. Common Room. Check. Quiet recreation – reading, television, table games.</td>
</tr>
<tr>
<td>8-20 pm</td>
<td>Boys now commence bedtime routine. Groups use the ablutions area in turn and return to the Common Room.</td>
</tr>
<tr>
<td>9-15 pm</td>
<td>Boys are escorted to dorms and settled down.</td>
</tr>
<tr>
<td>9-30 pm</td>
<td>Team goes off duty on arrival of Night Supervisors. Any important information should be passed to the Night Supervisors.</td>
</tr>
</tbody>
</table>
PART TWO

Observations on the statements of Complainants to HIA regarding their time in Lisnevin

HIA94 (statement dated 22/7/13) Lisnevin in Newtownards

68. Young person placed in care as a baby, first in St Joseph's Termonbaca, Derry, then Rubane House, Kircubbin and St Patricks TS. He was transferred to Lisnevin on 7 November 1973. This was soon after Lisnevin opened in autumn 73. I knew this young man and the dates appear to be right as I first met him at Christmas 1973 when working there (I had been seconded to a postgraduate course in Birmingham that year and was working during the Christmas break). He was 14 at the time of transfer. He already had a reputation as the most violent young person in Lisnevin. I remember there was a story as to how the brothers in St Patrick’s duped him into transferring to Lisnevin by telling him that they were taking him to the circus.

69. He appears to claim that he was sent to the Assessment Unit at Lisnevin. This is not correct as he was sent to the Special Unit. It is true that a significant number of the boys in the Assessment Unit would have been remanded by the courts for paramilitary involvement. Very few, if any, of the boys in the Special Unit would have been there for paramilitary activities. There was minimal contact between the boys in the two units.

70. During his time in Lisnevin he was often made to sleep in a single room on his own because he had got into lots of fights with the other boys. This was on the ground floor. LSN-1196 – LSN-1197 provides information in relation to recorded incidents of HIA 94 being placed in a ‘single room’ for disruptive behaviour. From these it would appear 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. It would be untrue to say that he was kept in almost solitary confinement. He may have been kept in a single room (on the ground floor, in a block of six, in an isolated part of the building) as punishment for fighting, absconding and the like. This single room was small (about 6 feet by 8 feet). Periods of confinement were used in quite a routine manner, even for small misdemeanours, such as smoking.

71. I remember HIA 94 being sent to Muckamore Abbey on at least one occasion for a five week assessment period. This would have been arranged by Dr Ray Moffatt, Consultant Psychiatrist at Muckamore Abbey. There would have been queries about the intellectual competence of the young man – hence the reason for assessment. But it would have been seen as very stigmatising and young people sent to Muckamore for assessment would have been the subject of ridicule by their peers. In reality it was seen as a form of punishment by both the young people and staff alike. I do not remember any meaningful therapeutic or
management advice stemming from such “assessments”. It is highly likely that he was put on medication when there to “supress” him.

72. HIA 94 alleges that he was beaten in the cells by housemasters called LN1 and LN2. In a supplementary statement (dated 12/3/14) the complainant acknowledges that LN1 and LN2 were in fact residents in Lisnevin and not staff. This is correct. Both boys would have been of similar age to the complainant. It is difficult to see how he could have made this mistake, unless it was a mistake when the statement was being written down. I believe that this person’s key worker was LN3 who was then a teacher in Lisnevin. She later went on to train as a social worker and became [redacted]. I believe that she is still alive and would have a good knowledge of what happened to this person in Lisnevin.

73. I believe that the statements about moving to borstal and prisons are correct. I met HIA 94 on at least a couple of occasions after Lisnevin and confirm that he lived a very difficult life in and out of prison and various institutions. The last time I met him he told me that he had five children. He came to Lisnevin a much damaged person and was one of the most disturbed and violent young people I have known.

HIA94: Addendum statement (dated 12/3/14)

74. HIA94 explained that LN1 and LN2 were in fact residents and not house masters as stated in previous statement. As noted above, this is correct. He says that he witnessed both boys getting beaten by various housemasters. I have no comment to make concerning the veracity of this statement.

75. He says that he remembers the names of three housemasters who would have beaten and kicked residents. One was called LN10, who he believed, became a police officer. There was a housemaster by the name of LN10. I do not believe that he stayed on the staff of Lisnevin for very long. There was also a housemaster called McCoy (or very similar name) who did play football for Ards, who again did not stay on the staff for long. The third was actually a craft teacher named LN8. He was a rugby player and very well built and strong. He was one of the few people who could handle the complainant when he became aggressive. He actually seemed to have quite a good relationship with the complainant. He stayed on the staff of Lisnevin for many years but retired early. There was an art teacher named Jo Byers, who certainly remained on the staff until the move to Millisle. I have no evidence that his accusations of assault are true, but I do remember LN8 telling me that he had the permission of the Principal, LN6, to use as much force as necessary to control the complainant’s behaviour.

76. Peter McLaughlin was an MP and head of Bryson House for many years. He is since deceased. He did go on weekend leave to McLaughlin’s House on many occasions. Eventually the leave had to be stopped because of the complainant’s behaviour. This included the use of alcohol and violence.
HIA275 (statement dated 5/3/15) Lisnevin in Millisle

77. From the account in the statement I do not believe that I know HIA 275 nor do I have any knowledge of the allegations he has made.

HIA374 (statement dated 19/3/15) Lisnevin in Newtownards

78. He would have been in the Assessment Unit and not the Special Unit. He said that he was there after his parents had some marital problems and that he was not sure why he had been sent to Lisnevin in Newtownards (old building).

79. He said that after he had been there a few days a member of staff (he could not remember his name and could only describe him as black haired) put his hand on his private parts while he was showering and said “no masturbating”. The norm in Lisnevin was for boys to have open communal showers in a downstairs bathroom/changing room. This happened every evening and after sports, etc. This meant that there were usually six or so boys in the shower at the same time. They were in full open view with no cubicles or curtains. Normally there would have been 3-4 staff present supervising showering and changing. This was to prevent bullying or any other sort of misbehaviour. It would have been extremely rare for one member of staff to be present with just one boy in the shower, but not impossible. Whilst it is possible that this could have taken place, say if someone joined the shower late or took longer than the others it is highly unlikely to have happened with other staff or boys present. One child protection aspect of Lisnevin in Newtownards was that care staff usually worked as a team, so there was little need for staff to be alone with a boy. I note from the transcript of HIA 374’s evidence to the Inquiry on the 9 September 2015 that he thought the touching was inappropriate but that he did not consider that it amounted to sexual abuse.

HIA418 (statement dated 18/5/15) Lisnevin in Millisle

80. From the account in the statement I do not believe that I know HIA 418 nor do I have any knowledge of the allegations he has made.

HIA138 (statement dated 6/5/15) Lisnevin in Millisle

81. From the account in the statement I do not believe that I know HIA 138 nor do I have any knowledge of the allegations he has made.

HIA434 (statement dated 1/6/15) Lisnevin in Millisle

82. From the account in the statement I do not believe that I know HIA 434 nor do I have any knowledge of the allegations he has made.
HIA400 (statement dated 19/4/15) Lisnevin in Newtownards

83. HIA400 was remanded to Lisnevin (Newtownards) for a five week assessment in the period of June- July 1974. He would have been around 14 at the time. I would have been working in Lisnevin Assessment Unit at the time but have no recollection of him being there. Nor do I have any knowledge of the allegations he has made.

84. He said that apart from being hit around the head a few times he had no complaints to make about Lisnevin. It was a reasonable place with good staff, who, for the most part, were caring and compassionate. It concerns me that he says he was “hit around the head”. This would have been within the first year of Lisnevin’s existence and I would be surprised if such assaults were common place. Staff worked as a team and at that time any assaults would have been looked upon as unacceptable. I had no sense of staff colluding in assaults. There was corporal punishment allowed but this happened very rarely and was always administered by cane by a person ranked senior assistant or above. Such punishments were always recorded.

Dr Bill Lockhart

9 October 2015
HIA REF:

NAME:

DATE:

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 – 1995

Witness statement of LN 25

will say as follows:

1. 

2. There was a senior Management structure within the Centre during normal office hours, i.e. 9:00-17:00. During those hours I was not the overall Manager, but was responsible for overseeing the teaching staff, the dining room staff and the cleaning staff generally. After hours, once senior Management had left the Centre i.e. after 5pm, I would often assume managerial responsibility for the entire Centre. During the course of my employment I considered myself reasonably well respected and popular amongst both the staff and boys alike.

3. I have read the witness statement of HIA 418 dated 18th May 2015 which has been provided to me, and wish to be given the opportunity to respond to the allegations raised therein, insofar as I am able to do so. I have no more than a vague recollection of Mr HIA 418, am very surprised by the allegations. As stated, 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 staff members. There was no religious segregation amongst the units and boys were simply placed into units on the basis of availability irrespective of age or background. I am also surprised that HIA 418 cannot recall the names of the individual staff members against whom he raises allegations of assault, intimidation and bullying, as these individuals would have been working with the young people within the unit on a day-to-day basis and were well known to them by name.

4. In paragraphs 5-7 of his witness statement HIA 418 refers to “the Block”. “The Block” was a colloquial term for the separation unit within the Centre. 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. I cannot recall precisely the nature of these Regulations given the passage of over 20 years.
Usually residents would only remain in the separation unit for a short period of time however, in the event of serious incidents of violence or aggressive/disruptive behaviour; a resident could remain in the separation unit for a longer period. Separation time was defined by Senior Management in each particular instance; it is impossible to be more specific in this regard.

5. From my experience and recollection it is not true that residents were given very little to eat and drink during spells in the separation unit. The Regulations provided that food and drink were never to be withheld from the occupants of the separation unit. Food was served at the same time as the rest of the Centre, i.e. breakfast at 09:00, lunch at 13:00 and dinner at 17:00. The occupant of the separation unit would be fed the same quantity and quality of food as the rest of the young people in the units. The only difference was that food was served in a hard plastic tray, and plastic cutlery was used to ensure the safety of the young person. Water and other drinks such as juice, tea and coffee were provided at meal times and also between meal times upon request.

6. I cannot recall whether the separation unit room had a broken window as claimed by Mr [HIA 418]. It was an empty room with a blue mattress on the floor. The purpose of the room was to ensure that an agitated resident would not be able to harm himself or others and it was therefore necessary to ensure it contained no furniture or other items which may have allowed the resident to do so. To the best of my recollection the room was kept clean and toilet facilities were available by knocking on the door upon which an officer would bring the young person to the toilet located at the bottom of the corridor. There was also an office at the end of the corridor which was staffed full-time whilst a resident was in the separation unit. A set of the Regulations referred to in paragraph 4 above were kept in this office for reference purposes. A staff member was required to enter a written report in the record at 15 minute intervals regarding the behaviour of the young person in the separation unit. When that member of staff deemed the young person to have calmed sufficiently during such an interval, the young person would be returned to his unit. I would say, however, that I witnessed a certain culture amongst the young people within the Centre that being taken to "the Block" was seen as a 'badge of honour'.

7. There were medical and psychology staff working at the Centre who were employed to attend to the residents' physical and mental health needs.

8. 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. By definition such techniques were used to restrain the resident but I certainly would not consider the techniques to have had the effect described in [HIA 418]'s statement and cannot ever recall witnessing such scenes at any time during my employment at the Centre. While I fully accept that I was aware that such restraining techniques were used by staff members, and that during the course of my employment I was occasionally required to restrain residents myself, I totally refute that the manner in which such actions were carried out amounted to the intimidation, bullying or assault of residents.

9. There was a working and effective complaints procedure in place within the Centre, whereby a senior member of Management would assess any complaints made by residents against any members of staff. To the best of my knowledge, during my employment at the Centre, I had a clean disciplinary record.
10. In paragraph 12 of his witness statement [HIA 418] raises the allegation that I made disparaging remarks about his religion, or the religion of other residents, by the alleged prohibition of playing cross shots in snooker. I must state that I am both confused and surprised by this allegation. I categorically deny using such terminology in a disparaging fashion and would state that the thought never entered my head to connect such a term with any form of religious discrimination. A ‘cross shot’ is common sporting parlance for a shot whereby a snooker player attempts to get out of a snooker position by hitting the ball off one or more cushions. This was and is quite common terminology in the context of a snooker game as far as I am concerned, and if it was used at all, would have been used absolutely innocently in that manner. I find it both incredible and distressing for it to be suggested that such terminology was in any way sectarian and I can categorically state, to the best of my knowledge, that there was never an instance of such terminology having been adopted by members of staff or the young people in such a fashion within the Centre.

Statement of Truth

I believe that the facts stated in this witness statement are true.
THE INQUIRY INTO INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of

1. [LN 8] will say as follows:-

1. Having taken time to read the contents of the file that I received on 19th September 2015, I wish to make the following Statement on behalf of myself in order to clarify a number of matters contained therein and refute any allegation made against me by Mr [HIA 94].

2. I am a retired teacher who taught in Lisnevin from its opening in 1973.

3. I refute without reservation that I was involved in the alleged incident to which [HIA 94] has referred.

4. I was Joint key-worker for [HIA 94] throughout his stay in Lisnevin.

5. It is my belief that [HIA 94] was the only admission to Lisnevin ever to be afforded two key-workers.

6. At an early stage I believe that the decision was taken by Senior Management to allocate a second key-worker for [HIA 94] due to the very aggressive and often physically threatening behavior that he displayed towards both staff and other young people in the Special Unit. At that time all staff worked a shift system and it was thought beneficial for Mr [HIA 94] to have a key-worker on each team. I believe that I may have been selected at that time simply because I was alphabetically at the top of the list.

7. Reference LSN-005/23. From recollection [HIA 94] was unable to cope with being placed in the larger bedrooms, and at a very early stage requested to be placed in one of the single rooms on the ground floor. These rooms served several purposes.
a. - as an isolation room for young people who were deemed by the nurse to be medically in need of isolation, as Lisnevín did not have alternative medical facilities in which young people could be isolated.

b. - on occasions as a facility when new admissions had difficulty integrating into the Special Unit group.

c. - as an isolation room for young people from the Special Unit group if they had been involved in serious incidents with either other young people or members of staff. On these occasions the time which a young person spend in these rooms was carefully monitored, and when it was deemed that they had settled down sufficiently, they were immediately reintegrated back into the group.

8.

Reference LSN-005/24. As joint key worker I have no recollection of any other young person or member of staff, ever making any complaint to me reference any form of assault. I would add however that it was often necessary for members of staff to physically remove Me [HIA 94] following a violent outburst.

9.

Reference LSN-009/4. I again without reservation refute the allegation that I beat Mr [HIA 94] at any time during his stay in Lisnevín.

As stated, I was indeed a rugby player and would have been one of the young people who regularly came and watched me play accompanied by other members of staff. I would add that I was not the only member of staff who played rugby and in fact we did have a staff rugby team as well as a staff football team. In addition a number of staff members also played gaelic sports.

10.

Reference LSN-091/19/08/1974. At no time did Senior Management ever come to our home on weekend leave. He did however stay with my wife and me on one occasion at the request of Senior Management, and that may well have been on 19/08/1974 as stated. On that one occasion, Senior Management had asked me as his on-duty key worker, to take Mr [HIA 94] overnight as another young person was to be admitted that evening to Lisnevín from St. Patrick’s Training School, and it was my understanding that they (Senior Management) did not want Mr [HIA 94] and the other young person to be in the same environment. I had been advised at that time that both young persons had previously been involved in a number of serious incidents, and there was great concern with regards to having them both in Lisnevín at the same time. Whilst I did not have occasion to meet the other young person, it was my understanding at that time that he was to be admitted to Lisnevín Special Unit on a temporary basis only, prior to being formally removed to the Borstal system. From recollection it was the following day that, at the request of Lisnevín, my wife and I took Mr [HIA 94] to Lisburn to stay with another befriending family who were known to Lisnevín. I cannot remember their name.

11.

LSN-163/Exhibit 1. As his joint key-worker I never had any difficulty talking to Michael, but I was always very careful not to put myself in a position where I was unable to withdraw should it become necessary. Following his frequent removals from class I would often allow him to join whichever class group I was teaching at the time, as an additional member of the group. Teachers in general were often reluctant to have him back into their class so soon after a violent outburst. However, he appeared to enjoy coming to my class and over time we developed a very good working relationship.
12. LSN-167/6. I was asked to attend Newtownards Juvenile Court as his key-worker on duty that morning. I was not asked to speak.

13. LSN-172-24th/25th January. I was on duty on the 25th January and was tasked with collecting from hospital. I believe that the hospital staff had requested his removal as he had become very aggressive and disruptive.

14. LSN-177/5th April. I have no recollection of this particular conversation, but I certainly would have had to speak to on numerous occasions with regard to the unacceptable language he frequently directed towards female members of staff in particular, and to staff and young people in general.

15. LSN-184/8th Sept. The removal of a ring from a boy's swollen finger was a procedure that I had to carry out on many occasions. It was completely painless and once the ring was removed it was placed in the young person's property.

16. Day 139 Page 144/16. I do remember this incident but I believe that I was not on duty at the time. I have no recollection with regards to the member of staff involved at that time.

17. Day 139 Page 146. From recollection I was in the Duty Office at the time of this incident. On hearing the screams for help from a member of staff I had immediately rushed out to give assistance. However there were already a number of other members of staff trying to intervene as was kicking and punching a member of staff in a most violent manner. I do not remember who these members of staff were. I recollect however that both boys and staff had barricaded themselves in the common room for fear of being attacked by . I assisted in the removal on one of the single rooms. This was carried out with a high degree of difficulty as he was an extremely strong young man. I believe this was the only time that I was ever actively involved in the removal of Mr

Statement of Truth

I believe that the facts stated in this witness statement are true.
DEPARTMENT OF JUSTICE

AND

DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

JOINT STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 7

TRAINING SCHOOLS AND YOUTH JUSTICE INSTITUTIONS

21 August 2015
Department of Justice Declaration

I, Karen Pearson, will say as follows:

This statement, has been provided on behalf of the Department of Justice (DOJ) in response to the Rule 9 request of the Historical Institutional Abuse Inquiry (HIAI) dated 22 July 2015. It has been prepared jointly with the Department of Health, Social Services and Public Safety (DHSSPS) on the basis of information contained in files currently held by both Departments and such evidence received from the HIAI as it has been possible to review within the required timeframe. As further information becomes available, it may be necessary to provide to the HIAI, revised or supplementary statements.

Mr Nick Perry’s Statement dated 17 May 2013, sets out the history and role of the DOJ and its predecessors, namely the Ministry of Home Affairs (MoHA) from 1922 to 1972 and the Northern Ireland Office (NIO) from 1972 to 1995.

Department of Health, Social Services and Public Safety Declaration

I, Hilary R Harrison will say as follows:

This statement (in so far as it refers to inspections of Training Schools and related activities undertaken by Inspectors from the former Department of Health and Social Services and its predecessors) has been provided on behalf of the DHSSPS in response to the HIAI Rule 9 Request dated 22 July 2015. The information presented here supplements the DHSSPS statement dated 30 July 2015 already submitted to the HIAI in respect of Module 7.

The role of the Department of Health and Social Services (DHSS) between the years 1972 and 1995 was, by arrangement with the NIO and through the auspices of the DHSS Social Work Advisory Group (SWAG) and subsequently, the Social Services Inspectorate (SSI), to:

- inspect and carry out other investigations related to Training Schools and juvenile justice institutions as requested by NIO; and
- provide policy and professional practice advice in relation to the functioning of the schools and juvenile justice system.

The DOJ and DHSSPS have reviewed a significant volume of archived documentation in the preparation of this statement. Given the gaps in our records and limited corporate memory of events which go back decades, it is not possible to confirm with absolute certainty the veracity, completeness and accuracy of the information provided. This statement represents the best efforts of both Departments, in collaboration, to bring together and explain the
most significant events and major developments relating to children and young people in the justice field during the period 1922 to 1995.

The statement contains annotations indicating which Department will act as lead witness in respect of the various matters addressed.

Signed:   Date: 21 August 2015
Karen Pearson

Signed:   Date 21 August 2015
Hilary Harrison
HIAI Question 1

1. A brief history and background to Training Schools

1.1 A number of reformatories, industrial schools, training schools and borstals1 existed in Northern Ireland during the 1922-1995 period. A broad timeline for these has been provided in Annex A to Mr N Perry’s statement to the HIAI dated 17 May 2013 (SNB 95334-95346). From 1922 to 1972, the Department responsible for training schools and juvenile justice was the Ministry of Home Affairs (MoHA). Following the proroguing of the Northern Ireland Parliament the NIO was established and assumed the former responsibilities of MoHA in relation to policy and legislation governing training schools and other juvenile justice services.

1.2 During the period 1922 to 1950, industrial and reformatory schools were the two main types of institutions within the juvenile justice system for children under the age of 17 years. Under the Children Act 1908 (the 1908 Act) (Exhibit 1), industrial schools were generally intended for the rescue, care and protection of children who by reason of family circumstances, environment or company were in danger of becoming delinquent. Reformatory schools were intended for the training and reformation of older boys who had committed offences (Exhibit 2)2.

1.3 A significant change in the juvenile justice system was brought about by the Children and Young Persons’ Act 1950 (the 1950 Act) (SPT 80001-80062), which replaced former industrial schools and reformatories with establishments to be known as “remand homes” and “training schools”. The Children and Young Persons Act (Northern Ireland) 1968 (the 1968 Act) (SPT 80096-80114) affirmed the 1950 legislation by maintaining the place of remand homes and training schools on the continuum of responses to troubled and troublesome young people. Under the provisions of the 1950 and 1968 Acts,(SPT 80001-80062; SPT 80096-80114) a juvenile court was empowered to commit a person under the age of 17 found guilty of an offence, to custody in a remand home. The court also had the power to make a Training School order in the case of both offenders and children who may not have offended but who were in need of care, protection or control.

1.4 There were no establishments in Northern Ireland that operated exclusively as remand homes. The remand function until 1973 was

---

1 Institutions run by HM Prison Service and intended to ‘reform seriously delinquent young people’.
2 The Roots of Rathgael booklet, page 1, Spectator Newspapers, Bangor. Document submitted to the inquiry on [date]. Not yet allocated a Bates reference number. It is attached for convenience at Exhibit 2.
administered through four training schools, established on the basis of gender and religion, namely: St Patrick’s and St Joseph’s Training Schools which catered for Catholic boys and girls respectively and Rathgael and Whiteabbey Training Schools, established for non-Roman Catholic boys and girls. A fifth non-denominational training school, Lisnevin, opened in 1973. Hydebank Young Offenders Centre (YOC), a Category C institution opened in June 1979, and replaced the closed borstal at Lisnevin.

1.5 The information to follow focuses on the four main institutions of particular interest to the Inquiry.

St Patrick’s Training School

1.6 The St Patrick’s institution was established in 1862 by the Roman Catholic Church and managed directly by the Diocese of Down and Connor. It was an Industrial school and from 1921 also catered for the reception of reformatory boys. In 1951, following approval by the MoHA under the 1950 Act (section 106) (SPT 80001-80062) it became a training school. St Patrick’s was also registered as a remand home under section 104 of the 1950 Act (SPT 80001-80062). It continued to function as a training school/remand home until 2001?

Rathgael and Whiteabbey Training Schools

1.7 Between 1950 and 1956 work was undertaken to amalgamate Malone Training School, Balmoral Training School and Whiteabbey Training School for Girls. The Malone and Whiteabbey Training Schools Act (Northern Ireland) 1956 (Exhibit 3) brought about a new Board of Management appointed by the Minister of Home Affairs. This resulted in the combining of Balmoral and Malone Training Schools into premises at Lislea Drive, Belfast, in 1958. The borstal part of Malone Training School was moved to Woburn House, near Millisle, County Down. A significant problem facing the new Board of Management at that time was accommodation. Although premises were altered, extended and modified the Board came to the conclusion in 1958 that a purpose built establishment was required. In 1959 the Board purchased the site at Rathgael Road, Bangor and in 1968, the Malone and Whiteabbey Training Schools Act (Northern Ireland) 1968 (Exhibit 4) established the Rathgael Training School. The Malone Training School for Boys was

---

3 A category C prison is a low security closed prison for people who cannot be trusted in an open prison, but are considered unlikely to make a determined escape attempt.

4 Document submitted to the inquiry on [date]. Not yet allocated a Bates reference number. It is attached for convenience at Exhibit 3.

5 [Document submitted to the inquiry on date]. Not yet allocated a Bates reference number. It is attached for convenience at Exhibit 3.
closed. In 1985, Whiteabbey Training School closed and the girls moved to the Rathgael Training School, thus creating for the first time a mixed gender Training School facility.

1.8 In the early 1990s, the accommodation units in Rathgael were restructured to enable the separation of children admitted for reasons of care and those who were offenders.

**Lisnevin Training School**

1.9 Lisnevin opened in 1973 at premises formerly called Kiltonga Home, on the outskirts of Newtownards, County Down. The new school provided secure residential assessment facilities for 20 remand boys and a longer term facility for another 20 committed boys, and was non-denominational. It was managed by a Board of Management set up by virtue of an Indenture between the Management Boards of St Patricks, St Josephps, Rathgael and Whiteabbey and MoHA. The membership of the Lisnevin Board was made up from members of the other Boards.

1.10 In 1978 the residential assessment unit of Lisnevin was relocated to the YOC Juvenile Remand Unit, Crumlin Road, Belfast and the longer term treatment unit (also known as the special unit) moved to Millisle in 1981. A 10-bed secure remand unit was opened in 1985 following the closure of the Juvenile Remand Unit at the YOC in Belfast. This meant that young people between the ages of 10 and 17 were no longer held within the adult penal system. Lisnevin closed in 2003.

**Hydebank Young Offenders’ Centre**

1.11 Hydebank Young Offenders Centre opened in June 1979. It was built to manage up to 325 young people, normally between the ages of 16 and 21. 15 year old boys who were convicted of certain offences including terrorist related offences, or who were considered manageable within the open school system were managed in Hydebank. Hydebank was managed by a Governor, and management team, and operated within prison rules. Hydebank continues in operation to the present day and currently also houses the women’s prison.

**HIAI Question 2**

2. An explanation of the statutory scheme or schemes relating to Training Schools during the period being investigated by the HIA Inquiry, including how it changed over time
2.1 Mr Perry's statement dated 17 May 2013 (SNB 95334-95346) has outlined the various statutory schemes that applied to training schools and their antecedents in the period 1922 to 1995. The paragraphs to follow trace the development of the key primary legislation and policy initiatives that shaped changes over time.

**The Children Act 1908 (the 1908 Act)**

2.2 Although reformatory schools had been first established in 1858 under the Poor Law (Amendment) Act, at the beginning of the period of the Inquiry's interest, reformatory and industrial schools were established, operated and managed under the 1908 Act (Exhibit 1). That Act put measures in place to regulate the care of children and young people. Section 133 of the Act (Exhibit 1) applied its provisions to Ireland, where the Chief Secretary for Ireland (“the Chief Secretary”) was to substitute for the Secretary of State. Following the partition of Ireland, the Ministry of Home Affairs for Northern Ireland became responsible for reformatory and industrial schools and inherited the powers exercised by the Chief Secretary of Ireland in that jurisdiction.

2.3 The 1908 Act (Exhibit 1) empowered the Chief Secretary, following an inspection, to certify that any reformatory or industrial schools were fit for the reception of youthful offenders or children to be sent there. The Chief Secretary was also empowered to withdraw such certification if dissatisfied with a school’s condition, rules, management, or superintendence. In that circumstance, the children or young people would have to be discharged or transferred to another certified school. To inform the Chief Secretary’s view, each certified school was required to be inspected at least annually by an inspector or assistant inspector appointed by the Chief Secretary.

2.4 Section 69 of the 1908 Act (Exhibit 1) empowered the Chief Secretary to discharge or transfer a child or youthful offender. Under section 70 of the 1908 Act (Exhibit 1), the Chief Secretary’s consent was also required for the disposal of a child or youthful offender to any trade, calling or service or by emigration.

2.5 The 1908 Act (Exhibit 1) placed general statutory duties on the institutions in respect of how children and young people were to be cared for. Managers of certified schools were “deemed to have undertaken to

---

6 Later amended by the Children (Amendment) Act (N.I.) 1931.
7 Children Act 1908, s.45(1)&(2).
8 Ibid., s.47 - s.51.
9 Children Act 1908, s.46.
10 Ibid., s.69&.70
teach, train, lodge, clothe and feed” children and ‘youthful offenders’\textsuperscript{11}. Managers of certified schools were also empowered to make rules regarding the management and discipline of the school and these rules were subject to approval by the Chief Secretary. The Chief Secretary could also require schools to make rules\textsuperscript{12}.

2.6 The 1908 Act (Exhibit 1) also made various provisions in relation to the funding of reformatory and industrial schools, together with measures which governed the circumstances in which children and young people were sent to the schools. Essentially, subject to certain limitations\textsuperscript{13}, if a youthful offender was ordered to be sent to a certified school, it was the duty of the local council to provide for his reception and maintenance\textsuperscript{14}. It was the duty of the local education authority to provide for the reception and maintenance of remaining children such as school refusers sent to certified industrial schools\textsuperscript{15}. The Chief Secretary was empowered to recommend that money be paid from the Treasury towards the expenses (including removal expenses) of any child or youthful offender up to certain limits\textsuperscript{16}.

2.7 The 1908 Act (Exhibit 1) also included various general measures designed to tackle cruelty to children and young people. Under these provisions, any person:

“who has the custody, charge, or care of any child or young person who wilfully assaults, ill-treats, neglects, abandons, or exposes such child or young person to be assaulted, ill-treated, neglected, abandoned, or exposed, in a manner likely to cause such young person unnecessary suffering or injury to his health (including injury to or loss of sight, or hearing, or limb, or organ of the body and any mental derangement), that person shall be guilty of misdemeanour” and liable on conviction to punishment\textsuperscript{17}.

Shaping the 1950 Act

2.8 A number of significant matters arose prior to the 1950 Act (PST 80001-80062), which influenced the policy and the 1950 Act. In January 1923, R Dawson Bates, Minister MOHA, appointed a Committee “to enquire

\textsuperscript{11} Ibid., s.52 \\
\textsuperscript{12} Ibid., s.54. \\
\textsuperscript{13} Ibid., s.74(5). \\
\textsuperscript{14} Ibid., s.74(1). \\
\textsuperscript{15} Ibid., s.74(2). \\
\textsuperscript{16} Ibid., s.73 \\
\textsuperscript{17} Ibid., s.12(1).
into the number and character of committals to reformatory and industrial schools, care of boys and girls after leaving the schools, the financial position, costs to be borne by Treasury, local authorities and parents and the provision of a borstal institution for youthful offenders”. The Committee made a number of recommendations (SPT 17081-17147) including:

- the provision of a Juvenile Courts system in separate buildings;
- children and young persons on remand to reformatory and industrial schools as places of detention should be kept separated from those already committed;
- suitable buildings (at a reasonable cost) should be made available for a borstal institution to be established in Northern Ireland;
- the substitution of the term ‘reformatory’ by ‘training school’.

2.9 In 1935, following developments in England and Wales which used probation services much more frequently to support children than was the case in Northern Ireland, the Committee on the Protection and Welfare of the Young and Treatment of Young Offenders (known as the Lynn Committee) was established. In 1936, appointing Probation Officers became the responsibility of the Minister MOHA.

2.10 The Lynn Committee published its report in 1938 (SPT 14461-14587). The report examined a number of issues that were believed to be contributory factors to offending behaviour in young people including: unemployment, inadequate housing, cinemas, dance halls and street trading. Due to the outbreak of World War II (1939 – 1945) recommendations emanating from report were not advanced at that time.

2.11 However, on 19 January 1948, the Minister of Home Affairs wrote to the Prime Minister of Northern Ireland about the lack of control over the juvenile justice system and the prospects of the introduction of a Children’s Bill (SPT 17149-17154). His letter stated:

“There is complete chaos in the matter of responsibility for the treatment of young offenders. The public, and probably most Members of Parliament, think that my Ministry is responsible for the care, treatment and reformative education of the children who are committed to one or other reformatory or industrial schools. They also think that I have powers and functions in connection with the prevention of juvenile
Although the State accepts complete responsibility for all wrongdoers over 16 years of age it declines to accept responsibility for those under 16. ....

The law provides that children under 16 may be sent to reformatory or industrial schools, but it does not provide any premises to which they may be sent. These premises must be provided by local authorities or by religious bodies or by voluntary charitable organisations. My Ministry has no direct or effective control. Home Office inspectors do visit the schools or homes, and they report on dietary, cooking, cleanliness and general order of the place… I do not appoint, nor can I dismiss staff, nor do I have the power to direct any course of training or treatment or reformative education. In short, I neither control nor direct policy.”

2.12 The Minister’s letter outlined a number of proposals to address the lack of effective control:

• the transfer of responsibility for the provision of reformatory and industrial schools from local authorities, religious bodies and charitable organisations to the State;

• the making of one central authority responsible for the care, treatment and reformation of all convicted children (it was suggested that this should be the Children’s Department within the MOHA);

• that MOHA should have the right to appoint staff who are to deal with the children; and

• the need to legislate to give the central authority power to care for and protect children who, by reason of circumstances, stand in need of such protection.

2.13 The Minister noted that there would be additional cost but emphasised “… this child service is a disgrace and has been starved for the past twenty years and we have trailed behind Britain’. Additionally, he noted that the Catholic Church would still have the right to run its own institutions, subject to the Ministry’s control of general policy.

2.14 Also in 1948, a white paper was presented by the Government of Northern Ireland entitled ‘The Protection and Welfare of the Young and the Treatment of the Young Offender (SPT 14588-14627)’ which reiterated the concerns of the Minister. The report underscored the
tensions between Government, local authorities and voluntary bodies. In one passage the following observation was made: "…It can be claimed that only as a last resort is any juvenile offender sentenced to reformatory and industrial schools. At the present time the duty of providing for the reception and maintenance of children and young persons sent to these schools by the court devolves to local authorities but it is the responsibility of the Minister (MOHA) to certify such schools as fit and proper".

2.15 The white paper (SPT 14588-14627), which cited the Curtis report\(^\text{18}\), noted that for well over a century the country had generally appreciated and had relied on voluntary effort for the care of neglected and other children. This voluntary work supplemented the facilities which had existed under the Poor Law code. It recommended that it was essential, and to ensure co-ordination, for one single Department i.e. MOHA to deal with all aspects of legislation affecting the care of the young and the treatment of young offenders. Other relevant recommendations of included:

- Welfare Authorities in relation to their responsibilities for children should come under the control of the MOHA;
- Voluntary Organisations operating homes for children should be required to comply with certain conditions;
- managers of institutions for delinquent children and young persons should be subject to measures of control;
- the establishment of Juvenile Courts on a new basis and the Probation Service should be extended;
- new legislation was required in relation to after-care schemes; and
- the appointment of an Advisory Committee to be known as the Child Welfare Council.

2.16 These recommendations and the above policy influences formed the basis of the Children and Young Persons Act (Northern Ireland) 1950 (SPT 80001-80062).

**The Children and Young Persons Act (N.I.) 1950 (The 1950 Act)**

\(^{18}\) An official Committee was set up under Miss Myra Curtis, the Committee looked at a wide range of issues including: destitution, the homeless, war orphans, disabled children, children removed from their families and adoption. The report heavily criticised the poor conditions found in many institutions and the lack of staff training. The Curtis Report’s proposals formed the basis of the 1948 Children’s Act in England and Wales.
The 1950 Act (SPT 80001-80062) was made in order to “clear away the last remaining traces of the old poor law in relation to children” and introduce “new and wider responsibilities” for welfare authorities\(^{19}\). It was also an attempt to “consolidate so far as possible all legislation regarding the care of children and their protection against moral and physical danger”\(^{20}\). The 1950 Act (SPT 80001-80062) reflected the increasing focus by the State on the new policy arena of social services in which the wellbeing of children was considered to be “bound up with the welfare of the community as a whole”. As the Northern Ireland Government’s 1948 white paper, The Protection and Welfare of the Young and the Treatment of the Young Offender (SPT 14588-14627), had made clear, the policy intent underpinning the 1950 Act (SPT 80001-80062) was to ensure that “every child and young person… whose future welfare is endangered either by neglect or by infringement of the law shall be dealt with in the manner best fitted to enable him to take his place as a valuable member of the community”\(^{21}\).

The 1950 Act (SPT 80001-80062) made changes to the oversight of ‘certified schools’, which were now to be merged and referred to as ‘training schools’. The court could order a child or young person guilty of an offence to be sent to a training school or a remand home pending disposal. The court could also make a Training School order if a child or young person was need of care, protection or control (whether or not they had committed an offence).

The Curtis report on the care of children (which formed the basis of the 1948 Children Act in England and Wales) recommended that ultimate responsibility for defining requirements, maintaining standards, and all aspects of legislation affecting the care of the young should rest with one central department. Thus, in relation to their responsibilities for children, welfare authorities came under the control of the MoHA (SPT 14588-14627).

MoHA was accorded the power to provide and maintain certified training schools and to make rules about the manner in which children committed to the schools were to be dealt with and the duties of those who cared for them.

---

\(^{19}\) 2nd Reading, 23 November 1949 (col. 1865)
\(^{20}\) Ibid.
\(^{21}\) Command Paper 264, p. 12.
2.21 The 1950 Act (SPT 80001-80062) also established the Child Welfare Council (CWC) which was given statutory authority to advise MoHA on any matter referred to it by MoHA in connection with the Ministry’s performance of its functions under the 1950 Act. The CWC could make representations to the Ministry with respect to any matter affecting the welfare of children and young persons. In its report on Juvenile Delinquency\textsuperscript{22}, (Exhibit 5) published in 1954 (the 1954 report), the CWC recommended “\textit{constructive use of leisure}” in Training Schools “\textit{as well as training for work} ..... \textit{In many cases rehabilitation might more easily be effected by awakened interests rather than by punitive measures}”. The 1954 report (Exhibit 5) stressed the importance of a good basic education for training school pupils and, recognising the vulnerability of children who might face a period of idleness between the school leaving age and the taking up of employment, the CWC recommended that the “\textit{law be amended to permit children being retained in Training Schools for an additional year over the present school leaving age}”.\textsuperscript{23} In 1960, the CWC produced a report on the “Operation of Juvenile Courts in Northern Ireland” (Exhibit 6)\textsuperscript{24} (The 1960 report).

2.22 The 1960 report (Exhibit 6) made a number of recommendations. With reference to training schools, the CWC noted that “\textit{many of the juveniles committed to Training Schools come from very unsatisfactory homes}” and it seemed to the CWC that “\textit{if they are to provide any lasting benefit from their training, a concentrated effort for improvement in their homes must be carried out before they return there}”. The CWC also recommended that the court should be given the power to direct the welfare authority, where necessary, to have a welfare officer visit the home for the purpose of giving advice and assisting the rehabilitation of the home\textsuperscript{25}. It also included the raising of the age of criminal responsibility from 8 to 10 years old. The recommendations of the CWC reports were to positively influence the development of court practice and juvenile justice proceedings over succeeding years.

The Children and Young Persons (NI) Act 1968 (The 1968 Act)

2.23 Following the 1950 Act (SPT 80001-80062), there was a rapid expansion in the statutory sector provision of residential care and as an increasing number of children came into the State’s care. The 1968 Act (SPT 80096-80114) effectively re-enacted the provisions of the 1950 Act (SPT

\textsuperscript{22} Juvenile Delinquency Interim report of the Northern Ireland Child Welfare Council. HMSO 1954
\textsuperscript{23} Paragraph 100 page 22.
\textsuperscript{24} Operation of Juvenile Courts in Northern Ireland. Report by the Northern Ireland Child Welfare Council 1960. HMSO Belfast
\textsuperscript{25} \textit{Ibid} paragraph 37.
80062) in relation to training schools with some amendments and raised the age of criminal responsibility (8 years in the 1950 Act) to 10 years. Under the 1968 Act (SPT 80096-80114), following the granting of three consecutive place of safety orders a child could be committed to a training school for a period of up to fifteen weeks, without the intervention of the court.

The Health and Personal Social Services (NI) Order 1972 (the 1972 Order)

2.24 Following the proroguing of the NI Parliament, the NIO assumed responsibility for training schools. Shortly thereafter, the Health and Personal Social Services (NI) Order 1972 made amendments to the arrangements for the financing of training schools; local authorities and parents were no longer required to make contributions. Following this, training schools were divided into two categories: (i) those which were funded by the NIO but managed by voluntary boards and (ii) those funded directly by the NIO and managed by boards appointed by the NIO.

The 1979 Children and Young Persons Review Group (The Black Committee)

2.25 The most significant policy development in the 1970s was the work of the Black Committee which reported in 1979 (HIA 570-638). The Committee’s remit was to look at services and legislation for children and young persons. The review group’s recommendations were wide-reaching but clearly advocated a clear distinction between the treatment of juvenile offenders and children in need of care, making the proposal that care cases should be separated from justice cases. While the report was generally well received, the key recommendation called into question the future of training schools and this was met with considerable hostility, including from churches and local politicians. (Exhibit 7)

2.26 A lack of political consensus meant that there was no possibility of legal separation at this time, leading to a decision by the Secretary of State to allow the Training Schools to continue in existence while ensuring the separation of children in need of care and young offenders in independently operated units in the same campus. This in effect split

---

26 The Children and Young Persons Review Group
27 Submission from G Buchanan (DHSS) to Lord Skelmersdale, August 1989 (ref. JK/139/89)
justice and care cases administratively, even though both remained under the control of the NIO\textsuperscript{28}.


2.27 Further structural changes were made to the administration of training schools under the Children (NI) Order 1995, which stopped short of a full implementation of the 1979 Black Committee’s recommendations. The 1995 Order introduced a statutory framework for the restriction of liberty of children looked after by Health and Social Services Trusts. The concept of committal to training school no longer applies to children in care. A child’s liberty can no longer be restricted for more than 72 hours without the intervention of the court. A Health and Social Services Trust may apply to the court for a secure accommodation order and if the court agrees, it can make an order giving permission for the child to be kept in secure accommodation and specifying the maximum period for which this will be allowed.

**HIAI Question 3**

3. An explanation of the regulatory regime for Training Schools that the statutory schemes set up, including how it or they changed over time.

3.1 The 1923 “Report of the Departmental Committee on Reformatory and Industrial Schools in Northern Ireland” (SPT 17081-17147)\textsuperscript{29} referred to the rules governing industrial schools approved by the Minister under section 54 of the 1908 Act (Exhibit 1). The rules covered the lodging; clothing; dietary; instruction; moral guidance; discipline and punishment of children, together with regulations in relation to the running of the institution. Little information is currently available regarding how these rules were implemented.

3.2 Following the introduction of the 1950 Act, MoHA introduced the Training School Rules 1952 (extant until 1999) which provided the main provision for the operation of training schools (SPT 80063-80073). The main features included:

- composition, role and remit of the Board of Management, including responsibility for “appointment, suspension or dismissal of staff of the school, provided that no person shall be appointed without the Ministry’s approval”;

\textsuperscript{28} A formal split did not take place until the commencement of the Children (Northern Ireland) Order 1995 in November 1996

\textsuperscript{29} See para 2.8
- the Ministry’s role in setting limits on numbers of boys or girls;
- details on the role of the manager responsible to the Board of Management for the efficient conduct of the school and to obtain authority of the Board (and notify Ministry) before leaving the school for more than 2 days;
- the care of boys and girls, suitable clothing, sufficient and varied food, approved by the Ministry;
- detailed provisions on discipline and punishment, including rewards, corporal punishment to be avoided, forfeiture of privileges, limits on separation; limits on corporal punishment (shall not exceed six strokes, to be witnessed by another member of staff, no other boys or girls present), record of punishment, potential dismissal for breaching the rule;
- record keeping;
- medical officer responsibilities; and
- the Board to arrange for the school to be opened for inspection on behalf of the Ministry.

3.3 Whilst the legislation governing training schools did not change significantly over the years in question, nevertheless change was being initiated through the oversight by MoHA of the way in which the care children was being delivered by the schools. For example with reference to the health of children a MoHA Inspector wrote in September 1955 to the Ministry’s Chief Medical Officer stating that medical officers had for some time supervised the health of children but highlighted the fact that “…our medical officers do not visit homes on a routine basis but are ‘on call’ for the MOHA … I have felt for some time that our staff should be making an annual visit to each and reporting through medical channels to you …. only in this way can a composite annual report be completed” (SPT 14419-14420). The Departments’ review of the records of medical officers appointed by Boards of Management of the Malone School indicate that inspections were conducted annually by the school’s medical officer and submitted to the Governor and MOHA. The records initially comprised half a page (“the boys generally looked healthy”) and gradually become more detailed (records reviewed, comments on access to dentist, general health, facilities, absconding levels and punishment (“strap used in several cases; deprivation of privileges”). Individual medical records were introduced by the mid-

---

30 Medical Inspectors Report annually from 1941 to 1954 (PRONI Records)
1950s, reflecting the changes in practice that were sought by the 1952 Rules (SPT 80063-80073). The 1952 Memorandum by the Home Office on the Conduct of Children’s Homes, which set out amongst other standards the desired medical arrangements for children’s homes appeared to inform the practice of the schools’ medical officers (SPT 80080-80095).

3.4 By the late 1950s MoHA officials were more involved with staffing matters for these schools. Whilst officials met with the managers of the schools operated by religious orders, they had very little involvement in the day-to-day running or decision-making. On the transfer of responsibilities from MoHA to the NIO, a Training Schools Branch was established in NIO to provide policy direction and funding for the schools and NIO officials held regular meetings with the Boards. As noted above (paragraph 1.4), 1973 saw the establishment of the first non-denominational training school, Lisnevin, where the Board’s membership comprised representatives from each school. This initiative was seen to bring together the expertise and learning of the different schools, and maintain a 50/50 balance between the two main religious denominations.

3.5 In 1986, the decision by the Secretary of State (paragraph 2.26) (Exhibit 7) to separate children committed to training schools for care reasons from those who had offended was a further step in modernising the juvenile justice system and the implementation of the Black Committee recommendations.

3.6 The 1989 SSI Report, “Residential Child Care in Northern Ireland: The Training Schools” (The 1989 SSI Overview Report) (SPT 16222-16310) which summarised the findings of inspections of the four extant schools (namely, Rathgael, St Patrick’s, St Joseph’s and Lisnevin Training Schools) during the period 1987-88 noted:

“For many years the schools fulfilled the role as defined for them by statute. The numbers of children being admitted to the schools probably peaked in the early 1970s when, at one stage, some 450-500 young people were in residence in Training Schools. At that time numbers meant that, in effect, routine programmes of education, vocational training and counselling were being pursued in a fairly institutional way.

As the spirit of the Black Report began to permeate the criminal justice system, coupled with changes in child care policy, social work though and the need to ensure a more effective use of resources, Training

31 Submission from senior official (DHSS) to Minister, August 1989 (ref. JK/139/89)
Schools’ management began to approach the task of dealing with young people in a more constructive, thoughtful and systematic way.”

3.7 The 1989 SSI Overview Report (SPT 16222-16310) sets out resulting positive changes in the philosophy of the schools and their approach to the care of young people.

HIAI Question 4

4. An explanation of who, at any given time, was executing the regulatory regime set down in the statutory scheme or schemes.

4.1 The day-to-day management of industrial and reformatory schools remained with the religious and charitable institutions that owned them.

4.2 It has already been noted above, that in 1948, the Minister for Home Affairs, made clear the lack of control which his Ministry had over the juvenile justice system. He confirmed that the Ministry undertook visits of schools and reported on dietary, cooking, cleanliness and the general order of the schools. In taking forward a new children’s bill he highlighted the fact that the Catholic Church would still have the right to run their own institutions, subject to the Ministry’s control of general policy.

4.3 The 1950 Act (SPT 80001-80062) which established training schools and the 1952 Training School rules (SPT 80063-80073) provided clear policy direction and stronger administrative structures. These including setting out: the role and remit of the Board; the role of the manager responsible to the Board of Management and the effective conduct of the school; provisions on discipline and punishment; and record keeping. The Rules (SPT 80063-80073) stated that the Board should arrange for the schools to be open for inspection on behalf of the Ministry. The Rules (SPT 80063-80073) provided a more robust management arrangements providing greater record keeping and transparency to the management of schools.

4.4 Boards of Management were responsible to MoHA for the effective conduct of schools, and inspections by MoHA were the main vehicle for providing assurance that schools were being run effectively and providing appropriate care and services. In maintaining an efficient standard throughout the school, Boards of Management were also required to take into consideration any reports which the Ministry brought to their notice.
4.5 Visits to and inspections of the schools were a further important element of statutory oversight by MoHA/NIO. With reference to the period prior to 1950, the Departments have noted some reports by the Department of Education Inspectors in the bundle of evidence received to date in respect of St Patrick’s Industrial School (SPT 10376-10386). Inspection reports by MoHA Inspectors during the period that St Patrick’s operated as an industrial school are not currently available and it is therefore not possible to comment on the extent to which the inspection regime informed statutory oversight of the school during this period.

4.6 However, the DHSSPS statement to the HIAI dated 30 July 2015 (Exhibit 9) refers to evidence indicating that from the inception of St Patrick’s as a training school, inspections may have been carried out with relative frequency between the years 1950 and 1971. There is also some evidence of inspection activity and frequent visiting of the school by Inspectors from the DHSS’s Social Work Advisory Group (SWAG) and subsequently, the Social Services Inspectorate (SSI) during the mid 1980s and 1990s. 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.

4.7 An example of such oversight was evident, when following a major inspection of St Patrick’s School in 1988, a follow-up inspection by SSI in 1990 found that the school had not made an acceptable standard of progress in implementing the recommendations of a 1988 inspection report. The situation was deemed by the NIO and the SSI to be of such gravity that the NIO wrote to the Chair of the Management Board, stating that unless action was taken by the school within a matter of days, the Chief Inspector, SSI would “have no alternative but to advise the Health and Social Services Boards not to send any children to St Patrick’s”.32 (Exhibit 9)

4.8 Again, with reference to the degree of oversight of the schools exercised by the NIO, the HIAI may wish to note the “Review of the Circumstances Leading to the Death of William Campbell”, undertaken by SSI in 1995 (SPT 12601-12921). William was an 11 year old boy who had been placed by the Western Health and Social Services Board (WHSSB) in St Patrick’s School under the provisions of a place of safety order. The review was undertaken at the request of the NIO and DHSS due to perceived deficiencies in the reports into the child’s death produced by the WHSSB and the St Patrick’s School. It resulted in some 23

recommendations, most of which were directed at the management board of the Training School.

4.9 During the same year, 1995, as part of a series of audits in the training school system to appraise the adequacy of the financial controls in each of the schools, the NIO Internal Audit Unit carried out an assessment of the arrangements in St Patrick’s. As a consequence of the audit findings, the Criminal Justice Services Division of the NIO arranged for the St Patrick’s Management Board to invite Price Waterhouse to conduct an exercise in the school. It was recognised the management structure of the school also needed to be appropriate to manage and supervise the institution’s core task of providing care, treatment and education for the boys. In that context the NIO commissioned SSI to carry out a parallel exercise to review and make recommendations regarding the St Patrick’s management structure. The SSI report (SPT 16316-16342), completed in 1996, made 18 recommendations, including several aimed at helping the school restructure in preparation for the changing profile of juvenile justice and care services to be introduced by the implementation of the Children (NI) Order in November 1996.

HIAI Question 5

5. How the regulatory regime was executed in practical terms

5.1 The Children and Young Persons Act 1950 (SPT 80001-80062) established training schools and set out clarity behind the structures and relationship between the MOHA and Boards of Management. Boards of Management had responsibility for the day-to-day running of the Schools, and they operated within the instructions provided through the 1952 Training School Rules (SPT 80063-80073).

5.2 The 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: Finance Committees, Board Minutes, standards of care, visits and Inspections.

5.3 In the period prior to the mid-1980s there is some evidence in log books, letters and minutes of inspections taking place in schools and of a variety of people visiting: doctors, educators, social workers, probation officers, civil servants and political figures. The reports, which these inspections and visits may have produced, have not been found in the Departments’
records. We have, therefore, no documentation to bring before the Inquiry for this early period. However, the sections of this statement to follow set out in detail the inspection arrangements and procedures that prevailed during the period in question based on the information currently to hand.

5.4 The Training School Branch in 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, 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. File disposal makes it hard to assess what level of follow up was applied to these minutes.

5.5 Training School Rules (SPT 80063-80073) required at least one member of the Board to visit once a month. Management Board visits reports 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 around 4-8 weeks. There was a focus on quality and cleanliness of facilities and general atmosphere. Overall the visitors were generally impressed, though towards the end of the period they express more concern about the need for renovations as a result of wear and tear. Initial reports are brief (one paragraph) but by 1989, 1-2 pages is more common (Exhibit 10).

5.6 In 1982, during the period of public focus on Kincora, the DHSS commissioned a review by the Department of Health in England of the arrangements for the monitoring of homes and hostels for children and young people. Whilst the report produced in 1983 and known as the ‘Sheridan report’, (HIA 639-655) dealt with the need for clear understanding of the extent of HSS Board and Departmental responsibility in the management, supervision, monitoring and inspection of children’s homes, it also served to introduce a framework of self-monitoring arrangements for children’s homes. In 1986, a DHSS Circular33 required the administering authorities of children’s homes to put in place stringent monitoring and reporting arrangements to both Health and Social Services Boards and the DHSS (SPT 80115-80118). With reference to voluntary homes the circular stated ‘The Department is

33 Department of Health and Social Services Circular ref: All48/83 to Chief Administrative Officers of each Health and Social Services Board, the Central Services Agency, Director and the Northern Ireland Staff Council
requesting voluntary bodies to review and, where necessary, strengthen the monitoring arrangements which they operate and to submit to the Department a statement of their arrangements as endorsed by the managing body’. The administering authorities of voluntary children’s homes subsequently established similar monitoring and reporting arrangements.

5.7 Our assessment of the file suggest that the arrangements set out in the 1986 DHSS circular would have extended to training schools. It is noted that the 1989 SSI Overview Report (SPT 16222-16310) with reference to monitoring activity by the Training Schools’ Boards of Management, cited the 1986 DHSS circular and recommended that “a system of monitoring akin to that used within the Health and Social Services Boards in respect of their residential child care services” should be adopted.

5.8 In 1989, guidance on the role of the Board Visitor was introduced by the NIO (SPT 80074-80079), including a 2-page pro forma covering record keeping; quality of social/emotional and physical care; examination of personal files; conversations with young people; conversations with staff; physical environment; any specialist observations; other matters; recommendations). The visitor was to be accompanied by a member of staff when gathering these observations. It is likely that these changes were introduced as a consequence of the recommendation in the SSI Overview report referred to above.

HIAI Question 6

6. The requirements to be recognised as a Training School and how those requirements were assessed and by whom

1922 – 1950

6.1 From 1922 to 1950, the Minister of Home Affairs in the Northern Ireland Government was empowered under the Children Act 1908 (Exhibit 1), upon application by the managers of any reformatory or industrial school, to certify any such school. In practice, many schools will have already been certified by the Chief Secretary of Ireland prior to the partition of Ireland. However, the 1908 Act (Exhibit 1) required the certifying Minister to first direct the Chief Inspector of Reformatory and Industrial Schools to examine the condition and regulations of the school and its fitness for the reception of youthful offenders or children. The Minister had to be satisfied that a school was fit for purpose before certifying it.
6.2 The certification could also be withdrawn by the Minister if, at any time, the Minister was dissatisfied with the condition, rules, management, or superintendence of a certified school.

1950-1995

6.3 As previously, the managers of training schools could, under the 1950 Act (SPT80001-80062), apply to MoHA to approve the school for that purpose. The Ministry could issue a certificate of approval after making “such inquiries as it [thought] fit”. Certificates were advertised in the Belfast Gazette. The Ministry could withdraw the certificate if it was dissatisfied with the condition or management of a training school, or if it considered its continuance as a training school unnecessary. It could also, additionally, by serving notice on the school, prohibit the admission of persons to the school. (s.106)

6.4 These provisions were then effectively reproduced in the Children and Young Persons Act (NI) 1968 (SPT80096-80114). However, that Act also provided that the Ministry itself could provide training schools and make arrangements with other bodies or persons for the provision of such schools (s.137, 138).

HIAI Question 7

7. What guidance there was at any given time for how Training Schools were to be operated including in relation to staffing ratios, facilities, etc.

7.1 Following the enactment of the Children and Young Persons Act (Northern Ireland) 1950 (SPT 80001-80062), which brought about the change from reformatory and industrial schools to training schools, the establishment of a dedicated borstal, and provided MOHA with central authority, the Ministry of Home Affairs issued a circular (7/1950, March 1950) (Exhibit 11) which set out guidance in relation to the training schools. The circular highlighted a number of key changes: extension of age limits; duration of Training School orders; provision of court materials to school management; retention of child after the expiry of the Training School order period; and provision of supervision and recall of children who have left the school.

7.2 The 1989 SSI Overview report (SPT 16222-16310) noted that training schools had by that time developed their own policy documentation setting out their aims and objectives, directives to staff and procedural guidance. That wider policy and best practice awareness affecting the
care of children in children’s homes following the Kincora case in the early 1980s had filtered through to the training schools is evident from the profile of staff qualifications and training set out in the above report, indicating continuing professional development of the service.

7.3 Inspectors found, for example, that there had been an extensive programme of secondments to full-time training in the late 1970s early 1980s. Several senior staff had completed a post-qualifying course, and most of the schools had a policy of recruiting professionally qualified staff to fill vacancies as they arose. In addition there was a commitment to sending staff on short term courses organised by the DHSS; Health and Social Services Board, voluntary organisations and universities. Several in-service training courses had also been arranged on subjects such as Sexuality in a Child Care Setting; Child Sexual Abuse; Staff Supervision and Handling Aggression and Conflict34.

HIAI Question 8

8. The staffing ratios that were expected for Training Schools, including where that changed over time

8.1 The NIO and DHSSPS are presently unable to locate any information relating to staff ratios or staffing requirements in training schools prior to the 1980s.

8.2 What we can say is that the Social Work Advisory Group (SWAG) and subsequently, SSI, provided advice on care staffing ratios and training needs. The information available to us suggests the ‘Castle Priory formula’ was used to calculate the staff requirements of the schools, allowing for differing staff ratios per type of unit providing care i.e. Open Units; Assessment/Reception Units and Closed/Secure Units. In addition to the basic Castle Priory formula, account was taken of staff leave entitlement and extra staff hours required during the school holidays. Staffing levels across the four training schools were generally found to be satisfactory with some shortfall noted resulting in employment of temporary staff and overtime working in some units. Overall, the view of the DHSSPS is that staffing ratios in the training schools in 1989 compared favourably with and may well have represented an improvement on the ratios that existed in a number of children’s homes at that time.

34 1989 SSI Overview Report paragraphs 5.9-5.11
8.3 Annual exercises were undertaken by NIO, usually in November of each year, to agree the staff required for the forthcoming financial year for all training schools\(^{35}\). (Exhibit 7)

**HIAI Question 9**

9. **How the inspection regime for Training Schools operated, including where that changed over time**

9.1 It has been noted above that the 1908 Act (Exhibit 1) required that inspections of industrial schools and reformatories should be carried out annually. Whilst it would appear the evidence received from the HIAI includes some reports of inspections of the St Patrick’s Industrial School made by DE Inspectors, there are no MoHA inspection reports currently available to the DHSSPS and DOJ in respect of this facility.

9.2 Prior to the transfer of training school inspection functions to the DHSS in the early 1970s, the evidence indicates that inspections of St Patrick’s Training School were carried out by MoHA children’s inspectors in the years, 1950; 1951; 1952; 1956; 1958; 1960; 1962; 1967 and 1971. (SPT 10440-10496) It is not presently known by the Departments whether this frequency of inspection applied to other training schools. It is also presently unclear to the Department whether inspections of training schools were undertaken by SWAG on behalf of the NIO between the early 1970s and the early 1980s. DHSSPS has already postulated to the HIAI that an apparent lack of inspection activity in relation to children’s homes during these years may have been due to the impact of the Seebohm report\(^{36}\) which proposed a shift in emphasis from a regulatory focus to the establishment by central government departments of advisory and supportive relationships with service providers. It is possible that this change of focus may also have been reflected in the approach of the NIO to its inspection requirements.

9.3 The few inspection reports or references to reports presently available to the Departments would indicate that the inspections prior to the early 1980s followed a methodology and style of reporting similar to that adopted by the MoHA in the inspection of children’s homes. The DHSSPS has already commented extensively in its written and oral evidence to the HIAI on the fact that the model of inspections and

---

\(^{35}\) Presentation to the Rathgael Board by Mary Madden, NIO, on 18 January 1993. Document submitted to the inquiry on [date]. Not yet allocated a Bates reference number. It is attached for convenience at Exhibit 7.

\(^{36}\) Report of the Committee on Local Authority and Allied Personal Social Services HMSO London 1968
reporting adopted prior to the early 1980s was reflective of the accepted approach at that time.

9.4 From the 1980s onwards there was a growing awareness of child protection issues and the measures that could be taken to improve monitoring and inspection. The HIAI has already received DHSSPS testimony to the fact that the Kincora case in the early 1980s and the Hughes Inquiry, which reported in 1986, led to a more rigorous inspection approach to children’s homes and, it would appear, to training schools. NIO papers from 1991\textsuperscript{37} state that the inspection arrangements for training schools were replaced with a formal financial arrangement with DHSS, and provided a draft paper setting out expectations for SSI inspections. Inspectors were required to apply standards of fairness, equity of treatment and noted the importance of balancing the need for a recognised set of rules alongside “tender care”. The SSI were also to advise NIO inter alia on control and aftercare issues in training schools.\textsuperscript{38} The SSI agreed with NIO that each training school would receive two unannounced visits each year\textsuperscript{39}.

9.5 NIO papers appear to confirm these arrangements. A note from the Director of Rathgael to senior staff in 1992 which recorded a meeting at Stormont, indicated that: inspections were to take place every four years (reports were to be made available to Social Services Boards and other relevant people); two unannounced visits were to be undertaken by SSI; and Annual Monitoring Reports were to be returned to the Management Board, the NIO and SSI by the Directors of each of the training schools based on the format introduced for children’s homes.

9.6 Major inspection reviews of the four extant training schools were undertaken during the 1987-1988 period. The report in relation to the inspection of Rathgael School is the only one of the reports presently available. It demonstrates an in-depth consideration of several aspects of the school, resulting in several recommendations. A similarly intensive inspection of St Patrick’s Training School took place in 1988\textsuperscript{40}. This has already been commented upon in paragraph 4.7.

9.7 From the evidence presently available to the DOJ and DHSSPS, it would appear that from the mid 1980s until the closure of the schools, major inspections of training schools may therefore have taken place at four-

\textsuperscript{37} Letter from Deputy Director Alan Shannon to Director Rathgael TS July 1991
\textsuperscript{38} Letter from Deputy Director Alan Shannon to Director Rathgael TS July 1991 - role of SSI. Also notes that Lisnevin (not others) has own Centre Rules to update 1952 rules.
\textsuperscript{39} 1993 letter from SSI.
\textsuperscript{40} 1988 SSI Inspection Report held by HIA, in the Rathgael Evidence bundle no reference allocated.
yearly intervals interspersed by more frequent less intensive reviews, referred to as ‘regulatory’ inspections. With reference to the latter reports currently available, it would appear that these made brief comment on the extent to which training schools were complying with relevant aspects of the 1952 regulations (SPT 80063-80073).

HIAI Question 10

10. Who carried out the inspections

10.1 The 1923 Report of the Departmental Committee on Reformatory and Industrial Schools in Northern Ireland (SPT 17081-17147), stated that a MoHA Principal Medical Officer was conducting inspections of reformatories and industrial schools. Appointments of Assistant Inspectors were also pending at that time. Inspections of the “literary” and “technical” instruction of the boys were also undertaken by Inspectors from the then Ministry of Education (ME).

10.2 From the evidence of archive records received from the HIAI, it would appear that between 1950 and 1972 and prior to the implementation of the Health and Personal Social Services (NI) Order 1972 (the 1972 Order) (Exhibit 12), inspection functions under the 1950 (SPT 80001-80062) and 1968 Acts (SPT 80096-80114) in respect of training schools were undertaken by MoHA children’s inspectors and medical officers who were responsible for the inspection of children’s homes. The HIAI will note that the names of Miss K Forrest and Dr N Simpson, which featured significantly in previous modules of the Inquiry with reference to MoHA inspections of voluntary children’s homes, also appear in the documentation associated with inspections of St Patrick’s Training School during the 1950s and 1960s. (SPT 10384-10386; SPT 10390; SPT 10393-4)

10.3 Previous statements to the HIAI by the DHSSPS have noted that the major restructuring of health and social care services under the 1972 Order (Exhibit 12) resulted in the transfer from the MoHA of policy, administrative and inspection responsibilities for children’s homes under the 1968 Act (SPT 80096-80114) to the newly created DHSS.

10.4 By virtue of the Department’s Transfer of Functions Order (NI) 1973 (Exhibit 13), certain functions under the 1968 Act (SPT 80096-80114),

41 Victor McElfatrick’s minute
including those contained in section 168 which related to the powers of inspection, transferred to the DHSS, subject to the provisions of the 1973 Order. Critically, for the purposes of this submission to the HIAI, Article 2 (2) of the Departments Transfer of Functions Order (NI) 1973 provided that the Secretary of State, as well as the Department of Home Affairs (i.e. the UK Home Office) “may exercise functions under sections 147, 167 and 168 of the Children and Young Person’s Act (Northern Ireland) 1968.” (SPT 80096-80114)

10.5 In effect, it would appear that the Departments Transfer of Functions (NI) Order 1973 together with the Modification of Enactments (NI) Order 1973 created a power of inspection on both the NIO and the DHSS in relation to all children’s institutions maintained under the 1968 Act but responsibility for the implementation of section 132 (4) of the 1968 Act (SPT 80096-80114) which imposed a duty on the MoHA to “cause remand homes to be inspected” fell to the NIO. In practice, NIO retained responsibility for the inspections of training schools and the DHSS assumed responsibility for inspections of children’s homes. The SWAG, subsequently the SSI, was evidently the body authorised by both the DHSS and the NIO to discharge each Department’s respective powers of inspection from 1973 onwards.

HIAI Question 11

11. **What guidance or criteria were the inspectors expected to apply, including how that changed over time**

11.1 Previous submissions to the HIAI by the DHSSPS have stated that standards for the inspections of children’s homes were first established by SWAG/SSI in 1986 when a DHSS circular (SPT 80115-80118) set out criteria which included regulatory and good practice standards devised to improve the process of inspection, the self-monitoring arrangements of children’s homes and the monitoring information requirements of the DHSS. These may have informed the format of inspections of training schools but as the various sections of the training school reports available for this period are not prefaced by standards statements, it is difficult to know whether this was the case.

11.2 A standards document entitled “Statement of Standards and Criteria for Juvenile Justice Centres in Northern Ireland”(Exhibit 11) was issued by

---

42 Sections 147 and 167 referred to the acquisition of land and the carrying out of investigations/inquiries
the NIO in January 1999 and informed the subsequent inspections by SSI of the new Juvenile Justice Centres, established by the Criminal Justice (Children) (NI) Order 1998.

HIAI Question 12

12. How Training Schools were funded, including how that changed over time

12.1 The 1908 Act (Exhibit 1) provided the Chief Secretary with powers to recommend that monies be paid from Treasury towards the expense of any child or youthful offender up to certain limits. The Act (Exhibit 1) also included Local Councils to provide for children’s reception and maintenance, but industrial schools run by voluntary organisations could also receive children privately admitted to care. In such cases the support of these children came from voluntary subscriptions and donations, to the body responsible for the school.

12.2 The Committee established by the Minister for Home Affairs in 1923 recommended that funding of homes should be by capitation grant of 2s,6d, per head per week from the Government and an equal amount provided by Local authorities (SPT 17081-17147).

12.3 During the 1950s and 1960s, training schools were financed through Government Grant, Local Authority/Welfare Authority grant, and in certain circumstances contributions from parents (Exhibit 1). However, the 1952 Training School Rules (SPT 80063-80073), drawn up under the 1950 Act (SPT 80001-80062), set out, inter alia, the responsibilities of the Management Board of the school. Pertinent rules regarding finance included:

- The Board of Management shall appoint a finance committee and such other committees as they think necessary for the efficient management of the school.

- The Board of management shall meet so far as practicable once a month at the school.

- The Board of management shall maintain an efficient standard throughout the school and for this purpose they shall take into consideration any report which may be communicated to them by or on behalf of the Ministry.

- The Board of Management shall exercise an effective control over all expenditure.
12.4 Article 150 of the Children and Young Persons Act 1968 (SPT 80096-80114) brought in new funding arrangements, confirming that funding for training schools was to be provided and controlled by Government. The grant, which was to cover the full costs of maintaining a child in a training school, was administered by MOHA and the NIO.

12.5 There is evidence to suggest that the NIO produced a document outlining the conditions for the payment of grant to training schools (Exhibit . It set out the key points in the financial relationship between the NIO and the schools and required schools to:

- Furnish the NIO with reports and accounts on request.
- Permit the audit by NIO of records and accounts.
- Comply with any directions by the NIO in respect of such records and accounts.
- Maintain records and accounts as directed by the NIO.
- Prepare an annual statement of accounts.
- Submit statements of account to the Comptroller and Auditor General.
- Submit quarterly and annual estimates of expenditure and maintain financial records enabling the school to monitor spending and plan future operation.

12.6 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 approval was obtained from the MOHA and NIO.

12.7 St Patrick’s Training School was an employer in its own right and managed the movement of Brothers within their schools. They also employed ancillary staff, which would not necessarily been brought to the MOHA/NIOs notice. The St Patrick’s Board would have sought approval of appointment of secular staff necessary to work with the children. The MOHA/NIO would have provided vetting of staff prior to their appointment.
12.8 All training schools submitted budgets for approval to MOHA/NIO and raised financial pressures with MOHA/NIO. Boards would provide estimates in October for the incoming business year, and following receipt of additional information and satisfactory explanations the MOHA/NIO would approve budgets. Grant was claimed on a monthly basis, and taking account for preventing debit balances and the existence of unnecessary large credit balances, payment would be approved and made to the school.

HIAI Question 13

13. Who could come to be resident in a Training School

13.1 The following main groupings of children comprised the population of training schools from the inception of training schools under the 1950 Act (SPT 80001-80062) to the implementation of the Children (NI) Order 1995:

- children who had been found guilty of an offence in respect of whom the court had granted a Training School order;
- children accused of an offence who were awaiting trial or disposal by a juvenile court and had been placed on remand by the court;
- children placed temporarily in the school by HSS Boards (and from 1992, HSS Trusts) under the provisions of a place of safety Order;
- children who were formerly in the care of HSS Boards in respect of whom the court had granted a Training School order;
- children who were committed by the court under the provisions of an interim detention order or a Training School order for non-attendance at school.

13.2 The papers available to us suggest that the number of “care” children in training schools at any one time outweighed the number of “offender” children committed to training school.

HIAI Question 14
14. The circumstances under which an individual could come to be resident in a Training Schools, including how that changed over time

14.1 With reference to children admitted to Training Schools for reasons of care and control, the 1950 (SPT 80001-80062) and 1968 Acts (SPT 80096-80114) empowered an HSS Board, with the consent of a Justice of the Peace, to place a child formerly in its care, in training school under the provisions of a Place of Safety order. Such an order committed the child to the training school for a period of up to 5 weeks. If necessary, HSS Boards could seek up to 3 consecutive orders (i.e a period of up to 15 weeks) to assess the child and make appropriate provision for his/her future care.

14.2 Place of Safety orders were generally sought on children who had long care histories and whose behaviour was not capable of being managed within a children’s home setting. Often the behaviour was such that it presented a serious risk to the child or other residents. It was considered that temporary periods in a training school could provide helpful ‘time out’ for a child and in later periods, the greater accessibility of the schools to psychological and psychiatric care meant that multi-disciplinary assessment was more readily available to the child in the training school setting than was the case in the children’s home. Many children returned to the care of the HSS Boards prior to the expiry of their Place of Safety Orders. In the case of significant numbers of children, however, care within a more structured and secure setting was deemed to be the only viable long term means of managing them. In such situations the HSS Boards would ask the court to grant a Training School order in respect of the child.

HIAI Question 15

15. Anything else the Department considers it should bring to the HIA Inquiry’s attention in respect of these matters

15.1 During the review of archived materials and Departmental files, the DOJ and DHSSPS have found a number of reports relating to investigations of allegations of abuse in Training Schools during the 1922-1995 period that will be of interest to the HIAI. It was not appropriate to address these matters within the context of the responses to the above questions posed by the Rule 9 request. It is the intention of the DOJ and DHSS to address these in a further joint statement to be submitted within a timeframe to be agreed with the HIAI.
Index of Exhibits

Exhibit 1 – The Children Act (1908)
Exhibit 2 – The Roots of Rathgael
Exhibit 3 – The Malone and Whiteabbey Training Schools Act (Northern Ireland) 1956
Exhibit 4 – Malone and Whiteabbey Training Schools Act (Northern Ireland) 1968
Exhibit 6 – The Operation of Juvenile Courts (1960)
Exhibit 7 – Submission from G Buchanan (DHSS) to Lord Skelmersdale, August 1989
Exhibit 8 – Ministry of Home Affairs (MoHA) Inspector's letter 1955
Exhibit 9 – DHSS Statement 30 July 2015
Exhibit 10 – Reports on visits to training schools 1956 - 1990
Exhibit 11 – Ministry of Home Affairs (MoHA) circular – 7/1950 (March 1950)
Exhibit 11 - Health and Personal Social Services - Establishment and Determination of Health and Social Services Boards Order (1972)
Exhibit 12 - Northern Ireland Departments (Transfer of Functions and Adaptation of Enactments) Order (1973)
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 1983-84. 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 Rangers 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 the letters of a proscribed terrorist organisation prominently tattooed on to the fingers of his left hand. He
reported to the Inquiry that the presence of the tattoo triggered negative comments and insults from members of staff, including insults of a sectarian character. 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).
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).

It will be noted that HIA 434 was a resident of Lisnevin in 1989, a year or so before HIA 138 was sent there, and three years before HIA 418 was sent there.

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 16 May 1994, 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.”

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.

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.

On the 7 May 1994 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 bearing a tattoo referencing a Republican paramilitary organisation, as in the case of HIA 138, might also attract adverse comment. If staff members engaged in such conduct it would be deeply regrettable even if a tattoo of this nature would be provocative and repugnant to many. 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 1988 “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 1989. 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 (1990); HIA 275 (1988-89); and HIA 418 (1992-93, and 1995-96).

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 1974-1975. 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 1990, 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 1990 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 1990 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 1989 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 17 March 1989 and 29 March 1989 (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.
GENERAL

1. I was a Northern Ireland civil servant from 1971-2013 and I worked in the Northern Ireland Office (NIO) from 1986-1999. I retired from the civil service on May 2013 at which time I held the post of Permanent Secretary to the Department of Employment and Learning.

2. From 1990-1992 I was head of a Division entitled “Compensation, Probation and Juveniles Division”. The Division was responsible for the Criminal Injuries and Criminal Damage Compensation Schemes, probation policy, the appointment, funding and direction of the Probation Board, and juvenile justice, including the training schools.

3. The Training Schools Branch (TSB) within my Division was headed by a Grade 7. It exercised a general oversight of the training schools - Rathgael and Whiteabbey, St Patrick’s, St Joseph’s, Middletown, Whitefield and Lisnevin, including budgetary control, the application of rules and guidance, and the promotion of good governance.

4. A separate Division, “Criminal Justice Division” was responsible for criminal justice policy and legislation, including the law on juveniles.

5. For most of the period both these Divisions answered directly to the Deputy Secretary, then John Ledlie. I was asked to carry out a review of the structure. My key recommendation was that a new post should be created at “Under-secretary” level to provide more drive and coordination of criminal justice policy and better oversight and support to the various agencies. This recommendation was accepted and John Lyon came in from the Home Office to fill that post in the autumn of 1991.

6. In addition, I had spent quite a bit of my time preparing to reconstitute the two branches administering the Criminal Injuries and Criminal Damage Schemes into a “Next Steps Agency”. When I left the Division in February 1992 (to become Comptroller of Prisons) my post was split into the Head of a “Criminal Justice Services Division” and the Chief Executive of a new “Compensation Agency”. This represented a significant enhancement of the NIO’s capacity in Criminal Justice matters and prepared the way for a series of significant reforms over the next decade.
POLICY

7. The key strategic issue affecting my role between 1990-92 was the need to anticipate the consequences of the proposed Children’s Order being prepared by DHSS. This was a major reform of the law relating to children and was several years in the making. The key official taking this forward was Mr Jimmy Kearney and we had regular liaison arrangements with him and his staff. The number of children being sent to Training Schools had been in decline for some years as professional and public opinion increasingly regarded confinement as a last resort, and as diversionary schemes and alternative disposals became available. In addition there was a gradual reduction in the average length of stay. The 1989 SSI Report\(^1\) (Exhibit 1) stated that numbers probably peaked in the early 1970’s at 450-500 whereas by 1987/88 the numbers on the roles had fallen to 315 with some 96 of those not actually resident on the dates when the snapshots were taken (paragraphs 3.2, 4.2, 4.6, 4.10 and 4.16). It was becoming clear that the Children’s Order would exacerbate this trend and constituted a threat to the viability of the current structures.

OVERSIGHT ARRANGEMENTS

8. I have read the joint statement of the Department of Justice and the Department of Health, Social Services and Public Safety dated 21 August 2015 and I endorse those paragraphs which relate to the period of my responsibility (4.7, 9.4, 12.7, 12.8, 13.1, 13.2, 14.1 and 14.2).

9. Training Schools Branch carried out the statutory responsibilities of the NIO and its Ministers in relation to the establishments. The two state schools (Rathgael and Lisnevin) were fully funded by the NIO. The two Roman Catholic Schools (St Patrick’s and St Josephs) were also fully funded but had access to additional sources of income from time to time. TSB secured the budget in the Government spending rounds on the back of a bidding process and allocated budgets to the institutions. There was provision for both running costs and capital. The schools were given delegated spending limits, above which TSB approval was required. During the 1990-92 period expenditure was being cut back in light of falling numbers of children so TSB was constantly pressing for the Training Schools to implement efficiency measures.

10. In addition to active budgetary control, TSB monitored performance routinely. A key control mechanism was the Training School Rules 1952\(^2\) (Exhibit 2), which, although they had been extant for many years, were still relied upon to cover governance (particularly the boards of management), the treatment of children, the appointment of staff, medical support and record keeping. The Rules were supplemented by guidance for management\(^3\) (Exhibit 3).

\(^1\) Residential Child Care in Northern Ireland – the Training Schools October 1989
\(^2\) Training Schools Rules 1952 SPT-80063 – SPT-80073
\(^3\) 1952 No 132 Training School Rules – info for management SPT-80074 – SPT-80079
11. The minutes of the Management Boards, including their supporting papers (such as the Director’s Report) were copied to TSB which scrutinized them. Issues of concern were followed up with senior staff or the Board Chairs. Statistical returns were sought on numbers, absconds, staffing, and financial performance.

12. The schools were inspected by the SSI of DHSS and education provision by the Schools Inspectorate of DENI. I have seen the statements by Dr Kevin McCoy and Mr Victor McElfatrick and they accord with my own recollection.

13. SSI staff acted as professional advisers to NIO on social work practice and policy. This included information about policy and practice in childcare generally in Northern Ireland but also about developments in GB and beyond.

14. SSI carried out a planned programme of inspections (as agreed with NIO) and was available to address any specific or pattern of incidents. The inspectorate also advised on a range of issues including policy and establishment design. Its reports were sent to the NIO and the relevant school’s management board. The responsibility for implementing SSI findings lay with the school management board. SSI would normally report on progress in its next report. NIO may have asked for progress reports from time to time, depending on the seriousness of the issue. The inspection arrangements were formalised in my time by an exchange of correspondence between Dr McCoy and myself (referred to in paragraph 9.7 of the DOJ/DHSSPS joint statement).

15. The general approach was to conduct a “full inspection” of each establishment every 4 years with less comprehensive inspections, some of them unannounced, in between. However, there were also “themed” inspections, for example that of Lisnevin and Shamrock House in Rathgael in 1992 in respect of secure accommodation following the “Pindown Report”. This report, which can be accessed via the link below (Exhibit 4), gave us reassurance that none of the practices that gave rise to concerns in England were prevalent in Northern Ireland.

16. Most of the day to day contact between NIO and the schools was between the staff in the branch and school staff at various levels. Both NIO and SSI staff were regular visitors to the schools. As Head of Division I had regular contact with Board Chairs, senior staff and SSI.

17. I was in post just a few weeks when SSI presented me with a report which came close to recommending the closure of St Patrick’s. It would have been helpful for me to have been able to read this report and the letter of Dr McCoy but at the time of providing this statement I understand that these documents

cannot be found. I wrote\(^5\) (Exhibit 5) to the Chair of the Management Board on 12 March 1990 expressing grave concern\(^6\) (Exhibit 6) at these findings and met with him and Board members shortly afterwards. I refer to the content of that letter. The most serious failings concerned fire safety and childcare practices. The Fire Service was consulted. It advised that there was no immediate threat to health and safety and it became clear that the deficiencies were susceptible to urgent remedial action. On childcare practice SSI offered to provide advice and guidance to help the school address the issues. While the Management Board did not readily accept all of the criticisms, there was a determined and constructive response which enabled us to work together to address the issues of concern and secure the future of the institution, at least for the time being.

18. This was a good example of the system working. It was important not just to have effective inspection but to ensure that findings were rigorously followed up, changes made and improvements confirmed.

RELATIONSHIP WITH BOARDS OF MANAGEMENT

19. The Boards were responsible for ensuring the effective discharge of the responsibilities of the schools. They employed the staff, approved expenditure, set direction, oversaw the care of the children and ensured that problems were dealt with in accordance with the rules and best practice. Board members paid formal visits to the schools on a monthly rotation, making themselves available to staff and children and made reports.

20. While the 1952 rules envisaged a common system of appointments to management boards, it was custom and practice for the Catholic Church to appoint the members of the Boards of the Catholic Schools. Otherwise all the schools were subjected to the same regulatory regime of rules, circulars, SSI guidance and inspection, and NIO approvals of budgets and numbers.

21. The Board of Rathgael was appointed by Ministers, and the NIO was fully involved in the selection process in accordance with the rules for public appointments. St Patrick’s and St Joseph’s were owned by the Church and therefore church authorities made Board appointments. The Lisnevin Board was a compilation of board members from the other schools.

22. In my time, the Chair of Rathgael was Lady Moira Quigley. The Board contained a number of eminent people including Lady Eames, wife of the Archbishop of Annagh, and was both proactive and effective. Lisnevin was chaired by Joe McReynolds who was also Chair of St Joseph’s. The Chair of St. Patricks was the auxiliary bishop for Down and Connor, Bishop Anthony Farquhar.

\(^5\) Letter from Alan Shannon to The Most Reverend Anthony Farquhar dated 12 March 1990 SPT-10420 – SPT-10423
\(^6\) Comments from the Board of Management of St. Patrick’s Training School Subsequent to the Follow-up Inspection Report forwarded to the Chairman by Mr Shannon on 12 March 1990 SPT-10424 - 10433
23. The Rathgael Board met monthly, as did a number of sub-committees and its papers were copied to TSB. I think the St Patrick’s Board met less often, possibly quarterly. I cannot recall how regularly Board papers from schools other than Rathgael were shared with the Department.

INVESTIGATIONS AND COMPLAINTS

24. The institutions had procedures in place to deal with abuse. Directors were required, as appropriate, to investigate, to notify the police, to suspend staff and to notify the NIO. Management Boards monitored complaints and Board members were sometimes involved in investigations.

25. I recall a case in Rathgael where a Deputy Director had been accused of inappropriate behaviour. The Director immediately effected a precautionary suspension and informed the Board, the NIO and the police. An investigation was carried out by a panel which included a Board member and a representative of SSI. In the event the allegations were not substantiated and the individual re-instated. The statement of Gary Wardrop dated 28 August 2015 (Exhibit 7) contains a more detailed description of how particular cases were handled.

26. Rathgael had systems in place to safeguard against abuse and suicide. Each young person had access to a key worker, a teacher, a team leader, a chaplain, a member of the resident medical staff, readily available senior staff and members of the Board. A policy of active night supervision was felt to have saved lives. Each young person had an “Individual Assessment Treatment Profile” reviewed monthly.

27. In addition, all the schools and their young people had access to the “Adolescent Psychological Research Unit” which provided both collective and individual advice.

28. It was also possible for the young people or their families to raise issues with public representatives. Apart from Lisnevin, the institutions were “open” and both absconding and home leave were common. For example, on the dates when the SSI recorded enrolments for its 1988 report (Exhibit 1), 96 of the 315 children enrolled were not currently resident. Most of these were on home leave. I recall the MP for North Down, James Kilfedder complaining that about the frequency of absconds from Rathgael. The issue was not one of undue harshness of regime but of a perceived laxity of control.

29. The other institutions had similar though not identical arrangements. As the one secure establishment Lisnevin had a necessarily more controlled regime but ran an “Independent Representative Scheme” in conjunction with the Northern Ireland Association for the Care and Resettlement of Offenders.

---

7 DOJ Supplementary statement to the Inquiry dated 28 August 2015
8 Residential Child Care in Northern Ireland – the Training Schools October 1989
30. SSI inspections routinely reported on the effectiveness of the procedures and provided reassurance.

**ACCOMMODATION STANDARDS**

31. There was an evolutionary process at work in design standards. We had moved away from the original model of a single building housing school, recreational facilities and dormitories to a “village” concept with individual house units perceived to be closer to a family setting for the young people and easier for staff to manage and cater for individual needs.

32. Rathgael was the most developed, with 10 separate house units, with scope to separate out care and justice, remands, juniors and seniors.

33. St Patrick’s still had a substantial school style central building but three new separate residential house units similar to Rathgael had been built previous to me taking up my post.

34. Lisnevin, while modern, was a single building with locks and bars, reflecting its origins as a prison service establishment.

35. Both Rathgael and St Patrick’s had outdoor pursuits centres at Runkerry, near Portballintrae and Kilmore House, near Cushendall, which they used to provide the children with opportunities for training in a range of skills, and to build self-esteem.

**FUNDING AND STAFFING**

36. As indicated earlier, the institutions were funded by the NIO in terms of both running costs and capital.

37. 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 NIO and appointees were subject to NIO security vetting. This was a routine employment check facilitated by NIO and provided by the police.

38. 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 NVQ’s and the CQSW.

**CONTROL AND RESTRAINT**

39. I recall the Director of Lisnevin raising with me the issue of control and restraint training. This referred to a Home Office approved system for dealing with violent behaviour which enabled prison staff to subdue prisoners in a
manner which is effective yet which minimises the risk of injury to all parties. He felt that it could be in the interests of staff and children in Lisnevin for such training to be made available. Training was available in the prison service college, which was on the same site as Lisnevin. I believe discussion took place with the Prison Service but I do not recall a decision on the matter being made while I was in post.

Alan Shannon

8th September 2015
RESIDENTIAL CHILD CARE IN NORTHERN IRELAND

THE TRAINING SCHOOLS

OCTOBER 1989
RESIDENTIAL CHILD CARE IN NORTHERN IRELAND

THE TRAINING SCHOOLS

OCTOBER 1989
PREFACE

This report is based on a programme of inspections of the Training Schools in Northern Ireland which was carried out at the request of the Northern Ireland Office by the Social Services Inspectorate of the Department of Health and Social Services. The inspections took place between May 1987 and April 1988. The Inspectors wish to place on record their sincere thanks to the Chairpersons, Members of the Management Boards, the Directors and staff of the Training Schools for their wholehearted co-operation in the exercise.

A special word of thanks is due to the children and young people in the schools for the manner in which they received the Inspectors and for their participation.

Social Services Inspectorate
Department of Health and Social Services
Dundonald House
Belfast

October 1989
<table>
<thead>
<tr>
<th>CONTENTS</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Historical Perspective</td>
<td>1</td>
</tr>
<tr>
<td>2. Methodology</td>
<td>11</td>
</tr>
<tr>
<td>3. Aims and Objectives</td>
<td>14</td>
</tr>
<tr>
<td>4. The Children and Young People Resident</td>
<td>13</td>
</tr>
<tr>
<td>5. The Staff</td>
<td>29</td>
</tr>
<tr>
<td>6. The Premises</td>
<td>36</td>
</tr>
<tr>
<td>7. Daily Life and Care of the Individual</td>
<td>46</td>
</tr>
<tr>
<td>8. Education/Voluntary Training/Employment</td>
<td>53</td>
</tr>
<tr>
<td>9. After Care</td>
<td>52</td>
</tr>
<tr>
<td>10. Health Care</td>
<td>66</td>
</tr>
<tr>
<td>11. Regulations and Records</td>
<td>71</td>
</tr>
<tr>
<td>12. Monitoring Arrangements</td>
<td>73</td>
</tr>
<tr>
<td>13. Conclusions</td>
<td>78</td>
</tr>
</tbody>
</table>

Appendices
1. HISTORICAL PERSPECTIVE

1.1 The past decade has seen major changes in the policy and practice of the Training Schools in Northern Ireland. These changes have come about as a result of the influence of social work practice, of the changing needs in the population of the Training Schools, of socio-economic changes in the community and the publication of the Report of the Children and Young Persons Review Group. The recommendations of the Black Report, relating to the provision of residential care brought about far reaching structural changes in the schools. Numbers in the schools have greatly reduced but those being admitted, in keeping with other areas of residential care, tend to present more acute problems of management. These changes have brought about a complete re-think about the approach to care of children in Training Schools.

1.2 There are four Training Schools in Northern Ireland and with the exception of Lisnevin all have grown out of the old industrial schools and reformities founded in the mid 19th century. In addition to the four Training Schools there is an outdoor pursuit centre at Runkerry near Bushmills and a day assessment facility at Whitefield House on Blanks Road, Belfast. These two facilities lie outside the remit of this overview.
St Joseph's School

1.3 The Sisters of St Louis came to Middletown on 21 June 1875. Mother Genevieve, the Irish Foundress had, in 1859 led the first group of Sisters to Ireland. The Sisters came to Ireland at the request of the Bishop of Clogher to open a reformatory in Monaghan town to care for deprived children. At the time the problems of child neglect and juvenile delinquency were serious in an island broken by landlordism, emaciated by famine and demoralised by poverty.

1.4 The foundation stone of St Joseph's was laid in 1876 and the Industrial School/Orphanage was opened on 25 June 1881. It was the second Industrial School in Ireland. On the opening day the Sisters received the first 8 girls committed to the newly finished Industrial School/Orphanage. In those days the school drew children mainly from the ancient province of Ulster but the original group of girls came from as far apart as Dublin, Belfast and Donegal. Records of the first group of children admitted to the school show the reasons for the committal, the time spent in the school and some of the early comments give a vivid picture of the social history of the day. Most of the children were described as "destitute orphans" found begging, and many of these were as young as 4 years.
old. Historical documents show that there was extensive
development in the first 50 years. On the same campus,
sharing the same facilities, were an exclusive boarding
school, industrial school/orphanage and a primary school.
With the Partition of Ireland the admissions of children
coming from the South virtually ceased.

1.5 The need for change was recognised and in 1942, the Sisters
of St Louis, who are radical and enlightened in their
thinking, decided to close the boarding school and to
concentrate their efforts on the industrial school/
orphanage.

1.6 In 1950 the then Ministry of Home Affairs invited
St Joseph's to become a training school, within the terms
of the Children and Young Persons Act (Northern Ireland)
1950. This invitation was accepted and the orphanage
closed. In 1965 the late Cardinal Conway and the Superior
General of the St Louis Order met officials of the Ministry
of Home Affairs to plan the reorganisation of St Joseph's.
The outcome of these discussions included a commitment by
both sides that they would honour a Deed of Covenant drawn
up in 1950. From its creation as a training school in 1952
the trustees of the school were drawn from the Order of St
Louis.

St Patrick's

1.7 In the Staff Procedural Manual provided as background
information to the inspection the historical perspective was traced. "St Patrick's Boys Home, as it is familiarly known in Belfast, was first established as a Catholic Boys Home in 1862 and was housed in premises in Donegall Street. In 1872 it moved to the premises at Milltown and in the following year it was certified by the Lord Lieutenant of Ireland as the first industrial school in Ireland. During all those years it catered for 100 boys and was operated by Lay Masters under the control of the Bishop of the Diocese. In 1917 at the request of the late Cardinal MacRory, the school was placed under the care of the De La Salle Brothers and, in that year, a staff of 5 Brothers took over the work. In 1921 a further change took place due to the partition of the country. As the only Industrial School for Catholic Boys in Northern Ireland was Milltown and as there was no Catholic institution for the reception of Reformatory boys who previously were sent to Glencre, County Wicklow, the Brothers, at the request of the Bishop extended their work to cope with this type of boy. As a result of this change the school, which had provided for 100 boys, had now to deal with 160 and the question of providing adequate accommodation became urgent. Consequently, in 1941, the Bishop of Down and Connor purchased a farm of land on the Glen Road with a view to transferring the school from Milltown. In 1957 the new St Patrick's Training School was opened on a 100-acre farm spanning the Glen Road and the Springfield Road."
Rathgael Centre

1.8 Rathgael, as with St Joseph's and St Patrick's, had its beginnings in the old Reformatories and Industrial Schools of the mid 19th century. In 1956 the Malone and Whiteabbey Training Schools Act led to the amalgamation of existing Junior School (Balmoral Training School) and the Senior School (Malone Training School). The effect of the Act was to place the Boys School and the Girls Training School at Whiteabbey under the control of a new board of management. The original membership of the Board consisted of 4 members of Belfast Corporation, because of the previous control of the old Balmoral Training Schools, several members of the principal religious denominations and members of the trade unions and business community. In addition there were representatives from the, then, Welfare and Educational agencies. The Board of Management was appointed by the then, Ministry of Home Affairs and this responsibility today rests with the Secretary of State for Northern Ireland.

1.9 From 1956 the Board was responsible for the management of a 2-site operation, the Boys School at Rathgael and the Girls School at Whiteabbey on the North side of Belfast Lough. In 1985 a decision was taken to amalgamate, the training school concept in Northern Ireland with the closure of the Girls School and the relocation of the school on the Rathgael campus. 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. Today the facility is known as the Rathgael Centre for Children and Young People as the Management Board felt the name more accurately reflected the nature of the work carried out there.

Lisnevin Training School

1.10 Lisnevin School was formerly located in Newtownards, County Down, where in 1973 two separate units offered secure residential assessment facilities for 20 boys and long-term facilities for another 20 committed boys. In 1977 the residential assessment unit moved to Blacks Road in Belfast and commenced day assessment and continues to do so today. In 1981 the long-term treatment or Special Unit, moved to Millisle to its present location.

1.11 In 1985, Lisnevin opened a 10-bed secure remand unit, to service the courts, following the closure of the Juvenile Remand Unit at the Young Offenders Centre in Belfast. Whilst it seemed likely that the demand for secure remand spaces would not exceed 10, in practice the number of places sought actually increased to almost three times that number. As a direct consequence of this demand for spaces, the Remand Unit now offers 25 bed spaces with a proportionate decrease in Special Unit spaces to 15.

1.12 Lisnevin School is a secure establishment located on the
outskirts of Millisle, County Down. The buildings used by
the school were designed for, and formerly used as a
secure Borstal. Several attempts have been made to modify
the buildings to meet the needs of the present client
groups.

1.13 The Ministry of Home Affairs in a handbook for guidance
entitled "Juvenile Offenders and those in need of Care,
Protection or Control", defined training schools as
residential establishments approved by the Ministry under
Section 137 of the Act for boys and girls whom the courts
consider to need not only removal from home, but also a
fairly long period of residential training. The primary
aim of the training school programme is to restore the
child or young person to society better equipped mentally
and emotionally to cope with the environment from which he
came and to accustom him to the habit of work. It is a
process of re-adjustment and social re-education. This
process of rehabilitation is based on an understanding of
the personality, history, abilities and aptitudes of each
boy or girl and a knowledge of the family situation, and is
promoted by (a) a stable environment which enables remedial
influences to be brought to bear and progressive training
to be given, (b) by contact with the home and (c) by help
and supervision after the girl or boy leaves school.

1.14 The handbook goes on to describe the admission procedure to
the schools. On a boy's admission to a training school he
passes through a reception procedure which incorporates,
among other administrative functions, a medical examination, intelligence and educational attainment tests and observations of the boy in a classroom or work department and in the social interaction during recreation and leisure periods. The tests for the senior boys also include performance tests which gives some indication of a boy's practical ability and assist in placement in an appropriate work department. All staff are encouraged towards objective observation of the boys in all situations.

Girls in Training Schools

1.15 The number of girls sent to training schools is small and this presents its own particular problems. Girls from insecure home backgrounds, often committed as being in need of care, protection and control and in moral danger present very real emotional problems which must be sympathetically understood. The admission procedure for girls is basically similar to that at the boys training schools. The most salient features are an educational test; observation of the girl in her new environment, and examination by a psychiatrist who continues psychiatric treatment in the more disturbed cases.

1.16 It should be remembered that the training schools are also registered remand homes and as such receive boys and girls remanded in custody for the purposes of obtaining information and those remanded for one month under
Sections 74(1)(a) and 75 of the Act or 6 months under Section 8(2) of the Northern Ireland (Emergency Provisions) Act 1973.

1.17 Although the procedures and philosophy described above may seem by today's standards as rigid, institutional and lacking in sensitivity, many of the assumptions underpinning the policy appear to be flawed. Perhaps it is worthwhile reflecting on the welfare thought that permeated the residential sector at that time. In the Interim Report of the Northern Ireland Child Welfare Council on Juvenile Delinquency published in 1954 the Committee addressed inter alia, such issues as Mothers at Work, the Lack of Religious Training, Lack of Parental Control, the Influence of Comics and the Cinema. The Committee concluded that "Mothers with children of school or pre-school age should not undertake full-time employment outside the home. The removal of the necessity to train the child for at least some part of the day tends, we feel, to develop in the mother a sense of lessened responsibility for the child's character and his general well-being; and for the very young child, the lack of a definitive and unchanging "mother figure" for its entire day can cause profound emotional disturbance. From the point of view of present day delinquency, however, it is the child of school age who is most affected by the mother's daily absence at work". The comics and the cinema did not escape censure. "We would urge that prompt and determined efforts be made by all responsible for children's welfare to prevent the spread in this country of
the type of comics which glorifies and stimulates violence and sexual appetite and encourages racial prejudice. Of the cinema the Committee concluded "The question of the directly harmful effects of some cinema shows upon children's conduct is still being closely observed, but most enquiries so far have failed to establish any direct connection between cinema attendants and juvenile delinquency. We would strongly support continued research into such matters as the physical and mental effects on children of frequent cinema attendances. We are unanimous in the view that excessive visits to the cinema, with its emotionally exciting and vitiated atmosphere, are harmful to children and that attendance of children under 12 at late performances should be discouraged.

1.18 One can only speculate at the response of the Committee in relation to today's video libraries and the range of material now freely available.
2. METHODOLOGY

2.1 Prior to the commencement of the inspections the Social Services Inspectorate requested a range of information from the Directors of training schools. Copies of policy documents, setting out the aims and objectives of the school, directives to staff, procedural guidelines and any other significant papers that were available to staff to assist them in their day-to-day working in the schools was sought. Information on all care staff, employed in the school at the time of the inspection, was also requested. This information was collected by way of a Staff Form, (see Appendix A), and the information was computerised to aid analysis.

2.2 Detailed information on each child resident in the school was also requested. A Resident's Form in respect of each child was completed on an agreed Census Day for each school. This was necessary because of the turnover in residents and in fact the Census Day was usually set one week before the commencement of the inspection. Details of the residents' forms are given at Appendix B and as with the staff the information was also computerised with the details of the child being coded for purposes of confidentiality.

2.3 Following receipt of the information, the Inspectors met with representatives of the Management Boards, Senior
Management and Staff to discuss the logistics of the inspection. A number of agenda notes were provided for the meetings with the different groups of staff.

2.4 The main methods of gathering information was by way of staff meetings, group and individual, observation and general discussion. The Inspectors spent between 2 and 3 weeks in each training school and as far as possible sought to evaluate the quality of care provided over a 24 hour period. This necessitated being in the schools when the young people were called in the morning until bedtime. Visits were paid to the schools on Saturdays and Sundays where attendance at divine worship was carried out.

2.5 A number of ancilliary and other staff were seen. The kitchens were visited, meals were seen under preparation. Time was spent with the Chaplins, Gardeners, Handymen and the classroom and workshop situations were observed. The purpose of the classroom visits was to assess behaviour in the classes, to discuss the liaison arrangements between teachers and care staff in relation to the children. No aspect of the educational component was examined as this was beyond the competence of the SSI’s and outside the inspection brief.

2.6 The young people were seen mainly in informal group settings as experience has shown that, by and large, many adolescents are reluctant to participate in formal group meetings.
with relative strangers. The Inspectors found participation with the young people during their leisure time as being the most fruitful ways of eliciting information and opinion. The Inspectors took part in games, swimming sessions, attended discos and generally sought to assess the feelings of the young people and the ethos that permeated the environment by the use of these methods.

2.7 At the completion of the inspection a brief verbal feedback was given to the Directors and Senior Staff. Before the completion of the draft report a more formal, detailed verbal presentation was made by the Inspectors. When the draft report of the inspection was prepared it was sent to the Directors and Management Board for comment.

2.8 The comments and observations of the Management Board and Senior Staff Team were considered by the Inspectors and where appropriate were embodied in the final inspection report. The Inspectors feel that the present method of sharing and openness between those involved in the inspection greatly enhances the rapport, mutual trust and the quality of the work undertaken.
3. AIMS AND OBJECTIVES

3.1 Training Schools are defined in Section 137 Children and Young Persons Act (Northern Ireland) 1968 and are approved by the Secretary of State as residential establishments for boys and girls for whom the court considers that removal from home is necessary. Training Schools act as Remand Homes and are deemed to be a Place of Safety under the Act.

3.2 For many years the schools fulfilled the role as defined for them by statute. The numbers of children being admitted to the schools probably peaked in the early 1970s when, at one stage, some 450-500 young people were in residence in the Training Schools. At that time numbers meant, that in effect, routine programmes of education, vocational training and counselling were being pursued in a fairly institutional way.

3.3 As the spirit of the Black Report began to permeate the criminal justice system, coupled with changes in child care policy, social work thought and the need to ensure a more effective use of resources, training schools management began to approach the task of dealing with young people in a more constructive, thoughtful and systematic way. This necessitated the definition of aims and objectives, clarification of role and the introduction of a range of activities, eg: extended leave, the use of professional
fostering, landlady schemes, all of which contributed to young people returning to the community much more quickly than had been the case previously.

3.4 Prior to the inspection, Directors were asked to set out the aims and objectives for their establishments. All of the schools set out a general statement of philosophy and aims. There were similarities between the schools in very general terms.

3.4.1 "The aim is to meet the needs of individual children. This includes the provision of care, taking into consideration the personality, stage of development and particular difficulties. It also considers the needs of each child for security in the form of personal respect and control".

3.4.2 "To provide the best possible service of education, care and treatment for each child whose needs are not being appropriately met within their social environment. To develop education and care programmes, based upon the identified needs of each young person and to foster in each a belief in their ability to make changes in their lives and experience success within the framework of society".

3.4.3 "To provide for adolescent girls whose emotional needs, behavioural problems and/or acute educational problems cannot be met or catered for suitably and adequately within the range of options or facilities available in Northern Ireland".

11.
3.5 Although all of the objectives have a broad common theme it is in the implementation of these objectives in the individual schools that brings a richness to the quality of care being provided. Just as each establishment has a general objective many of the house units, within training schools, have examined the special contribution they can make to the amelioration of the problems of the young people in their care.

3.6 At present the schools are following the concept of the segregation of care and offenders. Those young people defined as being offenders are referred to as "Youth Treatment" or "Justice". Care cases tend to include educational cases and the latter terms described youngsters who have been adjudicated as offenders. Fortunately the management of the schools, whilst ensuring that segregation is followed as far as possible, tend to apply a uniform approach to the care of the young people. Because of the remit of some of the establishments, for example Secure Remand at Lisnevin, the emphasis is on benign/humane containment where the young people are enabled to take part in educational, vocational and recreational programmes. Because many of them have not been adjudicated on by the Courts, no programme of assessment or treatment can be undertaken. In the case of the units in the open training schools who have been designated as Assessment/Reception/Short-term Care, the thrust of the work is geared towards the reception assessment and in
Increasing terms, diversion. This has already been referred to in Chapter 1.

3.7 The role of the reception/assessment units is vital within the training school system. The quality of reception often sets the tenor of behaviour and attitude of the young people. The comprehensive and sympathetic assessment ensures that young people are allocated to the most effective setting within the school. Considerable care is taken in this process so as to ensure that, when allocation to a house unit is made, the young person will remain there, benefiting from the security, the skills and strengths of the staff who may be the most suited to meet their needs.

3.8 It was evident that the objectives for training schools can be divided into 3 categories (i) School objectives, (ii) Unit objectives, (iii) Individual objectives and that those at (i) and (ii) have to be meaningful and appropriate if (iii) is to be achieved. The more structured setting of objectives by staff has meant a clearer understanding of the needs of the young person and the role that the training schools will be expected to play when the new child care legislation becomes operational.
4.0 THE CHILDREN AND YOUNG PEOPLE RESIDENT

4.1 In this chapter details of the children and young people resident will be given by individual establishments. It should be noted that the inspection of the training schools commenced in May 1987 and the programme was completed in April 1988. As the school populations tend to fluctuate quite quickly it is not possible to give details of the numbers in absolute terms. Details of the residents will be as those returned on the Census Day for each school. The proportion of care, justice and education cases will be examined as well as the number of Place of Safety Orders and finally an indication will be given of some of the general characteristics of the young people who are sent to training schools.

ST JOSEPH’S TRAINING SCHOOL

4.2 On 15 May 1987 St Joseph’s had on roll 32 girls aged between 12 years and 11 months and 17 years and 9 months. Two of the girls were sisters. There was a concentration of 22 young people of 16 years or over at the upper end of the age range with 9 others aged between 14 and 16. One girl was under 14 years of age. Twenty-five were in residence on the above date, 6 were on extended leave and one was spending the week-end away from the school.
4.3 Twenty-nine girls were the subjects of Training School Orders, 2 of Interim Detention Orders and one had been admitted to St Joseph's on a Place of Safety Order. One girl was a juvenile offender and 3 others had been committed for non-school attendance.

4.4 Twenty-five girls were deemed to be in need of "Care, Protection and Control" and were sent to the training school under Section 95(1)(a) of the Children and Young Persons Act (Northern Ireland) 1968. In the case of this group, and 3 others who were in St Joseph's on short term orders, the proceedings had been instigated by the Health and Social Services Boards. All 4 Boards had been involved, ie: Eastern - 11, Southern - 9, Western - 6 and Northern - 2.

Some of this group of girls had experienced several placements during their careers in care. Ten had come to St Joseph's from their own homes, one from hospital and another from a hostel. However 16 girls had been living in children's homes just before their admission to the training school. Of these one girl had been held in St Joseph's on an Interim Detention Order while a full assessment was undertaken. Ten others had been in training school at some other stage in their careers and prior to having been committed on Training School Orders. However 5 girls had been sent directly to St Joseph's by the Court following proceedings brought by Social Services.

4.5 Nine girls (28%) had been living in St Josephs for 6
months or less including the most recent admission who had been there for only one day. Fourteen others (45%) were there for more than one year including 4 girls (12%) who had been admitted for more than 2 years prior to the inspection. However, of the girls who were there the longest, 2 had been recalled to the training school from licence and one was in the hostel preparing for a placement where she could live independently. The home circumstances of another girl made it impracticable for her to return home and she was going out each day to work on a training scheme.

RATHGAEL CENTRE FOR CHILDREN AND YOUNG PEOPLE

4.6 On 7 September 1987 there were 147 young people on the Rathgael roll. However at the time only 85 boys and girls were in residence and another 6 boys, who were participating in an outdoor pursuits course at Runkerry Centre, Co Antrim, were temporarily absent. Thirty-nine young persons were living with relatives while on "Extended leave", and one girl was boarded-out with foster parents. Four boys had been transferred to the Secure Unit at Lisnevin Training School and 4 others, who were absent from Rathgael without permission were deemed to have absconded. A further 8 young people (6 boys and 2 girls) were living at home and travelling to the Centre on weekdays and were classified as "Day attenders".

4.7 One-hundred and twenty-seven boys and girls were the
Subject of Training School Orders, 3 of Interim Detention Orders and 11 had been admitted to Rathgael on Place of Safety Orders. Four others had been Remanded pending a court appearance.

4.8 The Centre had responsibility for 41 girls and 106 boys, whose ages ranged from 12-18 years. However the majority (114) were between 15 and 17 years old. Prior to being placed in Rathgael 92 of the young people were living at home, 40 were in children's homes and 3 were in foster care.

4.9 The Youth Treatment side of the Centre was responsible for 86 boys all of whom had been committed to Rathgael for offending and 4 boys who were charged with offences and remanded in custody. However the Care Side had responsibility for 41 girls and 36 boys of whom only 2 of the girls were committed for offences prior to coming to the Centre. Sixteen of this group came to Rathgael following court proceedings instigated by the Education and Library Boards for non-school attendance. Twenty-one girls and 22 boys had previously been in the care of one of the Health and Social Services Boards and another 9 girls and 7 boys had been sent to Rathgael by the courts following proceedings instigated by Social Services. All 4 Boards had been involved ie: Eastern - 33, Northern - 21, Southern - 3 and Western - 2.
ST PATRICK’S TRAINING SCHOOL

4.10 On Census Day, 15 December 1987, there were 95 young persons on St Patrick’s roll. However, only 61 boys were in residence. Twelve were temporarily resident in another school (Lisnevin), one was boarded-out, 3 were in hospital. 8 were on extended leave, 3 were absconders and there were 2 others (one at home on leave and one sick at home). The 8 boys on extended leave were living at home with relatives or guardians.

4.11 The legal status of the boys was as follows:

- Training School Orders - 85
- Place of Safety Orders - 4
- Fit Person Orders - 2
- Remands - 3

and one was on a one month’s committal. The latter sentence is now a seldom used disposal in the juvenile court.

4.12 The ages of the boys range from 12 to 18+ years, with the main concentration (59) in the 16-17 year category. The second largest group (26) was in the 14-15 year group. Prior to placement in St Patrick’s 63 of the boys had resided at home, 22 had come from children’s homes, 3 were admitted following foster home breakdown and one had been
in hospital, one in an assessment unit and 5 others were in

a variety of settings which included transfer from Care to

Justice and returning from the Lisnevin Remand Unit.

4.13 Of the population of 95, 34 were in the Care Side of the

school. This number includes education cases and the

remaining 61 were attached to the justice division of the

school. Seventeen boys were already the subject of Training

School Orders. All of the Health and Social Services Boards

had referred young people to the school on Care grounds

either by way of Place of Safety Orders or through committal

proceedings. The breakdown was as follows:-

EMSSB - 10
SHSSB - 7
WHSSB - 4
NHSSB - 3

Education and Library Boards had instigated court

proceedings, which had led to the committal of 10 young

people to the school for non-attendance. The breakdown of

these figures was as follows, Belfast and Education Library

Board - 7, South Eastern and Education and Library Board - 2

Southern Education and Library Board - 1.

4.14 All of the young people were engaged in education,

employment or voluntary work. The analysis is as follows:-
Education/Vocational - 71
Full time employment - 3
YTP Schemes or similar - 19
Voluntary work - 2

4.15 The length of stay in St Patrick's has come down significantly and this may be due to the development of the policy of extended leave. Despite the efforts of management there are still a few boys who stay in the school greatly exceeding the norm. The following table gives details of the length of stay of the total population.

<table>
<thead>
<tr>
<th>LENGTH OF STAY</th>
<th>NUMBER OF RESIDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 year</td>
<td>29</td>
</tr>
<tr>
<td>1 year</td>
<td>35</td>
</tr>
<tr>
<td>2 years</td>
<td>25</td>
</tr>
<tr>
<td>3 years</td>
<td>4</td>
</tr>
<tr>
<td>4 years</td>
<td>1</td>
</tr>
<tr>
<td>8 years</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>TOTAL 95</td>
</tr>
</tbody>
</table>

LISNEVIN TRAINING SCHOOL

4.16 On 15 April 1988 there were 41 boys on the Lisnevin roll. However, 3 had failed to return from home leave and another 2 had been remanded to prison by the courts leaving 36 boys
on campus. The majority (36) were between 14 and 16 years of age though 2 boys were over 18 years of age, and at the other end of the scale 2 boys were just 13 years old.

4.17 Sixteen boys were the subjects of Training School Orders and 25 had been removed to Lisnevin by the Courts under Section 51 of the Children and Young Persons Act 1968. However 19 of the remandees had previously been committed to training schools and their Training School Orders were still extant.

4.18 Ten of the Special Unit boys had been admitted from St Patrick's Training School and 6 from the Rathgael centre. All but one of them had previously been in Lisnevin Remand Unit. Two had been initially sent to training schools on "Care" grounds and they had resided within the Eastern Board's North and West Belfast Unit of Management. Nine others had home addresses in Belfast with one each coming from Bangor, Antrim, Craigavon, Fintona and Ardglass.

4.19 Eight boys had been less than one year in the Special Unit, including one who had been there for just 2 weeks. Another 2 had been approximately 9 months in residence but 5 had been in the Special Unit for more than one year. One boy had spent 2 years in security. Eleven Special Unit boys had been reviewed by the Lisnevin Licensing Committee during the 12 months prior to the inspection. There were plans to licence 12 boys to live with relatives and 2 others were being prepared to live independently in the community.
4.20 Ten boys had been residing in one of the training schools immediately prior to being remanded in Lisnavin by the courts. Another 5 were absconders from the training schools when they were sent to the Remand Unit. The Hydabank Young Offenders Centre had transferred 2 others to Lisnavin at the court's direction. Seven others had been living in their own homes, and another was said to have been "Living rough", before admission to the Remand Unit. The courts remanding boys to Lisnavin were Belfast (9), Antrim (1), Killyleagh (1), Craigavon (3), Lisburn (2), Londonderry (1), Limavady (1), Bangor (1), Newtownards (1) and Cookstown (1).

4.21 Most of the remandees had previous convictions eg: 19 had previously been committed to training schools. Thirteen were currently charged with offences relating to motor vehicles ie: 10 taking and driving away and 3 "allowing themselves to be carried". Several boys were charged with theft and in one case this was in conjunction with causing grievous bodily harm. The most serious offences were attempted murder (1), rape (1), arson (1) and possession of fire arms (1). Two boys had been in remand for 6 months, one for 4 months, 3 for 3 months and 3 for 2 months. The remainder had been in the Remand Unit for one month or less including 5 who were there for less than one week.

SUMMARY

4.22 Over the period of the inspection 102 children had been committed on care grounds, 136 were classified as offenders and 43 were committed for non-attendance at school. It
should be noted that complete segregation into one of these 3 categories is not possible in absolute terms. For the purposes of categorisation the legal "ticket" by which the young people were admitted to school has been used.

4.23 In attempting to describe some of the characteristics of the children and training school it must be said that the "typical child" could not be identified. The majority of the boys and girls on the care side of the training schools had previous histories of being in care. Some had been admitted from children's homes, where the problems of behaviour presented such acute management difficulties that a Training School Order seemed to be the only means of dealing with them. There appeared to be few adjudicated female offenders in the system. It is difficult to say to what extent care proceedings were instituted instead of the police becoming involved. It may be that the Courts still view girls as being at greater risk in terms of moral danger than boys.

4.24 Many of the girls had been the subject of sexual abuse. The length of stay of, for example, the girls in St Joseph's may be an indication of the considerable amount of time and effort that has to be spent in dealing with such cases.

4.25 Homelessness now features prominently in the lives of many of the young people in training schools. Many come from fragmented families or indeed situations where they have
experienced family rejection and the possibility of re-integration is remote. The subject of homeless and the changes in the socio-economic structure of society, coupled with the problems of social security entitlement will be explored in detail in Chapter 9 of the report on After Care.
5. THE STAFF

5.1 In training schools, there are 2 main categories of staff involved in the residential task; residential social workers and teachers. There is also a range of support staff, aftercare or community care social workers, night supervisors, administrative, finance, nursing, cooks, domestic, gardening and maintenance.

5.2 Through the use of a questionnaire the Inspectors collected information on the sex, age, designation, length of service, previous career experience, training and qualifications, of the social workers involved in community care and staff who contributed to the residential care task. Included in the latter group were teachers and instructors who performed extraneous duties in the residential units outside of school hours.

5.3 For many years the use of extraneous duty staff formed a substantial part of the caring process. Teachers, who received an additional allowance (Extraneous Duties Allowance), usually worked a total of 60 hours per month. This was not a universal policy as one school saw education and care as 2 quite separate entities. The same applied to the use of night supervisors. In 3 of the establishments a core of night supervisors take over the supervision of the young people after 9.30 pm. In the remaining facility the
staff perform sleeping-in duties in much the same pattern as that followed in the Area Board and voluntary children's homes.

5.4 In total 239 returns were made and the following table indicates the total staffing establishment for all training schools at the time of the inspections, but excludes ancillary staff, night supervisors and those teachers not performing extraneous duty.

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Directors</td>
<td>4</td>
</tr>
<tr>
<td>Senior Deputy Directors</td>
<td>3</td>
</tr>
<tr>
<td>Deputy Directors</td>
<td>5</td>
</tr>
<tr>
<td>Assistant Directors</td>
<td>9</td>
</tr>
<tr>
<td>Dep Assistant Directors</td>
<td>7</td>
</tr>
<tr>
<td>Senior Assistants</td>
<td>2</td>
</tr>
<tr>
<td>Unit Administrators</td>
<td>2</td>
</tr>
<tr>
<td>Principal Social Worker (Community Care)</td>
<td>1</td>
</tr>
<tr>
<td>Senior Residential Social Workers</td>
<td>22</td>
</tr>
<tr>
<td>Residential Social Workers</td>
<td>121</td>
</tr>
<tr>
<td>Wardens</td>
<td>7</td>
</tr>
<tr>
<td>Housemothers</td>
<td>11</td>
</tr>
<tr>
<td>Senior Social Workers (After Care)</td>
<td>2</td>
</tr>
<tr>
<td>Social Workers (After Care)</td>
<td>6</td>
</tr>
<tr>
<td>Intake Social Worker</td>
<td>1</td>
</tr>
<tr>
<td>Teachers/Instructors (ED)</td>
<td>36</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>239</strong></td>
</tr>
</tbody>
</table>


It will be seen from Table 1 that there is not a totally uniform staffing structure. One establishment has posts of Warden and Housemothers, another, Unit Administrators and Senior Assistants. Since the inspections a process of rationalisation is being undertaken and over a period of time it is likely that 2 main categories of residential staff will emerge is Senior Residential Social Workers and Residential Social Workers. The title of some of the posts are an amalgam of social work terms and some have their roots in the old Approved School System. The senior staffing structure has also been considerably rationalised in the past year.

### TABLE 2

<table>
<thead>
<tr>
<th>DESIGNATIONS</th>
<th>LENGTH OF SERVICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-1 2-5 6-9 10-14 15-19 20-24 25+ TOTAL</td>
</tr>
<tr>
<td>Directors</td>
<td></td>
</tr>
<tr>
<td>Senior Dep Directors</td>
<td>0 0 0 1 1 1 4</td>
</tr>
<tr>
<td>Dep Directors</td>
<td>0 0 0 2 0 1 3</td>
</tr>
<tr>
<td>Assistant Directors</td>
<td>0 0 0 3 1 1 5</td>
</tr>
<tr>
<td>Dep Assistant Directors</td>
<td>0 0 0 2 2 3 9</td>
</tr>
<tr>
<td>Senior Assistants</td>
<td>0 0 0 1 0 0 7</td>
</tr>
<tr>
<td>Unit Administrators</td>
<td>0 0 0 1 0 1 2</td>
</tr>
<tr>
<td>Sen Res Social Workers</td>
<td>0 2 3 12 5 0 22</td>
</tr>
<tr>
<td>Residential Social Workers</td>
<td>27 37 30 24 3 0 121</td>
</tr>
<tr>
<td>Wardens</td>
<td>0 0 5 2 0 0 7</td>
</tr>
<tr>
<td>Housemothers</td>
<td></td>
</tr>
<tr>
<td>Principal SW (Comm Care)</td>
<td>0 0 1 0 0 1 11</td>
</tr>
<tr>
<td>Sen SS (After Care)</td>
<td>0 0 0 2 0 0 2</td>
</tr>
<tr>
<td>SW (After Care)</td>
<td>0 0 3 1 0 0 6</td>
</tr>
<tr>
<td>SW (Intake)</td>
<td>0 0 1 0 0 0 1</td>
</tr>
<tr>
<td>Teacher/Instructor (EB)</td>
<td>1 3 13 8 2 1 36</td>
</tr>
<tr>
<td></td>
<td>30 44 45 77 29 8 6 239</td>
</tr>
</tbody>
</table>
5.7 Table 2 indicates the length of time spent in the training school service. It is clear that there is a low staff turnover. 87% of all staff have more than 2 years service, 69% had more than 6 years and 5% have more than 20 years service. There is also a high correlation between staff length of service and the length of time spent in residential care. A greater mixture of male and female staff would have been more desirable. In St Joseph's few male staff were employed and in St Patrick's the opposite is the case. In terms of female representation at senior level, i.e Deputy Assistant Director upwards, Rathgael had 2 women, St Patrick's one and there were no women senior staff in Lismore. In St Joseph's all of the senior staff were female.

5.8 Level of Qualified Staff

<table>
<thead>
<tr>
<th>DESIGNATIONS</th>
<th>LEVEL OF QUALIFIED STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CQSW</td>
</tr>
<tr>
<td>Directors</td>
<td>2</td>
</tr>
<tr>
<td>Senior Dep Directors</td>
<td>1</td>
</tr>
<tr>
<td>Dep Directors</td>
<td>1</td>
</tr>
<tr>
<td>Assistant Directors</td>
<td>1</td>
</tr>
<tr>
<td>Dep Ass Directors</td>
<td>1</td>
</tr>
<tr>
<td>Senior Assistants</td>
<td>1</td>
</tr>
<tr>
<td>Unit Administrators</td>
<td>1</td>
</tr>
<tr>
<td>Principal SW</td>
<td>1</td>
</tr>
<tr>
<td>Sen Res SW</td>
<td>5</td>
</tr>
<tr>
<td>Res SW</td>
<td>21</td>
</tr>
<tr>
<td>Wardens</td>
<td></td>
</tr>
<tr>
<td>Housemothers</td>
<td></td>
</tr>
<tr>
<td>Sen SW (After Care)</td>
<td>2</td>
</tr>
<tr>
<td>SW (After Care)</td>
<td></td>
</tr>
<tr>
<td>SW (Intake)</td>
<td></td>
</tr>
<tr>
<td>Teachers/Inst (ED)</td>
<td></td>
</tr>
<tr>
<td><strong>TOTALS</strong></td>
<td><strong>38</strong></td>
</tr>
</tbody>
</table>

32.
5.9 The professional qualifications of all training schools staff are set out in Table 3 against the designation. Ninety-one staff (39%) have qualifications in social work or residential child care (33 CSSW, 7 CSS, 46 SRCCYP and CRCYP, 3 ISSC, IPCSC, and 4I (17%) of all other staff involved in extraneous duties had educational qualifications. In addition a number of staff hold nursing qualifications and a variety of degrees. Several senior staff have also completed the Post-qualifying Social Work Course at Queen's University, Belfast. All staff have detailed job descriptions.

TRAINING

5.10 Most of the schools have a policy of recruiting professionally qualified staff to fill vacancies as they arise. When untrained staff are recruited they are encouraged to obtain professional qualifications and may be seconded to full-time training courses. In the late 1970s and early 1980s there was an extensive programme of full-time training. This has slowed down in recent years for a variety of reasons: finance and the availability of more trained staff seeking employment.

5.11 Every opportunity is taken to send the residential child care staff on relevant short courses, organised by the DHSS, HASS Boards, voluntary organisations and the universities. However Management have also found it beneficial to make arrangements for in-service training courses. In some cases the services of recognised
trainers/organisations have been brought in and several courses have been arranged by the Adolescent Psychological and Research Unit. The courses cover such subjects as Sexuality in a Child Care Setting, Child Sexual Abuse, Staff Supervision and Handling Aggression and Conflict.

SUPERVISION

5.12 The professional supervision of staff in the training schools is somewhat fragmented. A variety of models are in operation. One establishment is in the process of introducing a structured supervision programme. Two use a mixture of formal and informal supervision and another uses an amalgam of individual, group supervision with the additional element of an external consultancy service. All of the schools are progressing towards a system of professional supervision from senior staff downwards and a method of staff appraisal is also about to be introduced.

5.13 In calculating the staff requirement of the schools the Castle Priory method was adopted using the following equation.

\[
\text{Child waking week} \times \frac{\text{Capacity of units}}{\text{Staff Working week}} = \text{Number of Children requiring one staff}
\]

A ratio of staffing per child was used as follows:

- Open Units 1:4
- Assessment Reception Units 1:3.5
- Closed or Secure Units 1:2.

In addition to the basic formula account was taken of staff leave entitlement and extra staff hours required during the school holidays.
5.14 In general staffing levels were satisfactory. There was some shortfall which required overtime being worked and part-time temporary staff being used in some establishments. An important consideration in arriving at a requisite staffing level was the capacity of units, a vexed question in some establishments with the ever decreasing number of young people being admitted to the schools. Although the present pattern of admission is downward it is difficult to forecast when there may be a change and staffing must be maintained at a level which will enable adequate cover to be provided.
6. THE PREMISES

6.1 The 4 training schools represent a variety of architectural styles which reflect the current thinking in design of residential establishments covering the period from the early 1950s to the mid-1970s.

St Josephs

6.2 St Josephs is located about 10 miles south-west of Armagh City on the fringe of the village of Middletown. The school occupies a large open site and is surrounded by farmland. It stands unobtrusively behind a small wood and is approached by a winding tree-lined drive. The central piece of the site is a 3-storey Convent of the Sisters of St Louis. A chapel, with a distinctive round chancel is to the left of this building.

6.3 Complementing the Convent and in juxtaposition is the main school building/administrative block. In the past this building contained dormitory accommodation for the residents but in recent years the interior was adapted to provide school, office, cooking/dining facilities.

6.4 The young people are accommodated in 4, 2-storey house units. There are 2 blocks each containing 2 houses which are linked together by a connecting corridor at ground and first floor level. Each house is a self-contained unit for
3 girls, which can be extended to 9 or 10 in an emergency. All 4 units have the same architectural features and interior design. The units are bright, airy, clean, comfortable and tastefully decorated throughout. Each girl has her own room which has fitted wardrobes, cupboard space, vanity unit, dressing table and mirror, a chair and a bed.

5.5 A modern bungalow, situated on an elevated site, to the rear of the campus, is used to provide independence training for girls who are preparing to leave St Josephs. Known as the Hostel it can accommodate 3 girls and the amenities provided include a sitting room, dining room, reception room, bathroom and toilets. In addition there are 4 self-contained flats which can be used for a variety of reasons, staff sleeping in, emergency admissions following recall or at times of crisis in the young people's lives when a period of respite care is required.

6.6 A swimming pool and games hall complex is sited centrally between the hostel and the house units and is within easy reach of the school. The games hall is equipped for gymnastics and with a stage at one end, is suited for concerts, discos and other community functions.

5.7 The living accommodation for the young persons in St Josephs meets adequately the standards for space, size of bedrooms, set out in the Community Homes Design Guide.
Some of the features for example the fireplace, and
furniture together with the tasteful use of ornaments,
pictures, photographs and the style of the interior
decoration creates an atmosphere which could best be
described as "homely". As there are no domestic staff in
the house units the upkeep of the premises falls mainly to
the girls living there. Clearly these tasks are performed
to a very high standard. Furthermore although on occasions
there have been outbursts of very disturbing behaviour when
property, furniture and fittings can be vulnerable, there
were no obvious signs of damage anywhere on the site.

5.8 The question of the suitability of the location of
St Josephs was considered carefully. Few of the girls come
from homes within a convenient distance of the school and
therefore a lengthy journey has to be undertaken by
families and friends. Also those girls who have become
involved in Youth Training Programmes normally have to
travel by bus into Armagh. However, as St Josephs is
providing a service for girls from all over the Province
there is no ideal location, i.e. wherever the school is
placed it will not be close to every girl’s home.

Rathgael Centre

6.9 Rathgael Centre is located on the outskirts of Bangor about
3 miles from the centre of the town. It occupies a large
site of some 75-80 acres. The campus is surrounded by a
non-secure fence of hedges, wire netting and a brickwall in places. The House Units spread throughout the grounds, are modern flat roofed structures built in the 1960s style. The site contains an administrative complex, chapel, main school block, workshops, garages, swimming pool and a games hall.

6.10 The site, in pursuance of the concept of segregation of care and justice is naturally divided by the main drive that runs through the school grounds. To the left of the main drive are 6 care units and these can provide accommodation for 75 boys and girls. Two assessment/reception units known as Short Term Care are located alongside a 10 place Close Supervision Unit (Shamrock House). Also in this section of the school, but to the rear of the site are the 3 recently refurbished units known as the Adolescent Care Units.

5.11 On the opposite side of the main drive is the Youth Treatment section of the campus. This accommodation comprises of 2 double units which incorporate a reception unit and 3 main residential units. A secure self contained unit known as Fox Lodge is also located on this part of the site.

6.12 The 3 Adolescent Care Units have recently been refurbished as has the secure unit Fox Lodge. At present the Close Supervision Unit on the site is also being refurbished.
This is part of a rolling programme of repairs and
refurbishment which will modernise all the units bringing
the accommodation up to the standard that is in keeping
with current thought.

St Patricks

6.13 The school occupies a 100 acre site fronting on to the
Glen Road, with the Springfield Road to the rear and the
Monagh Road to one side. The school is located in a built
up area of West Belfast close to the housing estates of
Turf Lodge and Andersonstown.

6.14 There is a Gate Lodge beside the Glen Road entrance from
which the school is approached. The main building which is
of a block design and constructed of rustic brick, occupies
and elevated site and dominates the local landscape. From
its front steps a magnificent panorama of Belfast can be
observed. To one side of the building is a substantial
house where the religious community is domiciled. Four
staff houses are also located on the site just off the main
driveway.

6.15 A single storey administrative building juts out beyond the
site line and is connected to the school by a chapel and
gymnasium which enclose a small garden. The complex
comprises of a 3 story building running the length of the
school with wings at right angles to each side. At the

40.
Extremities the wings are joined by classrooms which turn inwards to provide 2 enclosed yards which are separated by the central kitchen and dining room.

6.16 The ground floor provides changing and showering facilities, toilets, recreational and leisure areas and office accommodation for residential social workers. The first and second floors are comprised mainly of cubicles in which the young people sleep and associated living rooms, washing and toilet facilities. One of the first floor wings provides an assessment unit of conference and interview rooms. The sick bay, medical and dental rooms are situated centrally on the second floor with a laundry, sewing room and clothing store located beneath on the first floor.

6.17 Other facilities include 3 Chalets, 1, 2 and 3. Chalets 1 and 2 can accommodate 11 boys each and the units have staff maisonettes attached. Chalet 3 has recently been refurbished and upgraded to provide a secure "Care" facility. Completing the range of resources on the site is an outdoor football pitch, 2 small all weather playing surfaces and handball alleys in close proximity to the indoor sports hall. The sports hall complex has an integrated 25 metre swimming pool with associated changing areas with toilets and showers.

6.18 The ground rises from the rear of the sports hall and
Chalets 1 and 2 towards the Springfield Road exit. Most of it is farmed by boys from the school under the supervision of a qualified instructor. The instructor has a residence close to the rear exit as are a number of outbuildings including 2 Dutch barns, a storage shed for machinery, a garage and 2 loose boxes.

Lisnevin School

5.19 Lisnevin Training School is located on the coast of County Down, approximately 2 miles from Millisle. The building presently occupied by the Training School, stands within the grounds of the former borstal training establishment at Woburn. In the early 1970s a decision was taken to build a secure provision adjacent to the open Borstal. The secure unit was built to Penal Category 3 standards and the building in the extensive grounds is enclosed within a 7 metre high perimeter fence. Following a change in penal policy in Northern Ireland, Borstal Training was dispensed with as an option to the courts, with the opening of the Young Offenders Centre at Hydebank. Shortly after this policy change, and as a result of a public enquiry, the Lisnevin Management Board were required to vacate the premises occupied by them at Newtownards. A Feasibility Study Group reported upon the 2 available buildings at Woburn and they opted for the use of the vacant secure borstal as the new home for Lisnevin Training School.
6.20 Because the secure unit was built on penal lines, it was, in many ways, unsuitable for use as a Special Unit for adolescent boys, where the philosophy was based upon child care considerations and the environment was not conducive to the furtherance of those principles. However, a major programme of refurbishing brought about considerable improvements to the building, in terms of colour scheme, use of fabrics, carpeting and the covering-in of the heavy iron doors which were a feature of the original building. Although the decor has been softened there are still problems left with the physical provision.

6.21 Pedestrian access to the building is via an entrance hall which is constantly manned between the hours of 7.00 am and 10.00 pm. Beyond the electronically controlled doors the reception area, dining room and a suite of offices which includes the offices of the 2 deputy directors. On the ground floor are 2 wings of sleeping accommodation, which are occupied by the Remand Unit. Associated with the ground floor accommodation are 2 common rooms, classrooms, snack kitchen and other offices. To the rear of the building, adjoined by an interior corridor, is the gymnasium and games room.

6.22 On the first floor are 2 wings of sleeping accommodation. These are used by the boys in the Special Unit. Other accommodation on the first floor comprises of office space, living rooms, hobbies room, TV room and classroom accommodation.
5.23 Outside the main building, but enclosed within the perimeter fence there are extensive workshops which provide such crafts as joinery, heavy craft, metal work and brickwork. To the rear of the main building is the chapel; a modern hexagonal structure built of matching red brick and the interior is finished in Norwegian Pine. The grounds within the fence are extensive and a full size football pitch is laid out.

5.24 The building with all its architectural shortcomings is in a very good state of repair. The use of bright paint, coloured tiles and fabrics does much to soften the institutional feel of the place.

SUMMARY

6.25 In general terms most of the accommodation is of a satisfactory standard. Some of the older property is beginning to show signs of wear and the need for a major programme of refurbishment has already been brought to the attention of the appropriate Government Department and the School's Management Board. The newly refurbished units have been upgraded in accordance with the Community Homes Design Guides and Health and Safety considerations. In the secure accommodation the latest fabrics, fittings and safety considerations have been embodied. Although the schools accommodate some of the most difficult young people in the Province, the buildings have not suffered unduly.
5.26 Lisnavin has had a number of major incidents when substantial damage was caused. Fortunately such incidents are rare and it is a tribute to all staff that not only do they exercise careful supervision of the young people and the premises but they have managed to engender a sense of "ownership" and pride in the minds of many of the young people in their care.
7. DAILY LIFE AND CARE OF THE INDIVIDUAL

7.1 In evaluating the daily life of children in training schools it has to be borne in mind, that although the routine of the day is basically similar, there is a considerable degree of difference between the schools. Indeed there are many differences in ethos and emphasis between units on the same campus.

7.2 For most children, during the normal school term, the day begins around 7.30 am. Those young people in employment or on YTP may rise earlier. Before breakfast there is the normal ablutions, tidying rooms and some communal duties have to be performed. These include clearing out and setting the fires, cleaning carpets, washing dishes etc. In some of the schools where all the meals are provided centrally there are fewer chores to be undertaken in relation to dishwashing. This is particularly true of Lisnevin where many of the domestic duties are undertaken by staff because of the secure ethos of the establishment the young people do not have access to the kitchen or cleaning implements as many of the latter could be used as weapons.

7.3 During term time the normal school timetable is followed, with breaks morning and afternoon, during which time the young people return to their units or places of accommodation for a cigarette. Further reference will be
made to smoking later in this Chapter. After school a range of recreational activities are available and in addition to the use of the swimming pool, games hall etc., many off-campus activities are available. These include visits to leisure centres, museums, forest parks and other places of interest. Again Lisnevin is the exception to this rule, particularly those young people being held there on secure remand.

7.4 Supper is served usually between 8.00 pm and 9.00 pm and bedtimes follow between 9.45 and 10.00 pm. Again there are many variations in bedtimes between schools, especially at weekends, where late night television may be watched and rising times on Saturday and Sunday are more flexible. Some of the schools strive for a more normal approach to bedtime with cups of tea or cocoa being taken around an open fire, with the young people in sleeping attire and this period is used as a time of winding down at the end of the day. A time for reflection, quiet conversation and sometimes, the occasional heated argument.

7.5 Perhaps it was the question of bedtimes that the Inspectors were most concerned about. There was a tendency to organise bedtimes in a way that ensured that all of the young people, irrespective of age or the time of the year, were in bed before the night staff commenced duty, in other words that the day staff had to settle the young people before they went off duty. Again there were variations
between the schools, and the issue referred to was less of a problem in those establishments where staff performed sleeping-in duty.

Care of the Individual

7.6 Although many of the young people coming into training schools are no strangers to residential institutions, nevertheless considerable importance is placed on their reception. Sympathetic and sensitive reception does much to allay anxieties and fears and the attitude and the response of many boys and girls is moulded by the experience of the first few hours and days in a training school. Of course there are administrative procedures to be followed, records completed and medical examinations carried out but it is the opinion of the Inspectors, based on observation and discussion with the young people, that in general, these procedures are handled with tact, care and understanding. Not all children are fearful and concerned. Some young people arrive in a highly agitated state, being brought from courts by police and absconding as quickly as possible may be the primary aim of many.

7.7 Over the years staff in the schools have developed skills of control and sensitive handling of the young people. Many of the children in training schools are there because other settings have failed and in the case of Place of
Safety Order these are often taken as a response to violence towards staff or property in children's homes. Control and management of difficult behaviour becomes a paramount consideration.

7.8 The past decade has seen an increase in the identification of young people being subjected to child sexual abuse. For many staff this phenomenon presents them with situations that they have had little experience of. New skills have to be developed, staff support systems have to be reviewed to enable the residential task to be performed with this special group of children and for the staff that their own values and attitudes have to be revised, protected and challenged.

Key Workers

7.9 The key worker or primary worker system is in operation throughout the training schools and although this works well it is necessary, because of the staff shift system and the fact that in most establishments the young people are supervised by separate night staff, to ensure that there is always someone on duty who is prepared to act in a key worker role to the young person.

Visiting

7.10 Every effort is made to maintain links between the young
people and their families. Visiting varies slightly between schools but in the main the weekends are the time for visits by parents and relatives. Distance from the boys or girls home can be a problem, not peculiar to the training schools, but every effort is made to assist parents with travel arrangements. Parents may visit at most times, outside of school hours, by arrangement.

Because many of the young people are granted home leave most weekends, parental visiting is minimal. However, it is a truism that despite the efforts of staff to encourage ongoing parental involvement many young people have few visitors.

Reviews

7.11 A comprehensive system of reviews of the young people in training schools is in operation. The quality of the reviews vary considerably but most are multi-disciplinary, with residential social workers, psychologists, teachers and where appropriate, nursing staff taking part. Some schools have a format based on Hoghughi's Problem Profiling and renamed Assessment Treatment Profile. This system provides possibly the most comprehensive method of identifying problem areas, allocating tasks and delineates the follow-up action to be taken. Further reference will be made to reviews in Chapter 11 of this report.

7.12 It was pleasing to find that in some establishments the young people were encouraged to play a full part in their
reviews. There was an openness and trust between key workers and the young person with reports being discussed freely and the young person being given the opportunity of writing their own contribution to the reviews if they so wished. There are times that the ability of children to set out their own feelings and the perceptions of their lives is greatly underestimated. The quality of the review process has been greatly enhanced by the young people's participation. The Inspector strongly supported the participation of the young people in their reviews if they so wished and stressed the need for the schools to re-examine their own review procedures.

Behaviour/Discipline

7.13 Many of the young people come to the training schools from situations where their behaviour was deemed to be uncontrollable and where they were not made amenable for breaches of discipline. The issue of control and management of difficult behaviour is a vexed area. It involves staff confidence, adequate support systems, confrontational skills and often physical skills when young people have to be restrained so that they do not damage themselves or others. Damage is frequently caused to furniture and fabrics and unacceptable behaviour has to be confronted. There is power under Schedule 5 of the Children and Young Persons Act (Northern Ireland) 1968 to deal with young people who are deemed to be "so seriously
unruly or disruptive" that they have to be removed from the school. In recent years this power has been used less and less and perhaps this is an indication of a change of attitude among staff. Sadly for some young people locking up is still an option that has to be used.

7.14 There are few sanctions that can be used as control mechanisms, eg withdrawal of privileges, cancellation of leave, fines and early bedtime. However the Inspectors found that some establishments were more successful in controlling behaviour. The importance of maintaining a relaxed informal milieu was emphasised with good communication being seen as a priority. When good communication has been established it is easier for staff to influence the young people. Discipline and order in one school was maintained by:-

i. A framework in each unit which the young people and staff clearly understand.

ii. Care, supervision and vigilance of staff.

iii. A unity between staff and the young people and a mutual support in implementing policy.

iv. Contractual arrangements with the young person.

v. Weekly meetings to assess individual and group progress.
vi. Loss of privileges, in terms of pocket money which is related to the marks system.

Marks System

7.15 All of the schools operate a marks system, which has its roots in the old Approved School system. Again the systems differ from one establishment to another. In most schools the young people earn marks for behaviour, attitude etc in the house units and in the educational setting. Allocation meetings are held weekly and pocket money, privileges and leave depend upon the level of marks obtained. The marks are allocated by a consensus of the staff and usually the young people are informed at the time of any infringement and that marks have been forfeited and the episode discussed with them. Marks are awarded for general behaviour, language, consideration, politeness, care of the individual's room and personal behaviour. Additional marks can be awarded which lead to bonuses being paid.

7.16 The marks systems has been examined on a number of occasions and its validity questioned. In general terms it points up aspects of life where there had been improvement in individual behaviour and those areas which require attention. At an individual level it is the method used by
management to assess

i. the young person's weekly progress;

ii. of helping the young person to see themselves within the group context;

iii. of setting limits for individuals and of implementing sanctions for inappropriate behaviour.

7.17 The Inspectors had the opportunity of seeing the allocation of the marks system in operation, and while recognising that any such system has limitation in assessing individual performance and behaviour, they conclude that in general the arrangement works well.

Pocket Money

7.18 Pocket Money is allocated to the young people having regard to a number of factors, including age and marks obtained. Additional sums can be earned by the undertaking of some extra "chores". In practice for many of the young people the allocation of pocket money is essentially a paper transaction when the pocket money is held for them, to reduce the possibility of theft etc. However, they are given their pocket money or savings when they go home on leave. In addition they receive allocations of money for Christmas presents, birthdays and holidays.
7.19 Generally children in care of the Health and Social Services Boards receive a higher rate of pocket money - on an age related scale - than those residing in the training schools. They also receive their pocket money as a right is without reductions as a sanction. However Rule 29(a) of the Training School Rules advocates "forfeiture of rewards or privileges (including pocket money) for minor acts of misbehaviour". The amount of pocket money paid to children in the training schools is set by the Northern Ireland Office and may be reduced as a disciplinary measure in accordance with the Training School Rules. The different approaches of the Health and Social Services Boards and the Training Schools may need to be addressed at some time in the future before new child care legislation is introduced.

Smoking

7.20 Many of the young people in training schools are regular smokers. In general smoking is strictly controlled by staff and limited to 5 cigarettes per day. Cigarettes are usually allocated at fixed times throughout the day. As with other aspects of daily life there are many variations between the schools. Some schools require parental consent for those young people under 14 years of age to smoke and some appear to have no restrictions at all. In some cases the young people can smoke as many cigarettes per day as their pocket money permits.
7.21 The Inspectors drew attention to some of the issues involved in smoking and these can be summarised as follows:

i. The law in relation to the sale of cigarettes to young people under 16 years of age.

ii. The well documented health hazards associated with smoking.

iii. The possible spread of infection (herpes) from the sharing of cigarettes between young people.

iv. The double standards of staff smoking on duty when the young people are not permitted to smoke.

v. The need to review policies on smoking and the introduction of a scheme of incentives for non-smoking.

Clothing

7.22 The method of purchasing clothing for the young people is broadly similar to that in Statutory and Voluntary Children's Homes. An allocation of money is set aside monthly and when clothing is to be purchased this is usually done in collaboration with the young person's key worker. In Rathgael Centre the boys and girls wear a
uniform to attend school and casual clothes thereafter.

The girls in St Joseph's wear casual clothing but the
wearing of jeans to school is not permitted. Lisnavin and
St Patrick's boys usually wear jeans and sweaters to
school. There were some examples of bulk buying and
clothing being held in a central store. As with the levels
of pocket money the policy regarding the allocation of
funds for clothing also needs to be addressed.
3. EDUCATION/VOCATIONAL TRAINING/EMPLOYMENT

3.1 Compulsory education for boys and girls, under 16 years of age, is available at all of the training schools. In addition, those young people, who are over 16 years and still in residence, have available to them a wide range of vocational opportunities. In addition a regular programme of social and life skills training is followed. In two of the schools a number of young people attend as day pupils availing of specialist education programmes whilst remaining in their own homes. A feature of the day attenders is that many travel a considerable distance and the attendance rates remain high.

3.2 In educational terms the usual range of general subjects are available plus art, physical education, craft design and technology. In some of the schools the educational component is divided into a junior and senior school format. The junior school deals mainly with young people under 15 years of age, with the emphasis on general subjects. In general the primary school model is used in that of the 35 periods of education that each child receives, 22 of them are spent with one teacher. It is understood that this policy brings about a more stable relationship in the school setting.

3.3 The senior schools cater for boys in the 15-19 year old category where the emphasis is on vocational training
and an element of remedial education is also available. Boys have the opportunity to attend courses in woodwork, engineering, building, painting and farming/horticultural pursuits. Most of these courses can lead to GCSE Craft Certification.

8.4 Other subjects are taught at the schools including wallpapering, decorating, motor engineering, specialist projects with a community emphasis, social studies, typing, commercial subjects and the programme is such that any specialist subject can be provided relative to the needs of the young person. If, for example, on admission to the school, a young person is following a particular course of study arrangements are made for these to be continued either on or off the premises.

8.5 Most of the schools have a general aim "to promote learning and enhance the pupil's skill and competence". There are special problems that teaching staff have to cope with. In the training schools education is provided in group situations which are completely different from those prevailing in a normal school setting. There are behavioural, confrontational situations which create stress for both pupils and staff. It is a truism that in many cases the young people see themselves as a captive audience and not always a co-operative one. Many of the young people have had a long history of school absenteeism and consequently are educationally immature and at times can
be hard to motivate.

3.6 Education in the special setting of the training schools requires close liaison with the educationalists and the residential care staff. Problems arising in the school setting or in residential units can be easily carried over into one or the other and consequently mechanisms have had to be established to ensure that as far as possible communication between the 2 sets of staff is open and comprehensive. In some schools this works better than others.

3.7 For many years it was the policy of the training schools' management to ensure that, as far as possible, suitable employment was found for a young person before they were licensed or discharged. In the Ministry of Home Affairs "Handbook for Guidance - Juvenile Offenders and Those in Need of Care, Protection or Control", Paragraph 80, it sets out the Manager's statutory duty ...."to ensure that the person under supervision is visited, advised and befriended and they are required to give him assistance (including financial assistance if necessary) in maintaining himself and finding suitable employment".

3.8 Unfortunately because of the present level of unemployment in the Province, it is not always possible to find "suitable employment". Indeed if a child were to be detained until a suitable long-term job could be found many would not be licensed or allowed home on extended leave as
early as is otherwise desirable. Nevertheless, job finding
is an important consideration in the planning for discharge
of a young person from training school.

3.9 Considerable use is made of YTP and other Government
schemes by the training schools. Despite the low level of
unemployment opportunities in many areas, considerable
success has been achieved, particularly by the After Care
staff to whom the task of finding employment usually falls.
Further reference will be made to this activity in Chapter
9.
9. AFTER CARE

9.1 Paragraph 49 of the Training School Rules (NI) 1952, provides that the Board of Management shall appoint "a suitably qualified" person to carry out the after care of pupils when they have left the school. All of the schools have staff who are designated to carry out this task. The numbers involved consist of one staff member in the smaller schools to a team organisation in Rathgael and St Patrick's.

9.2 For many years the after care function followed a well established traditional role. This role covered a number of functions such as obtaining suitable employment, accommodation, finance and giving general support to young people on licence. While these functions are still an integral part of the after care role the nature and content of the work has changed significantly. New perspectives in social work thought in relation to young people in institutional care, alterations in the socio-economic structure, demographic changes and developments in related fields of social legislation have all combined to bring about a much wider dimension to the after care function in the training schools. The use of the term after care is now really a misnomer.

9.3 A recently published report by the After Care Staff in Training Schools has clearly set out the changing face of
after care. "While the work of the after care departments
has developed differently in each training school there are
a number of features which are common to all and a number
of constraints within which they have to work. These can
be summarised as follows:

i. Since the publication of the Black Report (December
1979) and in keeping with recent research findings,
training schools have developed a greater awareness
of the importance of viable family and community
links for young people in care.

ii. Young people in training schools now receive
frequent and prolonged leave periods with their
families where appropriate. Return to the community
is much quicker than was formerly the case,
particularly in relation to those young people in
the justice sector of the schools.

iii. Many young people are working out of the training
schools and local employment schemes and some attend
the schools by day only.

iv. This increased community orientation has obviously
placed more demands on after care departments who
are frequently entrusted with the task of monitoring
home leave, finding job placements, encouraging
family and community links, planning and supervising
early release schemes.
9.4 In the care field, in keeping with recent developments in child care practice and shifts in the focus of social work scrutiny, the typical young person entering training schools is inclined to be seriously maladjusted. These include children who, prior to committal, may have experienced a series of residential or fostering placements which have not met their needs. For these young people rehabilitation within a family is impossible and often undesirable. As such very selective alternative accommodation has to be found. This work obviously necessitates time-consuming searches for appropriate placements which if found require careful and intensive monitoring and support. Placements sought include Barnados Professional Fostering Projects, specially selected landlords, hostels and members of extended families.

9.5 Changes in the social security system which has the clear policy objective of throwing young people back on dependency on their families, has put increased pressure on after care departments, trying to rehabilitate these young people who, for the reasons outlined, have no family contacts or have contacts which are potentially damaging to their physical, emotional and moral well-being.

9.6 As is the experience of many Social Services Departments the problems of alienated, homeless young people will probably be one of the main problems facing training schools in the coming years."
9.7 On the positive side there have been a number of very constructive initiatives emerging, the most notable being the Eastside Project. This joint Rathgael Centre/Eastern Health and Social Services Board initiative, began as a project whose raison d'etre was to establish a more speedy return to the community of those young people living in East Belfast and Castlereagh Unit of Management. From the early beginnings the project has grown and developed as a substantial plank in the Unit of Management's strategy for dealing with difficult adolescents. The project attracted national recognition in 1987 when it was awarded second prize in the Social Work Today competition.

9.8 The after care staff in training schools feel that the role has now a much stronger "community" orientation and that their designation should reflect that change. They conclude "that this role has extended to encompass a throughcare function and that the task of re-integration of the young person in the community has to commence on the day of admission. "Although the number of young people entering training schools has fallen the extent of the problem behaviour, presented by some, has placed additional and differing demands on staff and resources". 
10. HEALTH CARE

10.1 All training schools have Medical Officers appointed to carry out duties prescribed in Section 50 of the Training School Rules, these include making:

i. a thorough examination of each child on admission and before leaving the school;

ii. a quarterly inspection of each child;

iii. a quarterly general inspection of the school, from the hygiene point of view and advice as to dietary and general hygiene;

iv. the examination of all sick and ailing children;

v. the keeping of medical records; and

vi. the making of reports/certificates as required by the Board.

In pursuance of the duties set out above doctors attend the schools regularly. They hold their surgery in the medical rooms which are provided on all sites. The Medical Officers compile a quarterly report for the Department of Health and Social Services where it is seen by the Chief Medical Officer and by a Social Services Inspector.
10.2 The Medical Officers are General Practitioners and the children in the schools are normally transferred to their lists following their admission. When they are the subject of short-term orders, temporary transfers are arranged but full registration is completed for all children on Training School Orders.

Medical Records

10.3 If a child is admitted to a training school who has previously been in the care of the Health and Social Services Board then in some cases the Certificate of Health/Free from Infection Certificate is sent to the school. Social Services may also have obtained "parental consent to medical treatment and/or vaccination/immunisation". Following admission to the school the child is seen by the nurse who asks about the medical history, takes the height and weight measurements and notes this information on Medical Record Form RHM. This proforma is also used by the Medical Officer to record his observations when making a general medical inspection and to make clinical notes at the onset of an illness and its treatment etc. A completed Form RHN is held for each child residing in the training school and is kept in a filing cabinet in the medical sector of the school.

Nursing Care

10.4 The day to day oversight of the children's health is
provided for by the employment of qualified nursing staff. Most of the schools have a suite of rooms in which basic health care and medical examinations are carried out. Some of the schools have an area known as the sick bay where minor ailments are cared for and this includes the provision of a few beds. In practice should circumstances require urgent treatment the Out Patient facilities of local hospitals are used. The nurses have been used, from time to time, to assist with the programmes of general health and sex education.

Dental Care

10.5 Three of the four schools have fully equipped dental surgeries and the dentist visits once or twice weekly. The young people have a dental examination soon after admission and have regular examinations at 6-monthly intervals or more frequently if necessary. The full range of dental and orthodontist services is also available should children require specialist treatment.

Psychological Service

10.6 A service to training schools is provided by the Adolescent Psychological and Research Unit. The psychologists provide a diverse range of forensic, educational and clinical skills in the assessment of children and their families 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 the involvement with children and young persons, the psychologists contribute professional advice and support to all of the schools and have a direct role in evaluating potential admissions to the secure units at Rathgael and Lisnevin. Their professional independence makes a valuable contribution to the various models of inter-disciplinary assessment in the schools as well as providing an independent sounding board for staff and management. The APRU psychologists provide inter-agency contact with the various networks of Probation, Social Services, Health and Education and specific specialist resources within these agencies, for example, special education and adolescent psychiatry.

10.7 The skills of the psychologists are particularly valuable in that they have a major impact on the development of a professional ethic within the training school system. The quality of psychological input to the various schools is unanimously acclaimed and each of the schools seemingly would welcome more psychological time. By virtue of training and experience the APRU psychologists, as individuals and as a group, possess skills which are not found, or at least not developed, in other professional groups. These include skills in psychometrics, in the observation, scaling and measurement of behaviour, in research and evaluation and in the application of psychological principles to the management of behavioural
problems at an individual level and/or family level and to
management at an institutional level in terms of the
development of systems or policy. Among specific areas of
work coming to the attention of the Inspectors were
research on self-injurious behaviour and the development of
a pro-forma record form for such incidents, treatment of
sex offenders, diversion of care cases and offenders to the
community following psychological assessment and an
inter-agency treatment package, social skills training
making use of video. Neuropsychological investigation
(where there was a suspicion of minimal brain damage),
measurement and management of adolescent depression, staff
training in the handling and management of aggressive
behaviour, intervention in cases of child sexual abuse,
assessment and consultancy concerning potential admissions
of children to secure units, educational assessment and
research forms part of the work of AFRU. In addition the
psychologists have frequently organised training seminars
and workshops and the Inspectors feel they have an
important contribution to make to the development of
training initiatives within the schools.

Psychiatric Services

10.8 The full range of psychiatric services are available to the
training schools. Dr Ewan McEwan, Consultant in Adolescent
Psychiatry also provides a service to the schools. In some
situations he has a regular scheduled arrangement to visit
and in others he is available to accept appropriate
referrals.
11. REGULATIONS AND RECORDS

11.1 The Training School Rules SR0132/1952 sets out the regulatory framework for the administration of the Training Schools. Rule 53 of the Direction states that "The Management Board shall arrange for the keeping of all registers and records required by the Ministry and shall cause to be sent to the Ministry such returns, statements and other information as may be required from time to time".

11.2 All of the schools maintained the records required by the Rules. These records include an Admission and Discharge Register, Major Incident Book, Record of Fire Drills and a Licensing Certificate Book. The latter record refers to the formal Certificate of Licence that each young person receives upon their formal licence from the School. The Certificate of Licence gives details of the conditions as to residence and date of release.

11.3 Detailed case records are kept on each young person. The young people are reviewed every 3 months and after one year in residence they are reviewed by the Licensing Committee. The Licensing Committee is a sub-committee of the Management Board whose function is to review individual children and approve their licence. Some Licensing Committees act as an internal review body and some are supported by co-optees or resource persons who may have
a particular contribution to make to the review process for
example, managers of YTP Schemes or headmasters of local
schools.

11.4 The review process differs considerably between the
schools. One establishment concentrates all reviews
centrally with residential staff in attendance and
providing written reports. Another school invites the
young people to contribute to their reviews in writing if
they wish and the boys and girls are given an opportunity
to attend the reviews.

11.5 The records kept on the children were comprehensive and
well kept and the general standard of recording throughout
the schools was satisfactory.
12. MONITORING ARRANGEMENTS

12.1 The duties of the Board of Managements are set out in Rule 10 of the Training School Rules.

10(1) The Board of Management shall maintain an efficient standard throughout the school and for this purpose they shall take into consideration any report that may be communicated to them by or on behalf of the Ministry.

(2) It shall be the duty of the Board of Management to ensure that the condition of the school and the training, welfare and education of the boys and girls under their care are satisfactory, and for this purpose they shall pay frequent visits to the school.

(3) The school shall be visited at least once a month by at least one member of the Board of Management, who shall satisfy himself regarding the care of the boys or girls and the state of the school, and shall enter his conclusions in the log book or other convenient record kept at the school.

(4) The Board of Management shall exercise an effective control over all expenditure.
12.3 It was clear that the schools were being visited regularly by Board members. These visits were not limited to the requirements of the Rules ie monthly. However the quality of the records of the visits indicated that perhaps too much attention was paid to the physical condition of the buildings and the general fabric of the accommodation. Over the years the quality of the recording of the visits had improved somewhat.

12.3 The Inspectors felt that the general quality of visiting by Board Members on a formal basis could be improved if a system of monitoring, similar to that suggested in the Department of Health and Social Services Circular HSS(CC) 6/83 were introduced. The Inspectors recommended the adoption of a system of monitoring akin to that used within the Health and Social Services Boards in respect of their residential child care services.

12.4 Following the completion of the inspection programme formal discussions took place with all of the Management Boards and a framework for monitoring visits by Board Members was discussed. Board Members carrying out the monthly visits will:-

i. ensure that as far as possible, that the needs of the young people in the Training Schools are properly met; and
ii. that this will involve the visitor gradually getting
to know each young person and the particular
programme of care or plans that have been drawn up
for him/her.

12.5 The Members have been asked to concentrate on the quality
of the young person’s social/emotional care and will seek
to examine issues such as:-

i. general arrangements for the care of the young
person;

ii. supervision of the young people within the unit;

iii. the relationship between the young people and care
staff;

iv. methods of control and discipline used and sanctions
imposed;

v. arrangements for religious observance other than on
campus;

vi. social and recreational activities undertaken;

vii. contact with the local community.

12.6 The quality of physical care will be examined and the
framework will include:

i. general condition of the unit;

ii. standard of furnishing;

iii. arrangements for fire precautions;

iv. safety standards within the Unit;

v. arrangements for medical care and hygiene;

vi. the standard of catering;

vii. the standard of clothing;

viii. arrangements for pocket money.

12.7 The records required by the Rules will be examined and at the completion of the visit a report will be made available to the meeting of the Management Board and signed by the Chairman. Such detailed visiting and reporting is probably too much to ask of any one Board Member, having regard to the size of the facility, and consequently it is envisaged that the areas of work to be monitored will be undertaken by all Board Members over a period of time. Hopefully a pattern of the work being undertaken in the Schools will emerge and for the future a clearer statement of monitoring...
will be available to the Board itself and to the Northern Ireland Office.
13. CONCLUSIONS

13.1 The past 5 years has seen a period of unprecedented change within the training schools. Even the term training school no longer accurately reflects the nature of the work being undertaken. Management of the schools have embodied new thought and practice into the day to day operation of the facilities and this has reflected favourably upon the quality of care being provided.

13.2 For some staff the period of change has not been without its problems. New skills have had to be acquired, a openness in sharing with the children and young people in the schools have made new demands upon staff. For some the changes have been too great and they have sought employment elsewhere or taken early retirement. For many years the training schools were considered residential establishments where a "no nonsense approach" was adopted and they were often used as a threat to children misbehaving in other children's residential facilities.

13.3 Although some of the old ideas and terminology still prevails within the system, in general the staff in training schools are much more professional in their approach and have been prepared to adapt to change and in some circumstances are expert in their field. It is to the training schools that the organisation of secure accommodation have fallen. The emotive subject of locking
up children has often created much debate within social work. It has created much double think and has had obvious implications for practice. The training schools management have faced these issues and through the development of gatekeeping mechanisms have ensured that only those children absolutely requiring secure care are admitted. Although at this time secure accommodation is not covered by regulations, every effort has been made to follow the general guidelines that are a statutory requirement in other parts of Great Britain. When there have been incidences of the inappropriate use of security these have been highlighted by the Inspectorate and policy and practice has changed.

13.4 Training schools have come along way since the days of the Industrial Schools and the use of a tall ship moored in the Musgrave Channel. Those were the days when perhaps 2 staff had the responsibility for the care and supervision of up to 100 children at a time. As one old member of staff, now long since retired said, "When I started in the training schools I was given a table-tennis bat, a whistle and a bunch of keys and told to get on with it". That was leisure, control and security in the 1940s and not a social worker in sight.
### APPENDIX A

**Inspection of Training Schools**

**STAFF FORM**

<table>
<thead>
<tr>
<th>SECTION A: PERSONAL DETAILS</th>
<th>OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of Training School</td>
<td>[..]</td>
</tr>
<tr>
<td>2. Name of Staff Member</td>
<td>[..]</td>
</tr>
<tr>
<td>3. Date of Birth</td>
<td>[../../..]</td>
</tr>
<tr>
<td>4. Age</td>
<td>[..]</td>
</tr>
<tr>
<td>5. Sex:</td>
<td>[..]</td>
</tr>
<tr>
<td>(a) Male [ ]</td>
<td>(b) Female [ ]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SECTION B: IN-POST DETAILS</th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Designation:</td>
</tr>
<tr>
<td>(a) Director</td>
</tr>
<tr>
<td>(b) Senior Deputy Director</td>
</tr>
<tr>
<td>(c) Deputy Director</td>
</tr>
<tr>
<td>(d) Assistant Director</td>
</tr>
<tr>
<td>(e) Deputy Assistant Director</td>
</tr>
<tr>
<td>(f) Senior Assistant</td>
</tr>
<tr>
<td>(g) Senior Residential Social Worker</td>
</tr>
<tr>
<td>(h) Team Leader (Warden)</td>
</tr>
<tr>
<td>(i) Residential Social Work</td>
</tr>
<tr>
<td>(j) Housemother</td>
</tr>
<tr>
<td>(k) Field Social Worker (After Care)</td>
</tr>
<tr>
<td>(l) Teacher/Instructors (Those Involved in ED))</td>
</tr>
<tr>
<td>(m) Night Supervisor</td>
</tr>
<tr>
<td>(n) Other</td>
</tr>
</tbody>
</table>

| 7. Length of time in this Post (years) | [..] |
| 8. Length of time in the training school service (years) | [..] |
| 9. Length of time in residential child care (years) | [..] |
### SECTION C: QUALIFICATIONS

10. Does this person already possess: (Tick as many options as appropriate.)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>CGSW or Equivalent</td>
</tr>
<tr>
<td>(b)</td>
<td>CSS</td>
</tr>
<tr>
<td>(c)</td>
<td>SRN/SEN</td>
</tr>
<tr>
<td>(d)</td>
<td>NNEB</td>
</tr>
<tr>
<td>(e)</td>
<td>FCSC/FCCC/PCRC/PRC</td>
</tr>
<tr>
<td>(f)</td>
<td>CRCC/CRCCYP/SCRCCYP</td>
</tr>
<tr>
<td>(g)</td>
<td>DEGREES (BA BSc BSocSc)</td>
</tr>
<tr>
<td>(h)</td>
<td>ICSC/ISSC</td>
</tr>
<tr>
<td>(i)</td>
<td>Cert. in Education &amp; other teaching quals</td>
</tr>
<tr>
<td></td>
<td>Please Specify</td>
</tr>
<tr>
<td>(j)</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Please Specify</td>
</tr>
<tr>
<td>(k)</td>
<td>No Qualifications</td>
</tr>
</tbody>
</table>

11. Has this person completed a post qualifying course in:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Management Studies</td>
</tr>
<tr>
<td>(b)</td>
<td>Child Care</td>
</tr>
<tr>
<td>(c)</td>
<td>Another Subject</td>
</tr>
<tr>
<td></td>
<td>Please Specify</td>
</tr>
<tr>
<td>(d)</td>
<td>None of These</td>
</tr>
</tbody>
</table>

12. Other significant information:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>(a)</td>
<td>Employed previously in Children's Homes/Training School</td>
</tr>
<tr>
<td>(b)</td>
<td>Employed previously in Mental/Physically Handicapped Homes</td>
</tr>
<tr>
<td>(c)</td>
<td>Employed previously in OP Home</td>
</tr>
<tr>
<td>(d)</td>
<td>Clerical jobs only</td>
</tr>
<tr>
<td>(e)</td>
<td>Employed previously in nursery/primary/secondary schools</td>
</tr>
<tr>
<td>(f)</td>
<td>Youth Clubs</td>
</tr>
<tr>
<td>(h)</td>
<td>Nursing</td>
</tr>
<tr>
<td>(i)</td>
<td>Other</td>
</tr>
<tr>
<td></td>
<td>Please Specify</td>
</tr>
<tr>
<td>(j)</td>
<td>None of These</td>
</tr>
</tbody>
</table>
SECTION D: TRAINING

13. Is this person currently studying for: (Tick as many options as appropriate.)
   (a) QSW or Equivalent [ ]
   (b) CSS [ ]
   (c) NNEB [ ]
   (d) FCSC/PCCC/PRC [ ]
   (e) CRCC/CRCCYP [ ]
   (f) DEGREES (BA BSc BSocSc) [ ]
   (g) ICSC/ISSC [ ]
   (h) Cert in Education (& other teaching quals) [ ]
   Please Specify .................................... [ ]
   (i) Other [ ]
   Please Specify .................................... [ ]
   (j) No Qualifications [ ]

14. Is this person currently undertaking a post-qualifying course in:
   (a) Management Studies [ ]
   (b) Child Care [ ]
   (c) Another Subject [ ]
   Please Specify .................................... [ ]
   (d) None of These [ ]

15. Is this person currently receiving In-Service Training or Day Release to attend courses/seminars.
   (a) Yes [ ] (b) No [ ]

16. Please list all courses attended by this staff member in the last twelve months excluding those mentioned in questions 13 and 14.
   ...................................................................................
   ...................................................................................
   ...................................................................................
   ...................................................................................
   ...................................................................................

SECTION E: DETAILS OF OFFICER COMPLETING THIS STAFF FORM

17. NAME OF OFFICER ...........................................
18. DESIGNATION ...............................................
19. TELEPHONE ..............................................
20. SIGNATURE ............................................... [..../..../..]
21. DATE ......................................................
## Inspection of Training Schools

### RESIDENT'S FORM

**SECTION A: PERSONAL DETAILS**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Name of Training School</td>
<td></td>
</tr>
<tr>
<td>2. Name of Child/Young Person</td>
<td></td>
</tr>
<tr>
<td>3. Date of Birth</td>
<td></td>
</tr>
<tr>
<td>4. Age</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Sex</td>
<td></td>
</tr>
<tr>
<td>(a) Male [ ] (b) Female [ ]</td>
<td></td>
</tr>
<tr>
<td>6. Unit of Management responsible for child: (Care Cases ……</td>
<td></td>
</tr>
<tr>
<td>7. Please indicate where the young person is on Census Day</td>
<td></td>
</tr>
<tr>
<td>(a) In this Training School</td>
<td></td>
</tr>
<tr>
<td>(b) Temporarily resident in another Training School</td>
<td></td>
</tr>
<tr>
<td>(c) Boarded Out</td>
<td></td>
</tr>
<tr>
<td>(d) In Hospital</td>
<td></td>
</tr>
<tr>
<td>(e) Extended leave</td>
<td></td>
</tr>
<tr>
<td>(f) VDC</td>
<td></td>
</tr>
<tr>
<td>(g) Absconder</td>
<td></td>
</tr>
<tr>
<td>(h) Other</td>
<td></td>
</tr>
<tr>
<td>Please specify</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OFFICE USE ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
<tr>
<td>[... ]</td>
</tr>
</tbody>
</table>
SECTION B: RESIDENTIAL DETAILS

3. Legal Status:
   (a) Training School Order [ ]
   (b) Place of Safety [ ]
   (c) Interim Fit Person Order [ ]
   (d) Interim Detention Order [ ]
   (e) Remand [ ]
   (f) Other Please specify ..................... [ ]

3. Immediate Previous Placement:
   (a) Own Home [ ]
   (b) Children's Home [ ]
   (c) Foster Home [ ]
   (d) Assessment Centre [ ]
   (e) Hospital [ ]
   (f) Other (specify) ......................... [ ]

10. Date of Training School Order /../..

11. Date Admitted to this School /../..

12. Date of last Review /../..

13. Has this Child/Young Person been admitted to Training School previously [ ]
   (a) Yes [ ]
   (b) No [ ]
SECTION C: EDUCATION AND EMPLOYMENT

14. Is this Child/Young Person currently:
   (a) Employed Full-Time [ ]
   (b) Employed Part-Time [ ]
   (c) On a YTP scheme or similar [ ]
   (d) Voluntary work [ ]
   (e) None of these [ ]

15. Is this Child/Young Person receiving Education:
   (a) In Training School [ ]
   (b) Secondary/Grammar School [ ]
   (c) Technical College [ ]
   (d) Training School day pupil [ ]
   (e) Other [ ]
   (f) Please (specify) .................... [ ]
   (g) None of these [ ]

SECTION D: FUTURE PLANS (Tick as many options as appropriate)

16. Is this child/young person:
   (a) Being licensed to live with relatives [ ]
   (b) Extended leave with relatives [ ]
   (c) In preparation for Fostering [ ]
   (d) In Preparation for independent Flat/Accommodation [ ]
   (e) Transferring to other children's home/hospital/institution [ ]
   (f) None of these [ ]

17. Other significant information:
   (a) Lives with relatives for part of week [ ]
   (b) Physically/Mentally handicapped or requires other special care [ ]
   (c) Other [ ]
   (d) Please Specify .................... [ ]
   (e) None of these [ ]

SECTION E: DETAILS OF OFFICER COMPLETING THIS RESIDENTS FORM

18. NAME OF OFFICER ....................

19. DESIGNATION ....................

20. TELEPHONE ....................

21. SIGNATURE ....................

22. DATE ........../../
STATUTORY RULES AND ORDERS OF
NORTHERN IRELAND
1952. No. 132

TRAINING SCHOOLS

Rules

RULES, DATED 24TH JULY, 1952, MADE BY THE MINISTRY OF HOME
AFFAIRS UNDER PARAGRAPH I OF THE FOURTH SCHEDULE TO THE
CHILDREN AND YOUNG PERSONS ACT (NORTHERN IRELAND), 1950.

The Ministry of Home Affairs by virtue of the powers conferred
upon it by paragraph 1 of the Fourth Schedule to the Children and
Young Persons Act (Northern Ireland), 1950, and of all other powers
enabling it in that behalf, hereby makes the following Rules:

1. These Rules may be cited as the Training School Rules (Nor-
thern Ireland), 1952.

2. These Rules shall come into operation on the 1st day of October,
1952.

3. In these Rules the following expressions have the meanings
hereby respectively assigned to them, that is to say:

"the Act" means the Children and Young Persons Act (Northern
Ireland), 1950;

"the Ministry" means the Ministry of Home Affairs for Northern
Ireland;

"Fire Service" means in the area of the County Borough of Bel-
fast the Belfast Fire Brigade and elsewhere in Northern Ireland
the Northern Ireland Fire Authority;

"school" means a training school approved by the Ministry under
section one hundred and six of the Children and Young Persons
Act (N.I.), 1950;

"Board of Management", in relation to a training school estab-
lished or taken over by a local authority, means the local author-
ity, and, in relation to any other training school, other than those
under Government ownership, means the persons for the time
being having the management or control thereof;

"Manager" means the person appointed by the Board of Manage-
ment to take charge of the school;

"Inspector" means any one of the Inspectors appointed by the
Ministry of Home Affairs under section one hundred and thirty-
six of the Children and Young Persons Act (N.I.), 1950.
4. Two at least of the Board of Management of a boys' school shall be women, and two at least of the Board of Management of a girls' school shall be men.

5. The Board of Management shall appoint a finance committee and such other committees as they think necessary for the efficient management of the school. Any committee so appointed shall have such powers or duties as the Board of Management may determine.

6. The Board of Management shall appoint one of their number to be Chairman.

7. The Board of Management shall notify to the Ministry the names and addresses of their members and shall similarly notify any change due to death, retirement or other cause.

8. The Board of Management shall meet so far as practicable once a month at the school.

9. The Board of Management and any committee appointed by them shall keep minutes of their proceedings and these minutes shall be open to inspection by an Inspector of the Ministry.

10.—(1) The Board of Management shall maintain an efficient standard throughout the school and for this purpose they shall take into consideration any report which may be communicated to them by or on behalf of the Ministry.

(2) It shall be the duty of the Board of Management to ensure that the condition of the school and the training, welfare and education of the boys and girls under their care are satisfactory, and for this purpose they shall pay frequent visits to the school.

(3) The school shall be visited at least once a month by at least one member of the Board of Management, who shall satisfy himself regarding the care of the boys or girls and the state of the school, and shall enter his conclusions in the Log Book or other convenient record kept at the school.

(4) The Board of Management shall exercise an effective control over all expenditure.

11. The name of the school shall be chosen by the Board of Management subject to the approval of the Ministry.

Accommodation

12.—(1) The number of boys or girls resident in a school at any time, whether sent under the provisions of the Act or not, shall not exceed such number as may be fixed for that school from time to time by the Ministry.
(2) Except with the special authority of the Ministry, the Board of Management shall not receive or retain in the school any boy or girl otherwise than in accordance with the classification of the school as determined by the Ministry in pursuance of sub-section (1) of section one hundred and nine of the Act.

Stores Accounting and Stocktaking

13.—(1) The Board of Management shall arrange for the introduction of a system of stores accounting to ensure that adequate control is exercised over the various supplies of materials, equipment and other stores purchased for use at the school.

(2) Arrangements shall be made by the Board of Management for complete stocktaking to be held at the school not later than 31st March each year, and for a copy of the stocktaker's report to be furnished to the Ministry.

Fire Precautions

14. The Board of Management shall —
(a) obtain the advice of the Fire Service before opening a new Training School or making any structural alterations to an existing school;
(b) arrange for the periodic inspection of the school by the Fire Service;
(c) ensure that fire drills are carried out at regular intervals so that the staff and the pupils are well versed in the procedure for saving life in case of fire;
(d) arrange for a report to be sent to the Ministry forthwith in the event of an outbreak of fire in the school.

Appointment of Staff

15.—(1) The Board of Management shall be responsible for the appointment, suspension or dismissal of the staff of the school provided that no person shall be appointed to the staff of the school without the Ministry's approval.

(2) Any vacancy for a manager shall be advertised unless the Board of Management obtains the consent of the Ministry to dispense with this requirement.

16. The manager, deputy manager, matron, teachers and instructors shall be employed under a written agreement, or, in the case of a local authority school, under a minute of the local authority.

17. Except with the consent of the Ministry, no member of the staff shall be retained after he has reached the age of 65 years.

18. In every school, not being a local authority school, the Board of Management shall cause to be given to every member of the staff who is not eligible for superannuation under the Teachers' Superannuation
Acts immediately on his or her appointment a copy of the superannuation scheme approved by the Ministry, and shall take such steps as are necessary to allow any eligible member to enter the scheme.

Manager

19.—(1) The manager shall be responsible to the Board of Management for the efficient conduct of the school.

(2) He shall keep a Register of Admissions and Discharges in which shall be recorded all admissions, licences, revocations of licences, recalls, releases and discharges; a Log Book in which shall be entered every event of importance connected with the school; a Daily Register of the presence or absence of each boy or girl; and a Punishment Book. These shall be available for inspection by the Board of Management at all times. The Log Book shall be laid before the Board of Management at each of their meetings and shall be signed by the chairman.

(3) The manager shall not incur any expenditure, other than petty expenditure within a limit approved by the Board of Management, without their previous sanction or that of a member of the Board authorised to act on their behalf.

20. The manager, with the approval of the Board of Management, shall determine the duties of the other members of the staff. These duties may include duties connected with the supervision of the boys or girls in the school, their recreation and their after-care.

21. The manager shall obtain the authority of the Board of Management and shall also notify the Ministry before leaving the school for more than two days.

22.—(1) Where there is no deputy manager the Board of Management shall appoint in writing the principal teacher or other experienced member of the staff to exercise the functions of the manager during the manager's absence and shall communicate to the Ministry the name of the person so appointed.

(2) The deputy manager (or, as the case may be, the person appointed under paragraph (1) of this Rule) shall exercise the functions of the manager during the manager's absence and shall communicate to the Ministry the details of the powers and duties of the manager shall apply accordingly.

23. As soon as practicable after the admission of a boy or girl the manager shall inform the parent or guardian of his or her arrival.

Care of Boys and Girls

24. Each pupil shall be provided with a separate bed and shall be kept supplied with suitable clothing similar to that worn in ordinary life.

25.—(1) The manager shall submit to each year a report of the condition of the school, and such other reports as the Ministry may require.

(2) The manager shall notify the Ministry of the appointment of a new manager or of his or her resignation or retirement.

26.—(1) The manager shall keep a Register of Admissions and Discharges in which shall be recorded all admissions, licences, revocations of licences, recalls, releases and discharges; a Log Book in which shall be entered every event of importance connected with the school; a Daily Register of the presence or absence of each boy or girl; and a Punishment Book. These shall be available for inspection by the Board of Management at all times. The Log Book shall be laid before the Board of Management at each of their meetings and shall be signed by the chairman.

(2) The manager shall keep a Register of Admissions and Discharges in which shall be recorded all admissions, licences, revocations of licences, recalls, releases and discharges; a Log Book in which shall be entered every event of importance connected with the school; a Daily Register of the presence or absence of each boy or girl; and a Punishment Book. These shall be available for inspection by the Board of Management at all times. The Log Book shall be laid before the Board of Management at each of their meetings and shall be signed by the chairman.

(3) The manager shall not incur any expenditure, other than petty expenditure within a limit approved by the Board of Management, without their previous sanction or that of a member of the Board authorised to act on their behalf.

20. The manager, with the approval of the Board of Management, shall determine the duties of the other members of the staff. These duties may include duties connected with the supervision of the boys or girls in the school, their recreation and their after-care.

21. The manager shall obtain the authority of the Board of Management and shall also notify the Ministry before leaving the school for more than two days.

22.—(1) Where there is no deputy manager the Board of Management shall appoint in writing the principal teacher or other experienced member of the staff to exercise the functions of the manager during the manager's absence and shall communicate to the Ministry the name of the person so appointed.

(2) The deputy manager (or, as the case may be, the person appointed under paragraph (1) of this Rule) shall exercise the functions of the manager during the manager's absence and shall communicate to the Ministry the details of the powers and duties of the manager shall apply accordingly.

23. As soon as practicable after the admission of a boy or girl the manager shall inform the parent or guardian of his or her arrival.

24. Each pupil shall be provided with a separate bed and shall be kept supplied with suitable clothing similar to that worn in ordinary life.
25.—(1) Sufficient and varied food, based on a dietary scale to be drawn up by the Board of Management after consultation with the manager and medical officer, shall be provided. The dietary scale shall include a list of dishes and a table of quantities to be supplied to each pupil.

(2) The dietary scale shall be subject to the approval of the Ministry, and, except as provided for by Rule 39 (c), no substantial alteration shall be made in it without the Ministry's approval. A copy shall be kept posted in the school dining-room.

School Routine

26.—(1) The daily routine of the school (including the hours of rising, school-room instruction and practical training, domestic work, meals, recreation and retiring) shall be in accordance with a scheme drawn up by the Board of Management and approved by the Ministry.

(2) A copy of the daily routine shall be kept posted in some conspicuous place in the school.

(3) Any substantial deviation from the daily routine shall be entered in the Log Book and a notification shall be sent forthwith to the Ministry.

Education

27.—(1) The education of the pupils in the school shall be based on the principles of the Education Act (Northern Ireland), 1947, so as to secure efficient full-time primary or secondary education suitable to the age, ability and aptitude of each individual boy or girl while of compulsory school age and his or her further education thereafter as long as he or she remains in the school.

(2) The school-room time-table and syllabus shall be subject to the approval of the Ministry and a copy of the time-table shall be kept posted in the school-room.

28.—(1) The practical training of all pupils shall be in accordance with a scheme drawn up by the Board of Management and approved by the Ministry. Any substantial deviation from the scheme shall be recorded in the Log Book and a notification shall be sent forthwith to the Ministry.

(2) The practical training given to pupils over compulsory school age shall so far as practicable be directed to their preparation for a particular form of employment; regard shall be had to the capacity and preference of each pupil and in all suitable cases the parent or guardian shall be consulted.

29. The attendance of pupils at classes within the school (including classes of practical training) shall be recorded in registers kept for that purpose, and a separate register shall be maintained for each class.
Employment

30. No pupil shall be employed in such a way as to impair his or her capacity for profiting by instruction or to deprive him or her of reasonable recreation and leisure. Children under 12 shall not be employed except in light work such as making their own beds or cleaning their own boots or shoes.

Religious Instruction

31.—(1) Each day shall be begun and ended with prayer. So far as practicable arrangements shall be made for the attendance of the pupils each Sunday at a place of public worship.

(2) Holy days shall be observed in such manner as the Board of Management deem proper.

(3) Where adequate arrangements can be made religious instruction shall be given suited to the age and capacity of the pupils.

(4) Where the manager of a school for boys or girls of a particular religious persuasion has consented to receive a pupil who does not belong to that religious persuasion arrangements shall be made so far as practicable for such pupil to receive religious assistance and instruction from a minister of the religious persuasion to which he or she belongs.

Recreation, Visits and Letters

32.—(1) Adequate provision shall be made for free time and recreation including organised games and walks and visits outside the school boundaries; and except in bad weather at least one hour daily shall be spent in the open air.

(2) If a cadet contingent is maintained at the school, enlistment shall not be compulsory and training or drill shall not be used as a means of enforcing school discipline.

33.—(1) So far as reasonably possible, a holiday away from the school shall be arranged annually.

(2) Home leave shall be granted to each boy or girl each year unless circumstances make it undesirable.

(3) Except with the permission of the Ministry home leave shall not be granted in excess of sixteen days at any one time or twenty-four days in any year.

34. Boys and girls shall be encouraged to write to their parents at least once a month and for this purpose postage stamps shall be provided by the Board of Management.

35. Permission shall be given to receive letters from parents, relatives and friends and, at such reasonable intervals as the Board of Management may determine, visits from them shall be allowed.
36. Arrangements shall be made for the giving of pocket money each week subject to such conditions as may be approved by the Ministry.

37. The Manager may suspend any of the facilities mentioned in Rules 35 and 36 of these Rules if he is satisfied that they interfere with the discipline of the school; and any such suspension shall be recorded in the Log Book.

Discipline and Punishment

38. The person in charge of the school shall ensure that generally order is maintained by his personal influence and understanding and that of his staff, aided by a system of rewards and privileges which shall be subject to the Ministry's approval, and resort to corporal punishment shall be avoided as far as possible.

39. Where correction is needed for minor acts of misbehaviour one of the following methods shall be adopted —

(a) Forfeiture of rewards or privileges (including pocket money).
(b) Temporary loss of recreation in which case the offender shall be required to perform a useful task.
(c) Alteration of meals for a period not exceeding three days; provided that any such alteration shall be within the limits of a special dietary scale drawn up by the Board of Management after consultation with the manager and the school medical officer, and approved by the Ministry.
(d) Separation from other pupils: provided that this punishment shall only be used in exceptional cases and subject to the following conditions:

(i) No boy or girl under the age of twelve shall be kept in separation.
(ii) The room used for the purpose shall be light and airy and kept lighted after dark.
(iii) Some form of occupation shall be given.
(iv) Means of communication with a member of the staff shall be provided.
(v) If the separation is to be continued for more than 24 hours, the written consent of a member of the Board of Management shall be obtained and the circumstances shall be reported immediately to the Ministry.

40. —(1) Where corporal punishment is found necessary its application shall be in accordance with the following conditions:

(a) It shall be inflicted only on the hands or posterior with a light cane and shall not exceed six strokes in the case of a boy or girl over 10 years of age, and 2 strokes in the case of a boy or girl over 8 and under 10 years of age.
(b) It shall not be administered by any person other than the person in charge of the school or in his absence his duly authorised deputy.

(c) A second member of staff shall invariably be present to witness the proceedings.

(d) No caning shall be administered in the presence of another boy or girl.

(e) Any boy or girl known to have a physical or mental disability shall not be subjected to corporal punishment without the sanction of the medical officer.

(2) The mental state of boys or girls who render themselves liable to repeated corporal punishment shall be carefully investigated by the medical officer.

41. Notwithstanding the provisions of the preceding Rules 39 and 40 (b), (c) and (d), for minor offences committed in the school-room by boys or girls, the principal teacher may be authorised by the Board of Management to administer with the cane not more than two strokes on each hand.

42. Where the principal teacher is authorised as in Rule 41 to administer corporal punishment, he shall keep a book to be known as the School-room Punishment Book and he shall at once enter therein any corporal punishment inflicted by him under Rule 41.

43.—(1) The manager shall be responsible for the immediate recording of all corporal and other serious punishment in the Punishment Book which he is required to keep under Rule 19, except corporal punishment inflicted by the principal teacher under Rule 41.

(2) The manager shall examine the School-room Punishment Book, if any, at least once a week and shall sign it.

(3) The Punishment Book (and the School-room Punishment Book, if any) shall be examined at each meeting of the Board of Management and shall be signed by the chairman. They shall also be shown to the school medical officer at least once a quarter.

(4) At the commencement of each quarter, the manager shall furnish to the Ministry a return giving particulars of corporal punishment imposed during the preceding three months.

44. Except as provided by these Rules, no member of the staff shall inflict any kind of corporal punishment. The term "corporal punishment" includes striking, cuffing, shaking or any other form of physical violence. Any person who commits a breach of this Rule shall render himself or herself liable to dismissal.

45. No pupil shall be allowed to administer any form of punishment to any other pupil.
9

Placing-out and After-care

46.—(1) It shall be the duty of the Board of Management to place out on licence each boy or girl as soon as he or she has made sufficient progress in his or her training; and with this object in view they shall review the progress made by each boy or girl and all the circumstances of the case (including home surroundings) towards the end of his or her first year in the school and thereafter as often as may be necessary and at least quarterly.

(2) At each review the Board of Management shall consider the date at which the boy or girl is likely to be fit to be placed out on licence and for this purpose they shall receive and consider a report from the manager made after consultation with the staff.

(3) Where there is reason to believe that a boy or girl can be placed out on licence during the first twelve months of detention, the case shall be reported by the Board of Management to the Ministry with a view to its consent being obtained.

(4) The Board of Management shall maintain a Licensing Register showing the date and result of their review of each case and the reason for their decision.

47. The Board of Management shall see that every effort is made to obtain suitable employment for each boy or girl who is fit for release on licence and for this purpose they shall avail themselves where necessary of any help that can be obtained, whether from public organisations or private individuals. Where the home is unsatisfactory they shall place the boy or girl in a hostel or other suitable lodging.

48. The Board of Management shall provide every pupil on leaving with a sufficient outfit, and, if necessary, with a reasonable sum for travelling and subsistence, and they shall communicate with the parent or guardian and the local authority, if any, responsible for his or her maintenance.

49. It shall be the duty of the Board of Management to ensure that adequate arrangements are made for the after-care of every pupil released from the school until the statutory period of supervision expires and, subject to the approval of the Ministry, they shall appoint for each pupil a suitable person to carry out his or her after-care.

Medical Officer

50. The Board of Management shall appoint a Medical Officer whose duties shall include:

(a) a thorough examination of each boy or girl on admission and shortly before leaving the school;

(b) a quarterly inspection of each boy or girl;

(c) a quarterly general inspection of the school from the hygiene point of view and advice as to dietary and general hygiene;
(d) the examination and treatment of all sick and ailing boys or girls;
(e) the keeping of medical records in a form approved by the Ministry;
(f) the furnishing of such reports and certificates as the Board of Management may require.

Dental Treatment
51.—(1) Adequate arrangements shall be made by the Board of Management to enable each boy or girl to receive dental examination and such treatment as may be necessary from a dentist shortly after admission to the school and thereafter at least once in every six months.

(2) For each boy or girl who normally attends a Primary School outside the Training School, the fullest possible use shall be made of the dental services provided by the Health Authority.

(3) A dentist specially appointed for duty at a Training School shall keep a record of his work in a form approved by the Ministry.

Notification of Illness, etc.
52.—(1) Any occurrence of death, infectious disease or accident shall at once be reported by the manager to—
(a) the Ministry, and
(b) the parent or guardian of each boy or girl concerned.

The manager shall also furnish a report to the Ministry if any member of staff is involved.

(2) Each notification to the Ministry in regard to an accident shall be accompanied by a full explanation of the circumstances in which it occurred, together with a report from the Medical Officer as to the extent of the injury or injuries sustained.

Records
53. The Board of Management shall arrange for the keeping of all registers and records required by the Ministry and shall cause to be sent to the Ministry such returns, statements and other information as may be required from time to time.

Promulgation of Rules
54. The manager shall cause a copy of these Rules to be given to each member of the staff, including the Medical Officer and the dentist.

Inspection
55. The Board of Management shall arrange that the school shall be open at all times to inspection by or on behalf of the Ministry and they shall give all facilities for the examination of the books and records of the school.
Where, in the opinion of the Board of Management, it is desirable in the special circumstances of any case that the provisions of one or more of the foregoing Rules should not apply, a special arrangement may be made with the prior consent of the Ministry.

These Rules are in substitution for those in force hitherto and, where appropriate, shall apply to Government-owned training schools.

The Interpretation Act, 1889, shall apply to the interpretation of these Rules as it applies to the interpretation of an Act of Parliament.

Sealed with the Official Seal of the Ministry of Home Affairs for Northern Ireland this 24th day of July, Nineteen Hundred and Fifty-two in the presence of

J. B. O'Neill,
Assistant Secretary.
STATUTORY RULES AND ORDERS FOR NORTHERN IRELAND

1952 NO 132

TRAINING SCHOOL RULES

10(1) The Board of Management shall maintain an efficient standard throughout the school and for this purpose they shall take into consideration any report which may be communicated to them by or on behalf of the Ministry.

(2) It shall be the duty of the Board of Management to ensure that the condition of the school and the training, welfare and education of the boys and girls under their care are satisfactory, and for this purpose they shall pay frequent visits to the school.

(3) The school shall be visited at least once a month by at least one member of the Board of Management, who shall satisfy himself regarding the care of the boys or girls and the state of the school, and shall enter his conclusions in the log book or other convenient record kept at the school.

(4) The Board of Management shall exercise an effective control over all expenditure.
THE ROLE OF THE BOARD MEMBER CARRYING OUT MONTHLY VISITS

- TO ENSURE AS FAR AS POSSIBLE, THAT THE NEEDS OF THE YOUNG PEOPLE
  IN THE TRAINING SCHOOLS ARE PROPERLY MET

- THIS WILL INVOLVE THE VISITOR GRADUALLY GETTING TO KNOW EACH YOUNG
  PERSON AND THE PARTICULAR PROGRAMME OF CARE OR PLANS THAT HAVE BEEN
  DRAWN UP FOR HIM/HER
INSPECTION OF RECORDS - GENERAL

- RECORD OF ADMISSIONS AND DISCHARGES

- DIRECTOR'S EVENTS OF IMPORTANCE

- DAILY REGISTER

- RECORD OF MENUS

- RECORD OF SANCTIONS

- RECORD OF FIRE DRILLS
QUALITY OF SOCIAL/EMOTIONAL CARE

- GENERAL ARRANGEMENTS FOR THE CARE OF THE YOUNG PERSON

- SUPERVISION OF YOUNG PEOPLE WITHIN THE UNIT

- RELATIONSHIP BETWEEN THE YOUNG PEOPLE AND CARE STAFF

- METHODS OF CONTROL AND DISCIPLINE USED AND SANCTIONS IMPOSED

- ARRANGEMENTS FOR RELIGIOUS OBSERVANCE OTHER THAN ON CAMPUS

- SOCIAL AND RECREATIONAL ACTIVITIES UNDERTAKEN

- CONTACT WITH THE LOCAL COMMUNITY
QUALITY OF PHYSICAL CARE

- GENERAL CONDITION OF UNIT
- STANDARD OF FURNISHING
- ARRANGEMENTS FOR FIRE PRECAUTIONS
- SAFETY STANDARDS WITHIN THE UNIT
- ARRANGEMENTS FOR MEDICAL CARE AND HYGIENE
- STANDARD OF CATERING
- STANDARD OF CLOTHING
- ARRANGEMENTS FOR POCKET MONEY
METHODOLOGY OF RECORDING VISIT

- COMPLETE PRO FORMA TYPE REPORT

- CONTENTS OF THE REPORT

- NO GENERAL FORMAT DUE TO VARIATIONS BETWEEN SCHOOLS

- REPORT SHOULD CONTAIN THE ELEMENTS OUTLINED ABOVE

- REPORT SHOULD BE PRESENTED AT EACH FULL BOARD MEETING

- REPORT SHOULD BE COUNTERSIGNED BY A CHAIRPERSON AND FILED FOR FUTURE REFERENCE AND EXAMINATION
The Pindown Experience and the Protection of Children

The Report of the Staffordshire Child Care Inquiry 1990

Members

ALLAN LEVY QC

BARBARA KAHAAN

Published by Staffordshire County Council

1991
The Pindown Experience and the Protection of Children

The Report of the Staffordshire Child Care Inquiry 1990

Members
ALLAN LEVY QC
BARBARA KAHAN

Published by Staffordshire County Council 1991
# Index

## Part 1: Background and Procedure

<table>
<thead>
<tr>
<th>Chapter 1: Background to the Inquiry</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.5 The Inquiry</td>
<td>1</td>
</tr>
<tr>
<td>1.7 Terms of Reference</td>
<td>2</td>
</tr>
<tr>
<td>1.12 Extension of the Terms of Reference</td>
<td>3</td>
</tr>
<tr>
<td>1.13 Private or Public Inquiry</td>
<td>3</td>
</tr>
<tr>
<td>1.15 Publication</td>
<td>3</td>
</tr>
<tr>
<td>1.16 Procedure</td>
<td>3</td>
</tr>
<tr>
<td>1.18 Facts and Figures</td>
<td>4</td>
</tr>
<tr>
<td>1.19 Co-operation and Confidentiality</td>
<td>4</td>
</tr>
<tr>
<td>1.20 The District Auditor</td>
<td>4</td>
</tr>
<tr>
<td>1.21 Acknowledgments</td>
<td>4</td>
</tr>
</tbody>
</table>

## Part 2: The History

### Chapter 3: Pre-April 1983

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3 National Events</td>
<td>9</td>
</tr>
<tr>
<td>3.12 Staffordshire and its Social Services</td>
<td>11</td>
</tr>
<tr>
<td>3.22 County Council Financial Policies</td>
<td>14</td>
</tr>
<tr>
<td>3.35 Social Services Re-Organisation</td>
<td>15</td>
</tr>
<tr>
<td>3.47 The Career of Tony Latham</td>
<td>17</td>
</tr>
</tbody>
</table>

### Chapter 4: 1 April 1983 – 31 December 1983

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 National Events</td>
<td>21</td>
</tr>
<tr>
<td>4.3 Staffordshire and its Social Services</td>
<td>21</td>
</tr>
<tr>
<td>4.75 County Council Financial Policies</td>
<td>32</td>
</tr>
<tr>
<td>4.78 Social Services Re-Organisation</td>
<td>32</td>
</tr>
<tr>
<td>4.88 The Career of Tony Latham</td>
<td>33</td>
</tr>
</tbody>
</table>

### Chapter 5: 1984

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 National Events</td>
<td>35</td>
</tr>
<tr>
<td>5.10 Staffordshire and its Social Services</td>
<td>36</td>
</tr>
<tr>
<td>5.90 County Council Financial Policies</td>
<td>51</td>
</tr>
<tr>
<td>5.94 Social Services Re-Organisation</td>
<td>51</td>
</tr>
<tr>
<td>5.96 The Career of Tony Latham</td>
<td>51</td>
</tr>
</tbody>
</table>

### Chapter 6: 1985

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1 National Events</td>
<td>53</td>
</tr>
<tr>
<td>6.3 Staffordshire and its Social Services</td>
<td>53</td>
</tr>
<tr>
<td>6.57 County Council Financial Policies</td>
<td>61</td>
</tr>
<tr>
<td>6.61 Social Services Re-Organisation</td>
<td>62</td>
</tr>
<tr>
<td>6.70 The Career of Tony Latham</td>
<td>63</td>
</tr>
</tbody>
</table>
Contents

- Part 1: Background and Procedure
  1: Background to the Inquiry 1
  2: Introduction to the Report 7

- Part 2: The History
  3: Pre-April 1983 9
  4: April – December 1983 21
  5: 1984 35
  6: 1985 53
  7: 1986 65
  8: 1987 75
  9: 1988 85
  10: 1989 95

- Part 3: The Pindown Experience
  11: Pindown Profiles 107

- Part 4: Analysis
  12: Pindown 117
  13: Fundwell 131

- Part 5: The Protection of Children
  14: Residential establishments and the Protection of Children 139
  15: The visitor to 245 Hartshill Road 141
  16: The sex offender as landlord 145

- Part 6: Professional Issues
  17: Management 151
  18: Supervision 157
  19: Training 159
  20: Staffing 161
  21: National Implications 164

- Part 7: Conclusions and Summary of Recommendations
  22: Conclusions 167
  23: Summary of Recommendations 173

- Appendices
  A Members of the Inquiry 177
  B Terms of Reference 179
  C List of Representatives of parties 183
  D List of People who gave oral evidence 185
  E Documentary Evidence (selected) 187
  F The Pindown Documents 195
  G Tony Latham's memorandum 8 November 1983 257
  H Correspondence 1984-1985 (Fred Hill etc.) 259
  I Letter Elizabeth Brennan 11-7-86 275
  J Photographs 277
  K Statutory Visitors' forms 279
  L Community Homes Regulations 1972 283
  M Annex B, LAC (83) 18 291
  N Staffordshire County Council Education Committee Bye-Laws 293
  O Extract: 'Family Centres: A Change of Name or a Change of Practice' 297
Chapter 7: 1986

7.1 National Events
7.8 Staffordshire and its Social Services
7.54 County Council Financial Policies
7.57 Social Services Re-Organisation
7.65 The Career of Tony Latham

Chapter 8: 1987

8.1 National Events
8.6 Staffordshire and its Social Services
8.50 County Council Financial Policies
8.58 Social Services Re-Organisation
8.67 The Career of Tony Latham

Chapter 9: 1988

9.1 National Events
9.5 Staffordshire and its Social Services
9.50 County Council Financial Policies
9.52 Social Services Re-Organisation
9.67 The Career of Tony Latham

Chapter 10: 1989

10.1 National Events
10.2 Staffordshire and its Social Services
10.70 County Council Financial Policies
10.74 Social Services Re-Organisation
10.82 The Career of Tony Latham

Part 3: The Pindown Experience

Chapter 11: Pindown Profiles

11.2 (1) Jane
11.17 (2) Susan
11.36 (3) Michael
11.46 (4) Simon
11.56 (5) Sophie
11.67 (6) Peter
11.77 (7) Sheraz

Part 4: Analysis

Chapter 12: Pindown

12.2 The Nature of Pindown
12.4 Documentation
12.10 Basic Philosophies
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>12.14</td>
<td>Definition</td>
<td>119</td>
</tr>
<tr>
<td>12.19</td>
<td>The Regime</td>
<td>120</td>
</tr>
<tr>
<td>12.22</td>
<td>Staff Contact and Nature of Engagement</td>
<td>121</td>
</tr>
<tr>
<td>12.23</td>
<td>Variation in the Practice of Pindown</td>
<td>121</td>
</tr>
<tr>
<td>12.25</td>
<td>Places</td>
<td>121</td>
</tr>
<tr>
<td>12.29</td>
<td>Periods</td>
<td>122</td>
</tr>
<tr>
<td>12.30</td>
<td>Advice concerning the practice of Pindown</td>
<td>123</td>
</tr>
<tr>
<td>12.31</td>
<td>Written Procedures</td>
<td>123</td>
</tr>
<tr>
<td>12.32</td>
<td>Children Subject to Pindown</td>
<td>123</td>
</tr>
<tr>
<td>12.33</td>
<td>Impact of Pindown</td>
<td>123</td>
</tr>
<tr>
<td>12.35</td>
<td>Opinions on Pindown</td>
<td>124</td>
</tr>
<tr>
<td>12.48</td>
<td>The Legal Context</td>
<td>126</td>
</tr>
<tr>
<td>12.55</td>
<td>Conclusions regarding the Legal Context</td>
<td>127</td>
</tr>
<tr>
<td>12.62</td>
<td>Police Investigations</td>
<td>128</td>
</tr>
<tr>
<td>12.63</td>
<td>Civil Claims</td>
<td>128</td>
</tr>
<tr>
<td>12.65</td>
<td>Professional and Managerial Oversight</td>
<td>128</td>
</tr>
<tr>
<td>12.72</td>
<td>Statutory Visits</td>
<td>129</td>
</tr>
<tr>
<td>12.74</td>
<td>Social Services Inspectorate Visit</td>
<td>129</td>
</tr>
<tr>
<td>12.76</td>
<td>Recommendations</td>
<td>129</td>
</tr>
</tbody>
</table>

**Chapter 13: Fundwell**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>13.2</td>
<td>Nature and Extent of the Organisations</td>
<td>131</td>
</tr>
<tr>
<td>13.9</td>
<td>Nature and Extent of the Children’s Participation</td>
<td>132</td>
</tr>
<tr>
<td>13.15</td>
<td>Listing all the Children</td>
<td>134</td>
</tr>
<tr>
<td>13.16</td>
<td>Benefits and Disadvantages</td>
<td>134</td>
</tr>
<tr>
<td>13.29</td>
<td>Managerial and Professional Oversight</td>
<td>136</td>
</tr>
<tr>
<td>13.37</td>
<td>Recommendations</td>
<td>137</td>
</tr>
</tbody>
</table>

**Part 5: The Protection of Children**

**Chapter 14: Residential establishments and the Protection of Children**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.3</td>
<td>Concerns</td>
<td>139</td>
</tr>
<tr>
<td>14.4</td>
<td>Visits</td>
<td>139</td>
</tr>
<tr>
<td>14.6</td>
<td>Chapter 16</td>
<td>139</td>
</tr>
<tr>
<td>14.7</td>
<td>Identities</td>
<td>140</td>
</tr>
</tbody>
</table>

**Chapter 15: The visitor to 245 Hartshill Road**

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.4</td>
<td>245 Hartshill Road</td>
<td>141</td>
</tr>
<tr>
<td>15.6</td>
<td>Log book entries</td>
<td>141</td>
</tr>
<tr>
<td>15.10</td>
<td>Further entries</td>
<td>142</td>
</tr>
<tr>
<td>15.11</td>
<td>The video</td>
<td>142</td>
</tr>
<tr>
<td>15.12</td>
<td>Return of Philip Price</td>
<td>142</td>
</tr>
<tr>
<td>15.14</td>
<td>Enquiries</td>
<td>142</td>
</tr>
<tr>
<td>15.18</td>
<td>Staff Evidence</td>
<td>143</td>
</tr>
<tr>
<td>15.20</td>
<td>Conclusion</td>
<td>143</td>
</tr>
<tr>
<td>15.21</td>
<td>Concerns</td>
<td>143</td>
</tr>
<tr>
<td>15.23</td>
<td>Protection</td>
<td>144</td>
</tr>
<tr>
<td>15.25</td>
<td>Recommendations</td>
<td>144</td>
</tr>
</tbody>
</table>
# Chapter 16: The sex offender as landlord

16.4 Reservations  
16.6 The background  
16.15 The report  
16.17 The approved list  
16.22 Police checks  
16.25 Recommendations  
16.27 Schedule 1 offenders  
16.33 Recommendations

## Part 6: Professional Issues

### Chapter 17: Management

17.6 Senior managers  
17.13 Communication  
17.15 Complaints Procedure  
17.18 Management failure  
17.29 Management training  
17.30 District Advisory Sub-Committees  
17.31 Statutory visits  
17.33 Evaluation  
17.34 Radical change  
17.35 Recommendations

### Chapter 18: Supervision

18.3 SSI Reports  
18.6 Supervision document  
18.9 System of supervision  
18.16 Recommendations

### Chapter 19: Training

19.5 Spending  
19.9 Dangers  
19.11 Recommendation

### Chapter 20: Staffing

20.4 Advertising  
20.5 Promotions  
20.8 Qualifications  
20.14 Social work grades  
20.15 Night duty  
20.17 Structure  
20.22 Recommendation
Chapter 21: National Implications

21.2 Control of children in residential care
21.3 Residential care for children
21.4 Education of children in care
21.5 Health of children in care
21.7 Provision for children in care of 16 years of age or over
21.9 The protection of children

Part 7: Conclusions and Summary of Recommendations

Chapter 22: Conclusions

22.2 Pindown
22.3 Fundwell
22.4 Protection of Children
22.5 Professional Issues

Chapter 23: Summary of Recommendations

23.1 Chapter 12
23.11 Chapter 13
23.14 Chapter 15
23.21 Chapter 16
23.26 Chapter 17
23.41 Chapter 18
23.44 Chapter 19
23.46 Chapter 20

Appendices

A Members of the Inquiry
B Terms of Reference
C List of Representatives of parties
D List of People who gave oral evidence
E Documentary Evidence (selected)
F The Pindown Documents
G Tony Latham’s memorandum 8 November 1983
H Correspondence 1984-1985 (Fred Hill etc.)
I Letter Elizabeth Brennan 11-7-86
J Photographs
K Statutory Visitors’ forms
L Community Homes Regulations 1972
M Annex B, LAC(83) 18
N Staffordshire County Council Education Committee Bye-Laws
O Extract: ‘Family Centres: A Change of Name or a Change of Practice’
PART 1: Background and Procedure

Chapter 1

Background to the Inquiry

1.1 On 2 October 1989 John Spurr, a deputy director of Staffordshire County Council's social services department, was telephoned by a Stoke-on-Trent solicitor Kevin Williams, who was extremely concerned about a 15 year old girl for whom he was acting in care proceedings. The solicitor had previously spoken to the chairman of the social services committee about the girl who was in the interim care of the local authority. She had indicated that whilst in a residential home at 245 Hartshill Road, Stoke-on-Trent a few days earlier she had been put in a room with a bed, a chair and a table, made to wear pyjamas the whole time, only allowed out of the room to go to the toilet after knocking on the door, had not gone to school, had nothing to read and had to be in bed at 7 pm. She was also not allowed to communicate with other children. The following evening she had jumped out of the window of the room, a distance to the ground of about twenty feet, and had sprained her ankle. She had then gone in her pyjamas a considerable distance before she had been returned eventually by the police and had spent a further two days in the room. She described her experience as being in ‘Pindown’.

1.2 On the following day, after various consultations, the then Director of Social Services, Barry O’Neill, issued instructions for the ‘Pindown’ system at 245 Hartshill Road to cease.

1.3 Subsequently, the 15 year old girl and a boy of the same age were made wards of court by Kevin Williams. On 13 October 1989 the High Court, exercising the wardship jurisdiction, granted injunctions prohibiting the use of Pindown by social services, and in relation to the boy’s alleged experiences, restraining the employment of any child in care of school age during school hours other than in circumstances agreed in consultation with the Education Welfare Service. The actual terms of the injunction in respect of Pindown were: that no child or young person in the care of (the local authority) shall be subjected to the regime known as ‘pin down’ in any form whatsoever without the leave of the court save within the meaning of Regulation 10 of the Community Homes Regulations 1972.¹ By agreement the Official Solicitor was appointed to act on behalf of the children and he was given permission by the court, as was the local authority, to disclose the papers in the proceedings to the Department of Health.

1.4 Over the next few months very considerable public concern was expressed and taken up by the media about the use of Pindown in Staffordshire residential homes. Pindown was variously alleged to be solitary confinement, a behaviour control method, and humiliating and degrading treatment. In addition there was further concern about the activities of a senior member of the social services department, Tony Latham, regarding the running of a number of private companies providing many services to the department under the general name of the Fundwell companies. He was also said to be the architect and leading exponent of Pindown. The origin of the word ‘Pindown’ was said to be the use by Tony Latham of the words, ‘we must pin down the problem’ whilst he gestured with his forefinger pointing towards the floor. The children began to speak of ‘being in Pindown’.

The Inquiry

1.5 Members of Parliament, Councillors and child care specialists, amongst others, pressed for an independent Inquiry. Escalating interest in Pindown was reflected by a Granada Television ‘World in Action’ programme entitled ‘Pindown’ which was shown nationally on 25 June 1990.

1.6 On 29 June 1990 we were appointed by Staffordshire County Council to conduct an independent Inquiry.

¹ For the 1972 Regulations, see appendix L, and for a discussion of regulation 10, see Chapter 12, paragraphs 12.48 to 12.52 and 12.56.
Terms of Reference

1.7 Our Terms of Reference are set out in full in appendix B. Our central tasks were as follows:
   - To review the treatment and care of young persons at 245 Hartshill Road, Stoke-on-Trent, at 'The Birches', Newcastle-under-Lyme, and at any other location where the practice known as Pindown may have been used; (paragraph 1 of the Terms of Reference)
   - To consider any participation by young persons in care in the activities of undertakings not owned by the County Council and known as 'Fundwell' and to consider the need for any further investigation of the general activities of such undertakings and their relationship with the County Council and to recommend or carry out such investigation as may be required; (paragraph 2)
   - To draw out the strengths and weaknesses and legality of the practice and procedures in use in relation to the matters mentioned above; (paragraph 4)
   - To reach conclusions and to make any recommendations necessary to allay public concern and maintain public confidence in the social services department and its protection of the interests of children and young persons and of the public; (paragraph 5)

1.8 Pindown
   - To consider in relation to the practice known as Pindown:
     (a) The nature of the practice, the amount of staff contact and the nature of engagement, and the way the practice varied over the period it was used;
     (b) The places and periods over which the practice was used;
     (c) The nature and extent of any psychiatric, psychological or educational advice obtained before or after the practice was established:
     (d) What written procedures were applicable;
     (e) What children were subject to Pindown with information about age, sex, and length of time in Pindown;
     (f) How far it is possible to assess any impact of Pindown on those children and the nature of that impact;
     (g) The managerial and professional oversight of Pindown (paragraph 8)

1.9 Fundwell
   - To consider in relation to participation by young people in care in the activities of undertakings not owned by the County Council and known as Fundwell:
     (a) The nature and extent of the organisations generally known or associated together as Fundwell and in which children and young persons participated;
     (b) The nature and extent of the participation by young children and young persons in these organisations whether as employees, trainees on work experience placements, as tenants or licencees or otherwise;
     (c) (Making) a list of all the children participating with information about age, sex and length of participation;
     (d) The benefits or disadvantages resulting from the participation of children and young persons in these activities including any educational implications;
     (e) The managerial and professional oversight of such participation and any conflicts of interest of staff which might have arisen in connection with such participation. (paragraph 9)

Further matters

1.10 To consider any associated matters of concern to the Inquiry, including the adequacy or otherwise of the complaints procedures in use within the (social services) department; (paragraph 10)

1.11 Paragraph 12 of the Terms of Reference directed us to consider whether at any point in the Inquiry we had 'established matters which should be reported to the County Council as requiring immediate disciplinary action'. No such matters requiring immediate disciplinary action were established.
1.12 Extension of the Terms of Reference

On 5 October 1990 (Day 42 of the Inquiry) the Terms of Reference of the Inquiry were by agreement extended and we were directed in respect of a separate matter from Pindown and Fundwell:

- To consider whether children and young persons resident in Staffordshire child care establishments were appropriately protected, as may have been required, from any of the individuals who were subsequently convicted in the summer and autumn of 1989 of sexual offences against children and young persons; (paragraph 14)
- To make any appropriate recommendations. (paragraph 15).

Private or Public Inquiry

1.13 There was considerable debate prior to the commencement of the Inquiry as to whether it should be held in private or public. We took into account that our Terms of Reference (paragraph 6) directed us to consider ‘the establishment of methods of working which take full account of the need to obtain full and accurate information on all matters under review, whilst at the same time ensuring necessary consideration and protection of the interest of children in care, complainants and staff’. As it quickly became clear that our Inquiry would have to cover a period of almost six years, November 1983 to October 1989, and as a consequence look into the cases of hundreds of children in care, we concluded that it was necessary in the particular circumstances to proceed in private. We considered it of overriding importance that the children should be protected from any possibility of identification and publicity. We thought that if anyone wanted to identify themselves to the media, as a few did who were in the main adults who as children had been in Pindown, they ought to be able to take the decision themselves. There were, in our view, formidable practical problems in the way of the full panoply of a public Inquiry held under the scrutiny of the media. We were also of the view that we were most likely, in the absence of any powers to compel witnesses to attend and to order the production of documents, to obtain the fullest co-operation with the Inquiry if we proceeded in private.

1.14 Paragraph 11 of the Terms of Reference permitted us to inform the local authority if ‘at any point in the Inquiry (we considered) that the method of working adopted (was) inadequate for the issues at stake and should be substituted by a Public Inquiry or any other method of procedure’. We did not consider it necessary at any time to make any such recommendation.

Publication

1.15 We regarded publication of the Report in full as essential. The local authority agreed to this course from the outset.

Procedure

1.16 The following information relating to the Inquiry Procedure was widely circulated both prior to the commencement of the Inquiry on 23 July 1990, and during the following months:

1. We are interviewing in private anyone who can assist the Inquiry;
2. A witness may come along on his or her own or may prefer to be accompanied by a legal or union representative;
3. It would be helpful to receive a written or typed statement from the witness in advance, but this is not essential;
4. It may be necessary to re-call a witness at a later date but we would hope in the normal way to avoid doing so;
5. Contact in the first instance may be made with the solicitor to the Inquiry (his name, address, telephone and fax numbers were set out).

2 We have used ‘children’ in the Report as meaning anyone under the age of eighteen.
1.17 As indicated above it was decided to conduct the Inquiry in private but publish the Report in full. A few people chose to be legally represented or bring their union representative with them. We allowed others to bring friends or colleagues with them or in the case of children, their parents. We saw each witness separately and questioned them. If they were represented we permitted their lawyers to put questions to them and make submissions if they wished. Our aim was to conduct the Inquiry as informally as possible but with fairness and thoroughness. We asked some witnesses to return so that we could ensure that they had the opportunity to deal with all relevant matters. We indicated to witnesses as fully as possible, where necessary in writing, the areas in which we wanted assistance. We made sure that they understood any matters that might lead to concern or criticism. We urged witnesses to deal constructively with the issues arising and the improvement of practice.

1.18 Facts and Figures

The Inquiry sat for 75 days between 23 July and 29 November 1990. Evidence was mainly heard in Stafford and Stoke-on-Trent but was also received at a further 30 locations. 153 witnesses gave oral evidence and approximately 150,000 pages of documents including over 400 log books were considered by the Inquiry. We visited the following Stoke-on-Trent residential homes: 245 Hartshill Road, 100 Chell Heath Road and Heron Cross House. In addition we visited The Birches, Newcastle-under-Lyme and The Alders, Tamworth. We also went to see Duke's Lodge at the invitation of Tony Latham.

1.19 Co-operation and Confidentiality

Only one witness who was asked to attend failed to turn up. We cannot, of course, rule out the fact that for one reason or another people who could have assisted the Inquiry failed to do so. Bearing in mind, however, the number of witnesses who did attend and the vast volume of documentation produced to us, we are reasonably confident that we received a very comprehensive picture indeed of the relevant events. We were assisted enormously by the availability of almost every residential home log book and measures of control book concerning the practice of Pindown. A few were listed as 'missing'. Co-operation with the Inquiry was forthcoming in a number of cases on the promise of confidentiality. Some witnesses at their express wish have not therefore been named in the list of witnesses in appendix D. We have carefully taken into account when weighing the evidence, whether the fact of non-identification of a person could have in any way prejudiced anyone else. We were grateful to the local authority for urging its employees to co-operate with the Inquiry. We were extremely concerned to hear from a few witnesses that they had received telephone calls designed to deter them from giving evidence. There was no indication as to the identity of those responsible.

1.20 The District Auditor

On 30 August 1990, day 24 of the Inquiry, we wrote to the chief executive of the local authority concerning paragraph 2 of the Terms of Reference (see appendix B) relating to the possible need for any further investigation of the general activities of Fundwell and its relationship with the County Council. We wrote that: 'in the light of the oral and documentary evidence already presented to us, we have concluded that the purely financial matters concerning Fundwell should receive, as soon as possible, expert appraisal. We therefore recommend in the circumstances that the District Auditor, who has the necessary financial expertise and who is like our Inquiry independent of the local authority, should carry out a full investigation'. Our recommendation was immediately accepted and the District Auditor commenced an investigation.

Acknowledgments

1.21 We would like to offer our thanks to Hugh Howard, solicitor to the Inquiry and Dennis Spencer who assisted most energetically with various facets of the Inquiry.

1.22 We are most grateful also for the considerable assistance given to us by the legal and union representatives who appeared before the Inquiry. We would particularly like to thank firstly John
Trotter, partner in the firm of Bates Wells and Braithwaite who spent seven days at the Inquiry on behalf of his clients, for his always lucid and helpful advocacy; and secondly Michael Nicholls, solicitor in the Official Solicitor’s department for his interesting and illuminating legal submissions.

1.23 We owe an enormous debt of gratitude to Elaine McIntyre who for six months tirelessly ran the administrative machinery of the Inquiry with style and great efficiency. We are also very grateful to those who over the months assisted her.

1.24 We would like to express our thanks to the employees of Staffordshire County Council for cheerfully accepting our presence and the take-over of a number of their offices for the purposes of the Inquiry. To Bernard Price, County Clerk and Chief Executive and Roy Hudson, Deputy Clerk, we are particularly grateful for their administrative assistance and their continuing commitment to ensuring the total independence of the Inquiry.

1.25 We were most fortunate in having the manuscript ‘word-processed’ by Liz Pickard who did it with speed, accuracy, and a sharp eye for errors.
Chapter 2

Introduction to the Report

2.1 It is essential in order to understand and assess Pindown to consider comprehensively the background to its creation and the context in which it developed. Additionally, of course, one has to trace in some considerable detail the actual practice of Pindown during its active periods between November 1983 and October 1989 when its use was banned. The same considerations relating to background, context, and practice also apply to the aspects of Fundwell that we have to consider.

2.2 It quickly became apparent to us that it would be necessary to trace the following factors in respect of the background and context: national events, local characteristics of Staffordshire social services, county council financial policies, social services re-organisation and the career of Tony Latham who was the central figure regarding Pindown and Fundwell.

2.3 Accordingly, in the next chapter we describe and consider each factor in the period up to 1 April 1983 when a significant re-organisation in Staffordshire social services took place, some seven months before the birth of Pindown at 245 Hartshill Road, Stoke-on-Trent.

2.4 Chapter 4 deals under the same major headings with the period between 1 April and 31 December 1983.

2.5 Chapters 5 to 10 inclusive follow the same course, each dealing with the events of one year from 1984 to 1989. Chapter 10, therefore, documents amongst other things the demise of Pindown at the end of 1989. At the end of each chapter some facts and figures are set out concerning the use of Pindown in the particular year under consideration.

2.6 In Chapter 11 individual profiles are provided of 'the Pindown Experience' of seven children.

2.7 Chapters 12 and 13 contain comprehensive analyses of Pindown and Fundwell respectively.

2.8 Chapters 14, 15 and 16 deal with the quite separate matters relating to sex offenders and the protection of children which we were asked to consider when our Terms of Reference were extended on 5 October 1990 (see Chapter 1 paragraph 1.12).

2.9 In Chapters 17 to 21 inclusive we consider and comment upon a number of important professional issues.

2.10 Our conclusions and a summary of our recommendations are set out in chapters 22 and 23 respectively. Extensive appendices follow.
PART 2: The History

Chapter 3

Pre-April 1983

3.1 Pindown began on 3 November 1983 in a residential home at 245 Hartshill Road, Stoke-on-Trent. By this date the projects and activities later known collectively as Fundwell were already in existence. They had started in 1972, initially as a form of youth work and Intermediate Treatment, and subsequently ran concurrently with schemes organised under the auspices of the Manpower Services Commission. Both Pindown and Fundwell owed their origins to a social worker, Tony Latham. Between 1972 and 1989, the year Pindown ceased, Tony Latham held a number of posts in Staffordshire Social Services. He first became a social worker in Tunstall in 1972. Between 1975 and 1977 he was seconded to Ruskin College, Oxford where he obtained a Certificate of Qualification in Social Work. In 1979 he was promoted to senior social worker in Longton; in 1983 to area officer for the Newcastle-under-Lyme family centre and in 1985 to area officer (children and families) in Newcastle. In 1987 he moved to headquarters in Stafford as senior assistant, voluntary bodies co-ordinator. The following year he became senior assistant (children and families).

3.2 Our Inquiry into Pindown and Fundwell led us to examine a number of factors in the years leading up to 1983 which, in our view, contributed substantially to their development. As indicated in the last chapter they were:

(a) national events;
(b) local characteristics of Staffordshire and its social services department;
(c) county council financial policies;
(d) social services re-organisation;
(e) the career of Tony Latham.

Aspects of each factor at times overlapped and blended together.

(a) National Events

3.3 Childcare services administered by children’s departments in every county and county borough in England and Wales were first established under part VI of the Children Act 1948. Their aim was to ensure that ‘children deprived of a normal home life’ received adequate and sensitive substitute care. Large scale specialised training was also developed nationally to assist the children’s departments to develop the service to an appropriate professional standard. Between 1948 and 1970 when children’s departments became part of unified social services departments, a large body of legislation added to the responsibilities and powers of the child care service culminating in the Children and Young Persons Act 1969.

3.4 In the course of carrying out their responsibilities to deprived children, young offenders and children neglected or ill-treated at home, children’s officers and their colleagues became convinced that major changes in the law relating to young offenders and ‘children in trouble’ were needed. The Children and Young Persons Act 1969 embodied some of these changes. A major objective of the Act was to remove what were seen to be artificial distinctions between deprived and delinquent children and young people and to treat them all as equally in need of assistance, protection or care. The origins of their individual

3 A service for children and young people at risk ‘intermediate’ between being away from home in the care of a local authority and living at home with no provision for help.

4 See Para.1 of the Report of the Care of Children Committee, September 1946, HMSO Cmnd.6922 (The Curtis Committee).

5 See the White Paper ‘Children in Trouble’ (April 1968), HMSO, Cmnd 3601.
problems were acknowledged as having many similarities though they might be expressed in differing kinds of behaviour. Some of the changes brought about by the legislation were that:

(a) approved schools became community homes with education on the premises;
(b) care orders took the place of approved school and fit person orders;
(c) remand homes became observation and assessment centres;
(d) intermediate treatment was introduced;
(e) regional planning committees were set up to co-ordinate regional and local residential establishments such as community homes with education and observation and assessment centres, and to encourage use of regional and local resources in intermediate treatment.

3.5 As a result of the development of child care services which were required to carry out wide responsibilities to many children, both at home and in care, those involved had also identified the need for a wider and better co-ordinated system of personal social services which could meet need more effectively and more flexibly. Consequently, when the Seebohm Committee was set up in 1963 the child care service played a major role in proposals for the establishment of unified personal social services departments. These proposals were embodied in the Committee’s report in 1968.  

3.6 The report was implemented by the Local Authority Social Services Act 1970. This brought together within each county and county borough in England and Wales the former children’s departments, welfare departments and certain functions of the former local authority public health departments. The new directors of social services inherited staff from the three departments in which levels of training and approaches to service provision had differed greatly. In these circumstances some of the concentrated attention and planning for improved practice which the Children and Young Persons Act 1969 was intended to achieve was lost. Child care work also had to take its chance with the new style of generic social work and caseloads adopted by local authorities in 1970-71. Additionally training for social work was re-organised into a generic pattern and all specialist child care training courses, including those designed for residential staff were closed. Inevitably specialist experience and professional standards painstakingly developed by children’s departments between 1948 and 1970 began to be dissipated.

3.7 From the evidence presented to them the Seebohm Committee had seen ‘a strong case for re-organisation so that the services may attract more resources; . . . meet needs . . . being neglected . . . and be more accessible and comprehensible to those who need to use them.’ [Para. III] The new social services departments attracted both increased resources and greatly increased demand. They had had little time, however, to develop or consolidate their experience between 1970 and 1973 when they were overtaken by the re-organisation of local government as a whole in 1974.

3.8 In the process of re-organisation many local authorities were extinguished by the creation of a smaller number of larger units. Because of this there were many changes of personnel, directors of social services, senior and middle managers and other senior staff. Attempts to reconcile conflicting departmental loyalties and to deal fairly with those whose career prospects were affected, led to yet more changes. In addition staff often experienced major differences of management styles within a short space of time. When organisational turbulence began to subside trends in the national economy were already moving against local government expansion. Social services departments, which had been established to improve services for those in need, had to slow down their development and find ways of reducing expenditure.

3.9 Following the Children and Young Persons Act 1969 and the establishment of social services departments, central government and external professional initiatives were taken to assist local authorities and others to address their child care responsibilities. The Home Office Children's

6 Report of the Committee on Local Authority and Allied Personal Social Services, July 1968, HMSO, Cmd 3703, which had been set up jointly by four government departments.

7 See footnote 6 ante
Department set up a Development Group in 1969, which was transferred with the Children’s Inspectorate to the DHSS in 1971. The objectives of this group were to assist implementation of the 1969 Act by developing standards of good practice in residential child care, intermediate treatment, collaboration between field and residential social work, management of violent behaviour and a range of other areas of practice. The group produced many publications between 1970 and the mid 1980s, all of which were sent free of charge to social services departments. They included a design guide for the building, equipping and use of community homes and a statement of residential child care principles entitled ‘Care and Treatment in a Planned Environment.’ [HMSO 1970, reprinted 1972] A parallel initiative in 1968 by three professional child care organisations resulted in a publication entitled ‘Residential Task in Child Care – The Castle Priory Report’. [First Edition – 1969, Second Edition – 1972] This report related standards of good practice to detailed assessment of staffing needed to achieve it. The conclusions of the report were adopted in 1970 by The Home Office Children’s Department as guidelines for local authorities and voluntary organisations. During the late 1970s and early 1980s work was carried out which resulted in the publication of ‘Observations and Assessment – report of a working party’ (DHSS January 1981) and ‘Control and Discipline in Community Homes – report of a working party (DHSS January 1981). These were also circulated to local authorities to assist them in their thinking and planning of child care services. Like the work of the DHSS Development Group, a wide spectrum of practitioners and managers in social services and representatives from health and education services had been involved with the intention of ensuring that the advice and guidance disseminated to service providers were related to the realities of everyday experience.

3.10 The central government publications referred to above were sent to all local authorities, including Staffordshire. The Castle Priory Report was also available in Staffordshire. Some publications were particularly relevant to planning and decisions made in the child care service for example, ‘Control and Discipline in Community Homes’ and a number of the Development Group reports.

3.11 A further major national influence which impinged briefly on Staffordshire’s social services department was the work of the House of Commons Social Services Committee which carried out an investigation into ‘Children in Care’ between 1982 and 1984. Staffordshire in 1982 was one of four English local authorities visited by the committee. Amongst the examples of services they saw was a ‘modern residential observation and assessment centre’ which was to be used later as a family centre.

(b) Staffordshire and its Social Services

3.12 In 1974 the county boroughs of Stoke-on-Trent and Burton-on-Trent were absorbed into the county of Staffordshire as part of local government re-organisation. They had both had twenty-six years’ experience of providing firstly child care services and then social services through their own independent departments. Instead Stafford, sixteen miles south of Stoke, became their administrative centre. A witness told us that ‘members of (Stoke) social services department were not keen on being taken over by Stafford. . . . There was a feeling it was too big and Staffordshire did not have the interests of Stoke at heart.’ Nevertheless there was ‘still a lot of power within Stoke . . . we got the feeling . . . that if we could sort things out Stafford would be OK . . . unless it got really bad we would not bother the boys in Foregate Street.’

3.13 Although Stoke had little enthusiasm for being part of Staffordshire, we received considerable evidence suggesting that both local authorities were insular and inward-looking communities, reluctant to seek new ideas or new people outside their boundaries. Mark Fisher, a Stoke M.P., told us that ‘it is only very recently that we have begun to appoint people from outside the county . . . that makes for an incredibly narrow and limited perspective. . . . there have been no new ideas coming in as a result.’ Other witnesses referred to Staffordshire being in a time warp and believed this acted as a barrier to development of new concepts and methods. Barry O’Neill, the former director of social services, in his

8 The Association of Children’s Officers, The Association of Child Care Officers and The Residential Child Care Association.

written submission to the Inquiry, listed an ‘inward looking culture’ amongst the problems faced by his department when he was appointed in 1985. He added that ‘Staffordshire had not traditionally participated in regional and national events and initiatives under the regime of my predecessor. This contributed . . . both to morale issues and to problems in the recruitment and retention of qualified staff.’ A social worker coming from another local authority to work in Staffordshire told us she had a ‘very strong impression . . . of a social services department which seemed to be very parochial . . . very inward looking . . . consequently . . . resistant to change.’

3.14 Practice in Staffordshire was commented on by many witnesses. Eileen Robinson, who retired as an Assistant Director of Social Services in 1987, described how during the mid-1970s ‘there was no casework responsibility in the residential services (section).’ It was purely management, staffing, fulfilling the needs of the areas in the provision of places.’ In the later 1970s little had changed. There was still a ‘clear distinction between care and the . . . practical running of homes. The residential section was . . . the bricks and mortar and furnishings and fire officer and architect.’ Communication was by circulars and ‘there are literally hundreds of them covering everything from having a chimney swept to the care of children.’ It was not till about 1980 that a document entitled ‘Casework with Children’ was written and sent out to the residential homes. Looking ahead, it is interesting to note that Councillor Beech, a County Councillor, commenting on the Social Services Inspectorate’s report on visits to children’s homes in 1990 identified communication as still a major problem: ‘all sorts of policies, so called, which had been emanating from on high but had not been disseminated. People didn’t know about them.’

3.15 Looking back to the days of children’s departments, before 1970, Councillor Austin, the leader of the Council since 1981, said that in his experience ‘in the 1960s we had a different type of child. There wasn’t a drug problem and there wasn’t the aggressiveness we have now . . . We did not take kids into care as a punishment. It was to protect them basically from the outside world . . . If I were a top politician in Westminster I would do away with Seebohm and go back to the old system.’

3.16 Having only a small proportion of professionally qualified staff has characterised Staffordshire social services department for a long period. In 1979 the number of qualified field social workers was said to have fallen below 25%. In residential child care there was an almost total lack of qualified staff. Barry O’Neill told the Inquiry that by 1985 ‘training, other than the secondment of 13 staff a year on CQSW (Certificate of Qualification in Social Work) courses had been given a very low profile. In-service training was virtually non-existent. The training function for . . . 6,000 employees was dealt with by one member of staff who also had responsibilities for the traditional records and information gathering role.’ Not surprisingly supervision in the department was also inadequately provided or, as in residential work, non-existent.

3.17 Courts and police attitudes in Staffordshire were said to be relatively punitive. In their written evidence to us NACRO (National Association for the Care and Rehabilitation of Offenders) said that in their view the Pindown regime, which began in 1983, appeared ‘to have been developed in the context of a policy vacuum in juvenile justice.’ Even in 1990 they were of the opinion that ‘there is significant scope in Staffordshire for the development of a policy with regard to juvenile offenders.’ Attitudes of some Staffordshire social services staff to children in care and young offenders seemed to a number of social work witnesses to have been lacking in concern and more than one questioned whether politicians really cared what happened to the children and young people for whom social services were responsible.

3.18 The issue of secure accommodation was important in Staffordshire both before 1983 and subsequently. Until the re-organisation of residential child care facilities which took place in 1983 there had been three observation and assessment centres, one of which, Chadswell in Lichfield, had formerly been a remand home; two community homes with education (former approved schools), Rowley Hall for senior girls and Riverside for intermediate and senior boys; four working boys and girls hostels; and twenty-two children’s homes. Chadswell and Rowley Hall had both provided secure rooms. A witness, who was between thirteen and a half and fifteen years old when she had been in Rowley Hall, described her experiences: ‘the first time you run away they lock you up for so long, the second time it is seven days . . . and then it is up to twelve or thirteen days . . . I can always remember they could never lock you up.
for longer than fourteen days... they had to get a special something or other to give... permission to keep you in that room.' She remembered she wore nightclothes with no underclothes and no shoes. The room had been very small with just a bed and a bucket for a toilet. She had no exercise and her meals were brought to the room by staff. 'You wouldn't have a book to read, sometimes they would bring a magazine... to pass the time... Looking back at it, I mean, I watch Prisoner Cell Block H and that is luxury compared.'

3.19 Two secure units with two beds each had been provided in Riverside in 1981. They were established in consultation with the DHSS for young people needing security or separation. They were never, however, brought into use because the physical design did not meet the requirements for approval by the Secretary of State following new standards under the Criminal Justice Act 1982. Staffordshire sought grant aid from the DHSS to meet the cost of work needed to obtain approval, but their application was unsuccessful. After protracted discussions the then director of social services in February 1985 recommended that the social services committee should 'abandon the provision of secure accommodation.'

3.20 The Community Homes Regulations 1972\textsuperscript{10} required that from time to time the social services committee should review measures of control in use under the regulations. In a report to the committee on 28 February 1982, the director had reminded them that 'The control of a community home shall be maintained on the basis of good personal and professional relationships between the staff and the children... primarily by the influence achieved through gaining confidence and respect.' Some sanctions or other means of control had to be used on occasion but 'rewards are equally important in encouraging good behaviour.'

3.21 Barry O'Neill, who was appointed director in 1985, had been deputy to Paul Hudson the previous director and had worked in the social services department since the mid 1970s. In his written submission to the Inquiry he analysed the weaknesses of the department at the time he became director and it was clear that they were longstanding. In addition to the 'inward looking culture' and neglect of training he listed the following characteristics of the department:

(a) social services expenditure was the second lowest per head of counties in England and Wales;
(b) a proportion of middle management was still influenced by previous roles prior to local government re-organisation in 1974, and particularly by the different service models and culture inherited from the former county council and from Stoke-on-Trent and Burton-on-Trent;
(c) major cuts in services had been implemented in a hasty way which had left an unbalanced organisation;
(d) spending on management and support staff was the lowest percentage of expenditure compared with other local authorities;
(e) there was no formal participative management, decisions on priorities had been taken centrally and there was minimal joint planning with health authorities;
(f) from 1974 to 1984 Staffordshire had had three administrations: Labour from 1974; the Conservatives from 1977 and Labour again from 1981. This had resulted in a 'stop-go' culture in which longer term developments had been sacrificed for a more pragmatic approach based on opportunities as they arose;
(g) management structure had been shaped largely as a response to requirements for cuts in services in the late 1970s and early 1980s, supplemented by various 'sticking plaster' additions as opportunities permitted in the early 1980s;
(h) traditionally there had been over reliance on residential provision into which users had to fit rather than a range of services offering them choice. Staffing ratios in residential homes were much too low resulting in containment rather than care;
(i) written policies, procedures and joint strategies were noticeable by their absence or by being out of date;
(j) low service provision in Staffordshire social services had become accepted, with little prospect of any change in established patterns of expenditure.

Our investigation supports this analysis.

\textsuperscript{10} See appendix L.
(c) County Council Financial Policies

3.22 It was clear from the evidence we received that resources were a key issue in the history of Staffordshire social services from 1974 to 1989. Barry O’Neill, the former director, as noted above blamed political changes in the administration for a ‘stop-go’ policy which sacrificed long term planning to pragmatic opportunism. Statistics provided by his predecessor, Paul Hudson, for the House of Commons Social Services Committee’s visit in 1982 demonstrated that child care spending in Staffordshire had fallen steadily from a low baseline in 1975/76 to being the lowest of any other county in England and Wales in some aspects of the service.

3.23 We examined budgetary information from 1977 onwards. During the period between 1977 and 1983 the County Council required the social services committee to make significant cuts in their annual estimates of necessary expenditure.

3.24 National guidelines issued to local authorities in 1978 proposed that increases of expenditure overall should not exceed 1 per cent. In addition the government white paper on public expenditure envisaged very limited growth for some years ahead.

3.25 In the 1978/79 social services budget an increase of 2.69 per cent was proposed. This was reduced to 1 per cent. The following year the county council budget panel decided that 3 per cent must be cut. This figure was subsequently increased to 5 per cent with a requirement that a substantial proportion must be achieved by savings in manpower. In the following year further cuts of 5 per cent had to be made.

Examples of cuts were closures of residential homes, freezing social work posts and reducing clerical and administrative support staff. In a report to the social services committee on 2 September 1980 the then director, Paul Hudson said, ‘the social services department has been required by the county council to make savings . . . of approximately £1,400,000 . . . The reductions have made a real drop in standards of service to the public. This reduction should be seen against the background of a continued rise in demand for the services we provide of about 8 per cent per annum . . . In a two year period the gap between resources and demand is about 24 per cent’.

3.26 Whilst hearing the evidence we were often struck by a lack of adequate social services records, even when these were statutorily required, and the absence of recorded material generally. It became clear that this was related in part to major cuts in administrative and clerical support. Although the social services department’s administrative costs had been proportionately lower than any other local authorities, budgetary reductions required by the county council in 1981/82 could not be achieved without reducing ‘the clerical and administrative staff in area offices drastically, leaving only a minimal support service for the social workers.” [Report to the General Sub-Committee, 2 September 1980]

We were told by Barry O’Neill that the 1981/82 reductions in administrative staff, coming on top of large cuts in previous years were ‘a major blow to the delivery of services . . . It affected morale throughout the organisation and its impact was such that even a decade later various parts of the organisation have still not recovered from the changes imposed.’

3.27 1983/84 was another year in which substantial savings were made in the child care service. The plans for these were laid in 1982/83 and involved a total re-organisation of residential child care provision. In a report to the social services committee on 27 July 1982 the director recommended that ‘all existing 24 community homes, children’s hostels and the observation and assessment centre at Heron Cross . . . be discontinued in their present form.’ The detail of the plan to replace them, in the main, with family centres will be described in the next section. In budgetary terms the reduction of residential accommodation by 164 beds and the re-shaping of associated social work was anticipated to result in annual savings from 1 April 1983 of £350,000.

3.28 During the mid and late 1980s the county council no longer required the draconian cuts of the earlier years, but the state of the child care service as a result of those years presented a grave problem.

11 See Para 3.11 ante
Some witnesses saw the financial policies as not just a problem for social services. Mark Fisher M.P. said that 'historically we have been negligent both in expenditure and in policy . . . not just in social services. It is traditional . . . I think they are probably right in saying that the money is not there because they have always set very low budgets.' A county councillor supported the view that long-standing political attitudes were at least partly responsible for the problems. He complained that legitimate criticisms of poor service met with the response, 'there's no money to do anything about it . . . That's the answer to everything you know.'

3.29 Examples of financial short-sightedness which we were given included lack of waking night staff in residential homes and foster parent allowances which were so much lower than those in neighbouring authorities that Staffordshire residents were fostering children in care in Cheshire, Warwickshire and Coventry. In relation to staff we were told by NALGO how difficult it was to retain occasional recruits from other local authorities once they discovered some of Staffordshire's difficulties. One example was disbelief that the social services department had no library. Expenditure on food in residential homes was low by comparison with other local authorities and pocket money for teenagers was thought to be unrealistic by the standards of ordinary families.

3.30 Councillor Austin, the present leader of the Council, saw a connection between staff cuts and the development of Pindown: 'I think Pindown was administratively so easy. Give them a pair of pyjamas and put them in a room and that is it . . . I think it became a method after a while.'

3.31 More than one witness considered Tony Latham had been left to get on with his initiatives because of the general shortage of resources. Brendan Sulliva, who has worked for the local authority for twenty years and who is at present Assistant Director (Finance), for example, said 'if Mr Latham was prepared to take this activity . . . they would let him get on with it . . . the period in late 1970s, early 1980s, was one of a lot of cutbacks, and a lot of change and just getting through one day was success, never mind taking on additional work which perhaps you did not have to.' Barry O'Neill, the former director, told us, 'there was a clear policy decision to let (Tony Latham) get on with it and not to interfere as long as he 'produced the goods'.

3.32 Councillor Austin agreed with Councillor Poulter, the present chairman of the social services committee, that the department was understaffed, but although efforts had been made to improve the position they were 'starting from a very bad base in 1981'. Councillor Poulter, commenting on the re-organisation of residential child care in 1983 said 'the problems facing the county council at that time were severely financial and the family centres decision was a way of having a good idea to resolve that financial problem.'

3.33 The effects of cuts and shortages of resources on practice were significant. One social work witness was very critical of particular cuts: 'all the waking staff were cut out in residential homes . . . That was of great concern to me . . . the commonsense of fifteen beds with up to twenty odd people in, this really did concern me.' The same witness regretted that 'after years of cutbacks' the family centres 'had to come in as part of a cost cutting exercise which was a great pity . . . (they) started on the given dates coupled with cutbacks of staff, and that was a bad base to start from.'

3.34 In the period before November 1983 County Council financial policies relating to social services led, in our view, to serious shortages of resources and manpower over a long period. In this situation developments such as Fundwell and Pindown were more likely to be tolerated, even encouraged, than might have been the case if more realistic and generous responses had been made by the county council to the heavy and growing tasks of the social services department.

(d) Social Services Re-Organisation

3.35 Barry O'Neill, the former director of social services, pointed out that the department's 'management structure had been shaped largely as a response to requirements for cuts in services in the
late 1970s and early 1980s.' We were given structure charts which demonstrated four major re-organisations between 1982 and 1989. The first took place in 1982, the second in 1983.

3.36 As noted above, substantial budgetary savings were required between 1980/81 and 1982/83. These were partly achieved by drastically reducing support staff in social work offices. Reductions in staff at headquarters also had to be made, thus diminishing support to the field services even more.

3.37 Until 1982 there had been a director, a deputy and five assistant directors at headquarters. Three of the five assistant directors were responsible for the provision of services. Only field social work was delegated to area officers outside of headquarters. Principal and senior assistants were responsible to each assistant director. The chain of management responsibility was long; for example, six vertical layers of management separated heads of residential establishments from the director.

3.38 In the 1982 re-organisation a new post of senior assistant director was created and the remaining assistant directors reduced to three. One of these combined responsibility for the whole of service provision. Services were also regrouped into those for children and those for elderly and disabled people, each with a principal assistant and senior assistant attached. In a centralised department in one of the largest local authorities in England this structure represented minimal resources for the task.

3.39 When the next re-organisation took place on 1 April 1983, it was in the context of what Barry O'Neill described to the Inquiry as a 'major blow to the delivery of services . . . and morale.' A witness who had come to work in Staffordshire in 1982 said, 'when I came to social services I found . . . files were everywhere. Confidentiality was nowhere near the standard I was accustomed to and the filing system was in total disarray. It was a pile of documents . . . on top of a filing cabinet.'

3.40 Paul Hudson, the then director of social services, had outlined his proposals for re-organising child care services in a report to the general sub-committee on 27 July 1982. The plan was radical in its approach:
   (a) all existing community homes to be discontinued in their current form;
   (b) 387 beds in establishments to be reduced by 164 by 1 April 1983;
   (c) 164 children and young persons in the homes to be boarded out or returned home by 1 April 1983;
   (d) a family centre to be provided in each of the county’s nine areas12 with a range of new responsibilities in addition to providing residential care for 10-15 children and young people;
   (e) observation and assessment to be carried out by family centre staff in co-operation with area social workers instead of by residential observation and assessment centres;
   (f) residential care officers to become social workers on social work salaries and no longer eligible for overtime. Roles no longer to be divided between residential care officers and field social workers;
   (g) each family centre to be staffed by an area officer responsible to the principal area officer both for the centre and for re-organisation of children’s resources in the area;
   (h) family centre staff to work closely with area social work teams who would retain existing child care responsibilities;
   (i) five small community homes to be retained for children without families or who were difficult to foster;
   (j) forty places to be retained in independence units based in former staff accommodation.

3.41 In his report to the social services committee on 27 July 1982, Paul Hudson described the objectives of the re-organisation as ‘to provide a vigorous community based service for children and families with the aim of preventing admission to residential care.’ Family centres would participate in
   (a) developing fostering and intermediate treatment;
   (b) developing links with day nurseries, play groups and child minders.

Additionally they would provide day care, overnight or weekend stay and full residential care for children and young people as required and for families for short periods if this would be of value.

12 Stoke-on-Trent eventually had three family centres.
3.42 All the proposals put forward by the director to the Social Services General Sub-Committee on 27 July 1982 were agreed by the Committee and the implementation date set for 1 April 1983.

3.43 The staffing to be provided to carry out family centre roles and responsibilities was described in the director’s committee paper. In principle it was to be ‘a team of social workers, sufficient in number to man the residential and day care element of the family centre as well as to develop boarding out and family support in the community.’ In reality apart from the area officer who had considerable responsibilities outside of the family centre, in a fifteen bed centre there were to be a team leader and nine other (full time equivalent) posts. Of these four and half were to be only social work assistants on salary scales too low to attract experienced or qualified staff. In addition, as one witness pointed out, the fact that posts were allocated did not guarantee that they were filled, ‘the number of beds . . . were reduced by X . . . overnight. Staffing levels were increased on paper . . . A twenty-five . . . or thirty bedded home . . . (with) twenty children in anyway . . . was changed to a fifteen bedded home which didn’t mean a lot because the children were still there . . . The staffing (was) . . . increased . . . but it’s all very well getting staffing approval, you’ve got to fill the posts.’ The Birches had twenty-eight children, not fifteen as was planned but no adjustments were made to the staffing allocation.

3.44 It was not in dispute on the evidence that the residential child care re-organisation became a fait accompli with very little consultation having taken place in advance. Barry O’Neill claimed to have sown the seed of the family centre concept. John Spurr, then senior assistant director, was asked, at short notice, to prepare a scheme and the cost cutting element was widely recognised. Once it had received committee approval it was then policy to be implemented. Depleted and demoralised headquarters and area staffs had to prepare between August 1982 and March 1983 for a major upheaval involving many children and residential staff.

3.45 Within the limitations of headquarters and area staff groups, attempts were made to plan and prepare for the changes ahead. Meetings took place between area officers, senior social workers and individual children’s social workers. Consideration was given to redeployment of residential staff in relation to children whom they knew well. Some pre-admission visits were arranged, particularly for young people going to independence units. Peter Crockett, who was responsible for the overall operation, held meetings of principal area officers and other senior staff to try to anticipate some of the problems. He also went to meet all the staff who were to be involved to provide an opportunity to talk about changes ahead. One of the objectives of the re-organisation was to return children to their own communities to facilitate contacts with families and rehabilitation at home. Peter Crockett commented on what had taken place before: ‘prior to the family centre set up what happened was that if social workers needed a vacancy for a child they rang up and it was a matter of where vacancies were throughout the county. I got different coloured pins for the nine principal areas and put them in and the colour pattern was horrendous, how the kids had been moved around.’

3.46 In spite of the preparatory work outlined above, when the movements took place some children still did not know where they were going on the day they were to leave. Fred Hill, then a senior assistant, described what happened, ‘it was a very busy time because all the establishments changed use. . . (I) was running round and clearing things with the fire officer and moving furniture around . . . we virtually changed overnight, possibly too quickly and the same people were running things the next day but it was called something else.’

(e) The Career of Tony Latham

3.47 In 1972, two years after the Seebohm re-organisation, Tony Latham began to work for Staffordshire social services department as an unqualified social worker in Tunstall, near Stoke-on-Trent. He had done voluntary work in the area as a schoolboy and continued to do so after he left school. Before he became a social worker he had worked in offices, been a benefits officer in the Department of Employment, and a youth employment officer and later an education welfare officer in Staffordshire’s education department. He was twenty-four years old when he joined the social services department.
3.48 His social work caseload contained, as well as adults, a large number of young people on care and supervision orders. He soon found himself responsible for between sixty and seventy young people and decided to draw on the concept of intermediate treatment [See para. 3.1] for ideas in working with them as a group since the numbers were unmanageable individually. The group he formed was initially called the Voluntary Youth Project, and later the North Staffordshire Intermediate Treatment Unit. Money was raised using volunteers and other social workers and this enabled activities to be provided. The group catered for boys and girls from eight to sixteen years old, most of whom were connected in some way with social services. The activities available to them included artwork, gardening, woodwork, hair dressing, cooking, camping and fishing. An account of the project was included in 1977 in a DHSS Development Group publication 'Intermediate Treatment – 28 Choices.'

3.49 By 1974 Tony Latham was also involved part-time with his then wife in residential work for physically handicapped children and later in a children's home where she was the officer in charge. Intermediate treatment began to take up even more of his spare time and Peter Crockett, at that time principal area officer for Stoke-on-Trent and Cannock, decided that part of Tony Latham's social work post should be devoted to extending intermediate treatment to the whole of the Stoke area. This led to his involvement in referral meetings, case planning, writing reports for courts and working in contact with families as well as social workers. The chairman of the local magistrates' bench was on the project committee.

3.50 When Tony Latham was seconded to Ruskin College, Oxford in 1975 to train in social work, he continued to be involved in Stoke's intermediate treatment programme and related activities at the weekends. In 1976 the social services committee agreed both to assist financially and to provide cheap premises for further developments. Students from youth and community courses began to be placed for periods of time of up to three months. By the time Tony Latham returned from Ruskin College in 1977, having gained his Certificate of Qualification in Social Work, between 120 and 130 young people were involved in the project. Residential intermediate treatment had also begun and John Aston, initially a volunteer, was appointed as voluntary warden. Community service volunteers, both local and from overseas, were also being referred to the project.

3.51 During the same period the Manpower Services Commission ('MSC') was seeking sponsors for job creation schemes for long term unemployed people. The Voluntary Youth Project sponsored three schemes: the Penkhull youth project, the Community Warehouse and the Halfway House project. The resources and personnel involved in these schemes began also to be used to support intermediate treatment activities, and the network of inextricably related initiatives known as 'Latham's enterprises' and later, more formally, as Fundwell began to develop.

3.52 In 1979 a full-time intermediate treatment officer was appointed by the social services department and seconded to run the Voluntary Youth Project. Intermediate treatment had by this time become sufficiently well established in Stoke that nine intermediate treatment officer posts were created to work in other parts of Staffordshire as well. It was also in 1979 that Tony Latham became a senior social worker and was encouraged by his area officer, Audrey Williams, to set up further MSC schemes (Youth Opportunity Schemes known as YOPs) as a way of continuing to make use of MSC funding in the community. Through these initiatives schemes to help elderly people in day centres, and with cleaning, shopping and transport developed.

3.53 In August 1979 the Community and Social Services Project Youth Training Scheme was set up to provide employees to work for the intermediate treatment centre. In 1980 a Community Funding Project was set up to raise funds for all the other projects. In February 1981 the manager of the intermediate treatment scheme left and the scheme's administrative officer, Glynis Mellors (formerly Bonnie), was appointed in his place. Glynis Mellors, like John Aston, was later involved with Tony Latham in Pindown.

3.54 By August 1981 schemes of various kinds had been established, catering for about 120 young people. The YOP schemes included day centres for elderly people; building, gardening, painting and
decorating task groups; a clerical group; a playbus; the community warehouse; a remedial group; and mechanics and joinery groups. The groups linked closely with each other. The mechanics group, for example, serviced vehicles used in a number of other projects.

3.55 Towards the end of 1982 the government was considering further developments in the Community Programme. Tony Latham had hoped to enable his projects to benefit from these. They were delayed, however, until September 1983 and he had meanwhile been appointed area officer in Newcastle-under-Lyme in the re-organisation of residential child care which took place on 1 April 1983. His appointment meant that from that date he was based at The Birches, a former children's home which had become a family centre. His responsibilities were to develop child care services in the area, and to manage The Birches in Newcastle, a long stay children's home at Kidsgrove and a unit at 245 Hartshill Road, Stoke-on-Trent. This unit was for young people who had left school and were learning to be independent. It was 'semi-staffed' i.e. staff were only available for a limited number of hours a week, mainly in evenings and at weekends.

3.56 The Community Project which Tony Latham had founded under the Community Programme of the MSC was initially called the Longton Resource Centre Community Programme. When he changed jobs he changed the focus of the programme and took it into the Newcastle-under-Lyme area where it was renamed the North Staffs Resource CP Ltd. By this time Tony Latham had also moved his own home to Duke's Lodge, where a number of projects and intermediate treatment activities were already centred. Following his appointment as area officer in Newcastle he moved all the remaining projects for which he was responsible to Duke's Lodge or to the premises at 245 Hartshill Road, Stoke-on-Trent, and began to combine these initiatives with his work as an area officer responsible particularly for one of the new family centres. He was amongst those who felt enthusiasm for the opportunities offered by re-organisation.

3.57 The team leader at the family centre was Philip Price who had been officer in charge when it was a children's home. He had not welcomed the changes initially but found himself fired by Tony Latham's enthusiasm and began to work closely in partnership with him. Tony Latham's appointment as area officer brought together the activities he had already developed and his new responsibilities for residential facilities in which Pindown was to develop subsequently. His career was a significant factor which, together with the interaction of national and local events and the pre-April 1983 influences, contributed to the matters we were asked to investigate.
Chapter 4: 1 April 1983 – 31 December 1983

(a) National Events

4.1 The Secure Accommodation (No 2) Regulations 1983 were made on 7 December 1983, and came into operation on 1 January 1984. Local Authority Circular LAC (83) 18, dated 9 December 1983, ('Restriction of Children in Care'), reminded local authorities that from 31 December 1983 the Secretary of State would no longer approve the use of single secure rooms in community homes. With effect from 31 March 1984, current approvals for their use would no longer apply. If local authorities wished to continue to use them they would have to re-apply for approval and were advised that the Secretary of State intended to impose new strict conditions to govern their use.

4.2 Annex B to the circular LAC (83) 18, (see appendix M) provided guidance to local authorities on how the Secretary of State would define restriction of liberty for this purpose. Amongst the definitions, paragraph 4 provided the following: 'control imposed or implied by staff or other responsible adults will not be considered to constitute the restriction of liberty, though control should always be implied in a manner consistent with good child care practice.'

(b) Staffordshire and its Social Services

4.3 The date set for change in the residential child care service in Staffordshire was 1 April 1983. Family centres were the key to the re-organisation both in the use of resources and in the approach to problems for which the child care service was provided.

4.4 The concept of family centres was fashionable in the early 1980s. There was, however, a lack of clarity about their objectives. They were too 'often re-cycled children's homes converted into centres for a range of work with families and children.' They could be 'an unhappy mish-mash of family centre, playschool, crisis intervention centre and residential home.' [Para. 35 Second Report from the House of Commons Social Services Committee – Children in Care HMSO 1984] Some of those who gave evidence to the Inquiry thought that the re-organisation of residential child care and the family centres in Staffordshire were positive measures which enabled problems to be dealt with at local level with greater flexibility than formerly. There were others who rejected the changes as ill-planned and primarily concerned with cutting costs.

4.5 There had been little attempt to consult beforehand with experienced staff who were working with the children and young people concerned and who might have commented on the potential use of the buildings earmarked for family centres. Few adaptations were made to accommodate the new uses for these buildings. The emphasis on budget reductions required in 1983 led to staffing establishments which were unrealistic in relation to over ambitious objectives for the centres. In addition the speed with which re-organisation was implemented had not allowed time for a realistic approach to the reduction of the number of children needing residential care facilities in order to match the theoretical reduction in the number of beds at the centres.

4.6 The regrading of residential care staff to social workers on social work salaries had diminished the distinctions which previously existed between residential and field workers. The withdrawal thereby of the right to be paid overtime, however, did not help staff working many extra hours because there were too few people available. The whole scheme also ignored the reality that a complex list of tasks many of which required considerable skill, knowledge and experience, would in the main inevitably be carried out by inexperienced, untrained and unqualified staff.

4.7 The domestic work hours provided for family centres were so limited that child care staff had to carry out a range of housekeeping and physical care tasks which detracted from the time and energy available for individual children and important professional tasks and responsibilities.
4.8 On 6 May 1983, only five weeks after family centres had been established. Audrey Williams, then principal area social services officer for Stoke-on-Trent, wrote to Paul Hudson, director of social services, with a copy to Richard Thompson, assistant director (administration) and Peter Crockett, assistant director (service delivery). Heading her letter 'Family Centres and Long Stay Units' she wrote, 'following a meeting with team leaders today, I need to draw your attention to a problem experienced in all the above units ... the problem ... of laundry and members of staff who I feel should primarily be caring for the children are being overly involved in the task of laundry. It is not merely the day to day washing for children but the added problem of bed wetters ... in one such unit there are eight ... whose sheets need washing every day.' She asked for the problem to be looked at with 'some urgency'.

4.9 On 29 July 1983 Fred Hill, senior assistant, child care, wrote to Peter Crockett. In a memorandum on a number of proposals for child care buildings, he wrote 'the over-riding need at The Birches is for extra space to extend the work of the family centre. Even when the number of children accommodated falls to the establishment figure of 15, facilities for interviewing, day care and general activities will be restricted.' He reported that he was impressed with the flexible, imaginative way in which The Birches' staff were developing resources but thought there was 'a danger of trying to do too much too soon'.

4.10 The Birches, a former children's home in Newcastle-under-Lyme, like a number of others became a family centre on 1 April 1983. How they carried out their new role and tasks was left largely to their own initiative and no guidelines were issued from social services headquarters to assist them. Tony Latham told us in evidence 'one of the concepts of '83 was to make family centres an acceptable, easy, accessible resource ... we were encouraged at that time to ... be innovative about how we would make these resources available ... Phil (Price), Glynis (Mellors) and myself were the three people (in Newcastle) that were directly involved with providing the resources, either through residential, through intermediate treatment or through whatever else ... It was necessary for them to come to one of us ... to get a response.'

4.11 Former children's homes or hostels which neither retained their traditional role nor were transformed into family centres, became 'semi-staffed' independence units. One of these was 245 Hartshill Road, Stoke-on-Trent, situated about two miles from The Birches. In the new organisational structure these two units and a small long-stay children's home at Westmorland Avenue were under Tony Latham's management. He was accountable to Elizabeth Brennan, principal area officer, Newcastle-under-Lyme. Philip Price who had previously been the officer in charge at The Birches became team manager of the family centre.

4.12 At this time Peter Crockett, assistant director, (service delivery) held a number of meetings with other assistant directors, principal assistants at headquarters and principal area officers. These meetings had commenced in March 1981 and continued until April 1985, when after a few meetings under the chairmanship of John Spurr, (senior assistant director after Peter Crockett became deputy director) they ceased. During 1983 there were many problems for them to discuss arising out of the child care re-organisation.

4.13 Shortly after family centres were established, there was also a meeting between the area officers responsible for them. Peter Crockett's group was told on 23 May 1983 of this meeting and asked to make sure that they knew what the content and purpose of any such further area officers' meetings were. We do not know whether this discussion influenced events. No further meetings of area officers, however, took place and there was therefore no formal interchange between them since they did not attend the senior staff meetings chaired by Peter Crockett. Tony Latham told us in evidence that, 'where a group of people have come together to organise their own meetings and structures that has usually been discouraged because it's seen as a sort of threat against the management structure.'

4.14 Regarding the provision of information by the residential home, Regulation 16 of the Community Homes Regulations 1972, on information and records, requires that: 'the person in charge of a community home shall give to a person authorised under Section 58 of the (Children and Young Persons) Act (1969) to inspect the home, such information as he may require and as may be relevant to his
inspection of the home, its state and management, and of the children and their treatment, and shall further give to such authorised person access to records concerning the home kept therein, and the responsible body shall give to the person access to any records they may keep elsewhere in relation to the home.

4.15 Internally it was the practice at The Birches and 245 Hartshill Road to keep a running record each day, with occasional exceptions, of what was happening in the home from getting up in the morning till late at night, and when necessary during the night: a sort of 'slice of life' described by a member of staff on each shift. These records were in log books, frequently but not invariably, stiff backed A4 notebooks.

4.16 The Birches' log book which contained 1 April 1983 began on 9 February 1983 with a relatively short entry:

'L. B. came on a pre-placement visit... The C's social worker visited... D. C. in his pyjamas early... C. out to friends for a couple of hours... D. & M. doing homework. It's been a very quite night again. C. has been very quiet tonight – he doesn't look very well. GOODNIGHT.'

There was no explanation of why D. C. was in his pyjamas early, but it seems likely that it was a measure of control. Towards the end of April 1983 another entry records that a sixteen year old boy from a foster home was brought by his social worker to see Philip Price: 'he is not doing too well in the foster home, so he has been shown around the semi (staffed) unit (245 Hartshill Road) and here (The Birches), and has been told how things are run in both places. The idea being to show him the alternative if he doesn't try to make his foster placement work.'

4.17 The actual admissions of children from other parts of the county so as to be nearer to their own homes, part of the re-organisation plan, were difficult to detect in the log book in April 1983, but by May the number of children in The Birches was very high. In May, on a Saturday afternoon, 30 children from The Birches and 20 from 245 Hartshill Road were recorded as playing 'five a side' football games. The numbers for which the establishments were intended were exactly half in each case, 15 at The Birches and 10 at 245 Hartshill Road. By early June a boy who ran away from The Birches found there was no bed for him when he returned. He had to sleep on the floor. On 9 June 1983 there were still 23 children in The Birches and an entry in the log book on 11 June clearly indicated that difficulties were being experienced in managing too large a group: 'we had a talk (which Jaime (Rodriguez) conducted) explaining to the children the do's and don'ts of The Birches, we need to discuss this at the staff meeting. Children rather high and slow to settle.'

4.18 At the same period there were entries which indicated that working procedures and boundaries between field staff in the area office and residential social workers in the family centre which had been changed by re-organisation, needed to be clarified and sorted out.

4.19 On 6 June 1983 Peter Crockett was holding one of his meetings with senior staff. He discussed with them 'the enormous pressure under which the family centres (were) operating... numbers, staff shortages etc. and the necessity to face reality in agreeing programmes of care.' Inappropriate and disruptive short term admissions were said to be taking place at Riverside (a community home with education) and it was clear to the meeting that there were major problems as a result of re-organisation. It was noted that urban aid which provided for four intermediate treatment centres was coming to an end.

4.20 A few days after 6 June 1983 a fourteen year old boy was picked up by the police and brought to The Birches. He was a known glue-sniffer and had previously been in Heron Cross House (when it was an observation and assessment centre), Ruthwood (a similar establishment) and Riverside (a community home with education). Several older boys in The Birches were already glue-sniffing and the term 'off privileges' describing a range of sanctions was appearing in log book entries. An older boy brought to The Birches from a juvenile court on an interim care order for non-school attendance, had his tea and then ran away. Staff were warned about a suspicious character in a car outside the building who had been talking to some of the boys. Concern was being expressed about boys and girls in each others' bedrooms at night;
two boys were recorded as ‘under seven day house arrest’ and the boy who had run off after his tea, had been recovered and was to be seen by Philip Price ‘for punishment’.

4.21 On 27 June Brendan Sullivan, assistant director (finance), one of a group of senior staff selected to do so, visited The Birches to carry out a ‘statutory visit’. Regulation 3(2) of the Community Homes Regulations 1972 requires that a local authority providing a residential home for children must ‘arrange for the home to be visited at least once a month and a report made to them in writing upon the home by such persons as they consider appropriate’.

4.22 Staffordshire social services committee had decided that a rota of senior staff and managers in the department should undertake these visits. The rota included administrative staff and staff concerned with other client groups, for example, elderly people, as well as senior staff responsible for child care services. The rationale for this was that no-one would visit too frequently (there were between 15 to 20 people on the rota) and that the fact that they were not all concerned with child care would not prevent them from carrying out an inspection task.

4.23 A copy of the report form (SW197) which was used for this purpose appears in appendix K. Although there was opportunity for a fairly detailed set of comments if the statutory visitor wished to make them, the forms often contained little significant comment other than routine remarks. Some visitors were conscientious in checking fire drill dates and inspections. The heading ‘control’ also usually had some comment, though often brief. This heading covered the number of absconds and additional measures of control recorded since the previous visit. When the report was completed it had to be sent to the director’s secretary. It appears that in the main the reports were looked at by an assistant director and John Spurr carried out this task for some years. The reports were then in most cases shortened and forwarded on another form (SW199; see appendix K) to the District Advisory Sub-Committee.

4.24 Brendan Sullivan, the statutory visitor on 27 June 1983, drew attention to the absence of fire drills and testing of fire equipment during the preceding weeks of May and June. He also noted that there were no entries in the measures of control book and assumed it was ‘obviously only used for the more serious occurrences’. His general comment was that ‘despite the obvious enthusiasm and effort put in by the staff, my overall impression of the home was a little depressing compared to other more modern and better furnished homes’. When this report went to the District Advisory Sub-Committee they were told that ‘the home, although clean, was in very poor decorative condition. The standard of furnishing in particular is very poor’. The general comment was that ‘the effort and enthusiasm of the staff in coping with the high numbers is commendable’.

4.25 On 2 July 1983 problems were experienced at The Birches with a ‘group of Riverside lads on home leave . . . causing a nuisance . . . (and) not prepared to leave without confrontation’. In addition the log book was receiving entries on children who were bed wetters and some who soiled themselves as well; and entries expressing dissatisfaction about shortages of essential equipment and lack of adequate domestic work to support the child care work were in strong terms. Tempers were beginning to fray and on Saturday 9 July 1983 Jaime Rodriguez, who before 1983 had been deputy in charge at The Birches, but on 1 April had reverted to a social work post, recorded the following entry: ‘I had another encounter with A. this morning in reference to his attitude to my directives from staff. After telling him several times to turn down the record player I ended up taking the record off and breaking it in half. He was extremely annoyed by this and I had to escort him upstairs until he calmed down and we were able to discuss the matter.’

4.26 During this period there was a great deal of moving of beds and children around and one boy under medication for epilepsy had a fit after an escape and which resulted in him being moved into a six bedded room. The lack of adaptation of buildings in preparation for the wide age range of children and wide range of problems in family centres was being demonstrated by insufficient and inadequately flexible sleeping accommodation. This made the provision of privacy or, when required, the protection of one child from another, extremely difficult. Bicycle stealing, fighting, defiance, shouting, crying and non-school attendance, which were problems made worse by overcrowding and understaffing, were affecting staff and children alike. One member of staff recorded, ‘I had a long talk with A. in the office, but I don’t think
4.27 Fred Hill had written to Peter Crockett about the need for ‘extra space’ at The Birches and Tony Latham was pressing for agreement to use empty staff accommodation both at The Birches (a separate staff house in the grounds) and at 245 Harthill Road (a staff maisonette and a staff flat). He wanted to use the staff house at The Birches for rehabilitation work with families, and accommodation at 245 Hartshill Road as a base for the intermediate treatment programme. He was also proposing to convert a garage at 245 Hartshill Road into a workshop and to construct a greenhouse in the grounds there as part of a gardening project. He had already made 245 Hartshill Road the administrative centre for the Community Programme which he had deflected from Stoke-on-Trent to the Newcastle area. This programme was based on the first floor of the building at 245 Hartshill Road.

4.28 On Tuesday 16 August 1983 an adolescent girl returning late in the evening having been on an off license without permission, was confronted by Jaime Rodriguez. He recorded in the log book what happened next. He told her that she was to move for the night into a single room. She refused to do so. He then physically removed her from the bigger bedroom to which she had gone. He wrote that ‘she became physically and verbally abusive’ throwing bedding and furniture about. ‘I had to restrain her (by the back of her hair) for some 10 to 15 minutes.’ The girl threatened to make a complaint of assault; Jaime Rodriguez called the police. When the police arrived the girl was still angry and throwing things about. She was removed by the police and spent the night in the police station.

4.29 At meetings of the senior staff chaired by Peter Crockett in July and August 1983 staffing problems at the family centres were discussed. Principal area officers were asked to contact Fred Hill, a senior assistant, for help with temporary staff, and because it was recognised that vacancies could not remain unfilled, it was agreed that special arrangements would have to be made for short contract workers to cover these posts.

4.30 The September meeting of the senior staff group had to address a new problem, referred to in the notes of that meeting as ‘the developing situation’ of industrial action by residential staff. It was agreed that principal area officers would be personally consulted about requests for admissions to care and would monitor them closely. They would also approach residential establishments themselves for beds if necessary and would be held responsible for sufficient ‘cover’ in view of staff ‘refusal to be flexible in respect of roles’. Staff were being advised by NALGO to refuse to work split shifts. The meeting was told that the county council had agreed to some additional community support resources.

4.31 During July, August and September 1983 some of the pressure at The Birches had been relieved by small parties of children being away on camping holidays in North Wales and elsewhere, but by the end of the school holidays this relief was no longer available.

4.32 By 21 September five boys who had absconded were required to wear shorts or pyjamas except when they were at school. Nevertheless abscondings continued and by the beginning of October 1983 the police were making it clear that they were not happy about the amount of time they had to spend on runaways. Log book entries reveal considerable stress in the whole group and one boy was described one evening as ‘high as a kite’ at bedtime and talking to himself. A member of staff asked in the log book whether he should have psychiatric help. ‘Yes, definitly (sic)’ responded another. There was no evidence that such help was sought or obtained.

4.33 On 13 October 1983 the log book recorded that NALGO was requesting all residential staff to walk out from work on Monday 17 October from 7 am – 10.30 pm. A meeting of the staff was to be held to consider this and Elizabeth Brennan, principal area officer, was to be present.

4.34 Industrial action was discussed at the next three meetings of Peter Crockett’s senior staff group in
September, October and November 1983. Riverside (a community home with education) would be accepting back young people on certificates of unruliness. Consideration was given to the problems of children admitted to care who would not be able to go into residential accommodation. Staff also discussed the problems which would arise at half term, and for much longer in the Christmas holidays, when children in care who were at residential boarding schools would be expecting to come back home to the family centres.

4.35 On 16 October 1983 Jaime Rodriguez recorded in the log book an incident with an older boy. He had been spending some time discussing the ways in which the boy could achieve a 'new improved self' and had been putting 'together a contract'. He recorded that 'half an hour later I caught him glue sniffing again... He refused to surrender the glue and had to be physically removed to his room. In the scuffle a necklace belonging to him snapped. He stated that he wanted to complain to his social worker, to which I answered that I would arrange for him to visit P. (the boy). I found two bags of glue after a further search in the room. I put him in pyjamas and restricted to play room until bedtime at 21.00 hours.'

4.36 On the following day, 17 October, the log book recorded: 'Liz Brennan (principal area officer) and Fred Hill (senior assistant) visited to see if all was satisfactory on this DAY of ACTION.' Yet interspersed with the increasing tension and angry incidents, the log book reminded staff to feed 'The Birches' cat, send milk for the cats at 245 Hartshill Road, and recorded events in the life of a pet rabbit. Temporary improvements in the behaviour of certain key adolescents also gave rise to hopeful comments.

4.37 The log book recorded that industrial action ballot papers from NALGO arrived on 24 October, to be returned on 31 October. During the next few days two enjoyable trips to Blackpool took place, the rabbit sustained a broken leg when a child tripped over it in the grass; Halloween came and went. One staff member was sufficiently disoriented to record that two absconders had been put on 'total lack of restrictions for 7 days. P.'s mouth to be watched if he gives lip to anyone it's to be noted down.'

4.38 The result of the NALGO ballot was announced in the log book on 1 November. It was a call for industrial action by residential staff with a ban on split shifts, clerical duties and answering the telephone.

4.39 On 2 November 1983 three boys who had been absconding were back in 'The Birches' and they set off for school. They did not arrive. The same day the staff were informed that 'escalated industrial action' was to take place on 3 November. The log book explained that 'the Union Escalation action is as follows--no residential NALGO member is to answer the phone from 8.0 a.m. till 6.0 p.m. Monday to Friday... if by refusing to answer the call you are financially or otherwise inconvenience management then you are instructed by Your Union to do so, if the residents (or staff) would suffer by refusing to answer the phone, then that is not part of the action... if you have files to fill in please do so, but don't pass them on to Stafford--if they want something they must come and fetch it. There is a Union instruction to refuse to work split shifts.'

4.40 The Birches runaways were picked up by the police on 3 November 1983. There was no record of who collected them from Newcastle-under-Lyme police station. The three boys were interviewed separately by the Inquiry in September 1990, nearly seven years after the events. Each recalled that after being handed over by the police they had their clothes removed, probably at The Birches, and were then taken to 245 Hartshill Road in their underpants without shoes. Tony Latham confirmed this account to the Inquiry. He also agreed that, as one of the boys had told us, they might well have been terrorised by the experience.

4.41 The adolescent girl who had absconded with them returned to The Birches where she was subject to 'loss of privileges'. The Birches log book makes no comment on where the boys were, but had an instruction to staff: 'children are not to be told where A., D. and P. (the three boys) are sleeping tonight'.

4.42 John Aston, a member of the residential staff, received the three boys at 245 Hartshill Road. They each recalled being required to try to break through a locked fire door into the part of the house where
they were to be accommodated. Eventually the key was found and it was unlocked. The boys were all put into the same room. This had initially been empty but after, as John Aston recorded ‘they moved the furniture’ it contained a table and upright chairs. They were required to have ‘a cold shower, then ½ hour to keep fit. They then sat in silence till Phil (Price) and Tony (Latham) arrived.’ The log book records that they were given cheese on toast, tea ‘and even a fag’. They then went to bed sleeping in a second room on mattresses on the floor with no other bedding. John Aston was also sleeping on the floor. The boys were told that they were in an intermediate treatment unit and would have to earn back their clothes.

4.43 Two of the boys, A. and P., recalled that the next morning they were required to do physical exercises outdoors in their underwear. The third boy, D., had an indistinct recollection of what occurred.

4.44 A. said that ‘(Rodriguez) had us doing bunny hops around in a circle and everytime you went past him he would hit you with a cane’. This continued for about twenty minutes in the ‘back yard’. A. added, ‘I didn’t think it was funny and neither did the other two, he wasn’t just messing about he was hitting’. A. when interviewed was asked if there were any other children around and he replied that, ‘we never saw anybody’.

4.45 P. recalled that they were taken to ‘a concrete square’ and he (Rodriguez) had us bunny hopping round there . . . and he had a stick and he was standing there in the middle . . . we had nothing on, just our underpants still, nothing on our feet, and we were bunny hopping round and he was saying move over and he was whipping us, he is mad, but I was laughing, so I was getting it and he was taking it worse because I was laughing . . . Fundwell have got up at the top some sheds, garages, actually on the ground. Fundwell workers were actually working there . . . they were up at the top watching it happen they thought it was hilarious.’

4.46 Jaime Rodriguez, when questioned at the Inquiry, strongly denied hitting the boys. He said that, ‘I might have had a cane. After all . . . on many occasions I might have had something in my hand and you played with people. You messed about with children very often. It wasn’t a situation where you were serious all the time. After all, children lived there and the relationship we had, it wasn’t one of warden and prisoner.’ He did not recall any specific times when he had a cane or a stick in his hand. He added that ‘I do not deny that might have happened . . . many times. I was not in the habit of having sticks to carry around. I never did it. I might have had one at some point. I cannot deny that. I cannot affirm it positively that on one occasion I had.’

4.47 Despite the length of time between the incident and the recounting of it by only two of the three boys, we are satisfied on the evidence that at the very least the boys were subjected on the morning of 4 November 1983 to a calibrate episode of humiliation at the hands of the residential worker.

4.48 After the first two days the boys had outdoor exercise under the supervision of other staff and eventually had exercises indoors.

4.49 That first morning they had to wait for Tony Latham and Philip Price to come and see them and John Aston recorded ‘boredom and no fags is killing them’. When they arrived it was decided that one of the three boys should go to school from 245 Hartshill Road, but the other two would remain within the building. John Aston’s log book entry continued, ‘to work. All day they moved furniture. Work their socks off! Shame they are not wearing any.’ Later the same day a fourth non-school attendant from The Birches joined the group. John Aston recorded that one of them was complaining of ‘diarrhrea (sic). Medecine is a privelege (sic) to be earned! Will see what he is like tomorrow’.

4.50 The transfer of the fourth boy from The Birches to 245 Hartshill Road was recorded in the log book as ‘R. is at the secure unit at Hartshill’ (emphasis added).

4.51 On Sunday 6 November 1983 two of the boys who had been taken to 245 Hartshill Road were taken back to The Birches ‘on trial’. By 8 November one of them was said to be reverting to his usual mouthy unco-operative and arrogant’ ways. At 245 Hartshill Road on 6 November Tony Latham carried out a
short shift and made an entry in the log book: ‘boredom and isolation I feel is beginning to bite . . . restrictions and lack of privileges are beginning to cut in.’ Philip Price was also there that day and John Aston recorded that there had been discussion of the ‘special unit’ and ‘the fact that it is here to stay and every time someone “visits” us they will find it harder and longer’. The boys were given a task on 6 November to write about the ‘special unit’ and complete a diary including names of staff, meals and what they had been doing.

4.52 The three boys in the unit on 7 November were roused at 7.30 a.m. and according to the log book ‘kicked . . . out of bed’ by John Aston. He also made a note in the log book at the same time of a ‘New Rule. 5 swear words a day. No. 6 gives extra day here. Please record.’ One of the boys asked John Aston ‘if he belong (sic) in a “nut house” . . . . How can I comment on this?’ he queried in the log book. The next morning was similar: ‘7.30 woke everyone. 7-35 trampled on everyone. . . . learning to get out of bed quicker’.

4.53 On 8 November 1983 Tony Latham issued an ‘URGENT AND IMPORTANT’ memo to all staff at The Birches family centre, the semi-staffed unit at 245 Hartshill Road, the children’s home at Westmorland Avenue, the intermediate treatment centre at 245 Hartshill Road and (what was called) the ‘Special Unit’. There was no indication of what had prompted the memo which was found stapled to the left hand page of The Birches’ log book opposite the page recording events on 8 November 1983. It appears in appendix G.

4.54 It was essentially about punishment and addressed all staff ‘WITHOUT EXCEPTION’. The main points in the memo were:

(1) Application of punishment or loss of privileges required prior agreement with Tony Latham or Philip Price;

(2) Punishment without prior consultation with the area officer or the team leader was precluded by The Community Homes Regulations 1972;

(3) The area officer (Tony Latham) was prepared to allow a ‘senior shift leader’ to deal with ‘minor problems’ if neither he nor the team leader (Philip Price) was available, so long as measures taken were properly recorded and that as soon as possible afterwards he or the team leader were notified and the ‘punishment book’ completed;

(4) All loss of privileges or punishment was to be ‘properly recorded in the punishment book’; the semi-staffed unit (at 245 Hartshill Road) was to seek prior agreement to punishments; and each establishment was to keep a separate punishment book.

In conclusion Tony Latham stated his intention ‘to examine closely the methods of control carried out in all establishments’ and to ‘examine regularly with the team leaders the appropriateness of the measures.’ The final line was an admonishment ‘PLEASE TAKE CAREFUL NOTE OF THIS INSTRUCTION.’ It was signed by Tony Latham as area officer on 8 November 1983. The Inquiry found no evidence that the intention to examine methods of control was ever carried out.

4.55 On 9 November 1983 John Aston, who was on duty a great deal in the first days of the ‘special unit’, recorded in the log book that he decided to allow the boys in the unit to socialize for a time with other boys in the semi-staffed independence section of 245 Hartshill Road. Tony Latham paid a very brief visit and after he had gone John Aston further recorded in the log book: ‘(I) get the impression I shouldn’t have allowed the lads to socialize. Programme changed again. Next week the lads to come here again.’ Immediately under the entry quoted above John Aston decided to express his own view and wrote: ‘TONY PLEASE NOTE I believe if this is prolonged to (sic) much R. will abscond so he doesn’t want to come here. We will have pushed him to (sic) much! Their (sic) is a fine line between pushing him to the point that he will make the effort not to come back and pushing to (sic) far so he absconds so he doesn’t have to come back.’ Having put a number of proposals to Tony Latham which he wished to discuss he continued: ‘to keep the impression of a special (sic)/secure unit going means no allowance of prevelges (sic) as it would defeat our “face” to other members of The Birches’.

4.56 Elizabeth Brennan, the principal area officer, told us in evidence that truancy lay close to the heart of the developments which soon became known as Pindown. Prior to November 1983 she and Tony
Latham had had many discussions about truancy, about family meetings and about the need for flexibility of provision and the need for movement of children in the care system. She said that 'we were trying to get turnover...we had grave difficulties in the early days'. She added that day care as well as residential care was taking place at The Birches. They were trying to fulfil many purposes in one building, trying to get residential and field social work staff used to new ideas, and also trying to explain their role and tasks to magistrates, probation officers and the education service.

4.57 Proposals for changes in the use of 245 Harthill Road had been discussed at meetings and in memoranda between the Newcastle area, Fred Hill (senior assistant, child care), Peter Crockett (assistant director), and the county fire officer for some months prior to November 1983. A long letter about fire precautions had been sent by the county fire officer to the director of social services on 19 October 1983, accompanied by a detailed sketch plan of the (then) empty former staff maisonette. This was being considered for intermediate treatment purposes. Following the fire officer's letter the director of social services wrote to Tony Latham as area officer (The Birches) on 4 November concerning these plans. His letter concluded: 'finally, none of the proposals should be put into operation until all the recommendations made by the County Fire Officer have been implemented.' He suggested that the building inspector might help to expedite matters. Before this letter had reached Tony Latham he had already used the premises for the young people from The Birches.

4.58 When asked by the Inquiry whether the events of 3 November 1983 and subsequently had been planned, Tony Latham replied: 'it was a sudden response.' There was a 'hopeless situation at The Birches...It was around the time when children were coming home to roost...part of the family centre concept was to bring your own children back to your area...so we had long stay, short stay, some didn't really want to come, new referrals...twenty eight kids in a...fifteen bedded place...As a child care service...the whole thing was in a state of disarray.' He acknowledged that he had not consulted his line manager, Elizabeth Brennan, in advance.

4.59 Tony Latham argued that in the circumstances at the time the staff rota worked 'staff might have been off duty for two or three days' and not available if the unrest with the adolescent boys 'had escalated...we created things very quickly, names and things very quickly. I can't recollect any major plan of putting it together'. Action, in fact, appeared to have been taken so swiftly that staff at 245 Harthill Road who had been using the bathroom facilities in the maisonette, arrived on duty to find they were no longer available.

4.60 Elizabeth Brennan acknowledged that 'it developed rather more quickly than it should have done without my knowledge' and that she was not fully aware of all that was going on at the time regarding the way that Tony Latham was developing his role. Concerning 245 Harthill Road she said in evidence that she and Tony Latham had early recognised the concept of a semi-staffed unit was impractical because of insufficient resources particularly in staff time which was only available for seventy hours a week. This had led them soon after re-organisation to 'start working the two units together'. There were no extra staff, however, the only available addition being 'family aids' (described by Elizabeth Brennan as 'glorified home helps') who were all untrained and 'paid 8p an hour plussage' on their home help wages. Most of the other staff were also untrained and unqualified. Tony Latham and Philip Price gave some 'sit by Nellie' type training but nothing else was available.

4.61 On 10 November 1983 staff at The Birches were informed through the log book that NALGO wished to conduct a ballot in the residential homes as to what action they would be prepared to take in the event of a member being suspended for taking part in industrial action. The minimum action under discussion would be a walk out from 6-8 P.M. The same day at 245 Harthill Road, a week after the first young people went into the 'special unit' bunk beds were delivered and erected. One of the first four boys had by this time absconded and was brought back on 14 November. John Aston recorded in the log book that he 'was stripped and put to bed. Clothes locked up'. He had to wear shorts and needed 'permission to speak from staff if he wants to say something'. Having 'allowed R...the privilege of talking for 5 mins' John Aston found he did not want to talk and seemed determined to run away again. Later that day the boy was required to wear pyjamas, not shorts. A week later he was still there and on 17 November 1983
Philip Price set him four questions to write about since he ‘wasn’t very clear about anything’.

4.62 The four questions were recorded in the log book by another social worker at The Birches and 245 Hartshill Road, Peter Nicol-Harper. They were:
1. What he thinks of the Secure Unit (emphasis added);
2. What he thinks of school;
3. The Birches;
4. What he thinks about having another chance.’

4.63 The next day 18 November 1983 the boy had a medical appointment because of suspected epilepsy and on 19 November he was recorded in the log book as ‘head banging again last night’. He was sixteen years old and in addition to being in the ‘special unit’ he was on an attendance centre order. On 21 November 1983 he was described in the log book as ‘depressed’.

4.64 The development of the ‘special unit’ was not plain sailing. On 1 December 1983 John Aston was recording that: ‘Jaime (Rodriguez) and I find their (sic) are some inconsistencies between the staff. Jaime knows the ropes. A conversation with Ray (Crutdace – another member of the residential staff) would be beneficial (sic)’.

4.65 There were also practical problems such as lack of food provisions and other basic necessities. The log book records on 2 December 1983: ‘up and ready for breakfast by 7.50, unfortunately there wasn’t any – we didn’t fancy dry wheatabix (sic)!, . . . P. found 4 remaining slices of bread for us to eat’. The problem of providing adequate, nutritious food on time was a recurring theme at 245 Hartshill Road, not only in the first few weeks or months but over several years. In addition equipment was a constant source of difficulty. The cooker was so faulty that only one ring worked. There were no work surfaces on which to prepare food or clear up after meals. A frying pan had a dangerously loose handle. The refrigerator frequently went wrong or was left turned off because there were insufficient power points to accommodate it and other equipment.

4.66 The arrangement which had been made to cater for 245 Hartshill Road was that all main meals would be brought from The Birches (about two miles away) and that the kitchen there should also order and supply basic foods such as milk, butter, bread, cereals and other foods necessary for breakfast and suppers. Frequently these were forgotten; cooked meals arrived very late and often cold and the diet in the unit was not suitable for growing boys and girls. Toast and tea, snacks on toast, crisps and other convenience food featured constantly. The occasional balanced meal, especially if hot, was recorded in the log books with considerable pleasure. One of the young people who had been in the unit during 1983 and later, told the Inquiry that ‘we were given crap food, toast, it was always cold the food because they brought it from The Birches . . . there was no nutrition, it was rubbish, toast, toast and jam’. One boy just arriving in the unit was presented with an evening meal which was macaroni cheese, two rounds of bread and a cup of tea. He did not like macaroni cheese so only had bread and tea. Another boy already in the unit had an exchange with Jaime Rodriguez which he (Rodriguez) recorded in the log book. The boy had asked ‘Is decent food a privilege? I answered “Yes”’. Another boy the same day who was complaining of hunger was told ‘not to talk to conserve energy’.

4.67 It was not only food which was a source of frustration. Washing powder, bedding, towels, toilet rolls, toothbrushes, combs, shampoo, cleaning materials, cutlery, crockery were all quoted, not just in the early months but regularly, by exasperated staff in the log books as missing, late or inadequate. there was frequent borrowing from the semi-staffed unit and sometimes staff had to use their own money to obtain basic necessities, being refunded later.

4.68 The ‘special unit’ was ill-equipped from the outset and was staffed by people who had had little preparation for their task. Some of the entries in the log books demonstrate this clearly. On 2 December 1983 describing one of the boys in the unit a member of staff wrote: ‘he has being (sic) here for three days and it is bening (sic) to get to him he has become allot (sic) quieter than on tuesday. 5-0 p.m. I made his tea and read this book.’ Another entry about a boy of sixteen years old explained that for ‘back answering
and refusing to do something he is told to do make (sic) to stand in corner of the room with hand on top of his head.

4.69 One of the first three boys in the ‘special unit’ had returned to The Birches after three days but on 29 November 1983 had been brought back to 245 Hartshill Road. On 3 December he absconded again and was picked up and questioned by the police. The log book records that subsequently he was ‘stripped and put to bed. No conversation!’ John Aston who made the entry had also been talking to the boy’s grandmother. He noted that she ‘says it sounds like a concentration camp’ and he decided that he should ‘speak to Tony . . . she seems to have taken in all that P. has said’.

4.70 The boy concerned in the above recordings left the ‘special unit’ on 9 December 1983. Another boy was admitted for one day on 15 December. He was seen by Tony Latham, Philip Price and Glynis Mellors who by this time was involved in 245 Hartshill Road as manager of the intermediate treatment centre which was based there. The boy, M. was very upset when told he would have to stay in the unit. After some discussion he was told to write down the reasons why he should not stay. He did this and it was later agreed that he could return home on certain conditions. There were no further entries in the log book for 1983 and there appear to have been no young people in the unit during the rest of December and for the first nine days of the new year.

4.71 In December 1983 there appeared to be continued tension at The Birches. Philip Price as the team leader decided to make his feelings explicit and on 7 December made the following entry in the log book: ‘I feel it is appropriate to note in this book that the evening has been an extremely enjoyable experience with no problems at all . . . everyone in extremely pleasant moods . . . I find it difficult to assess many of the problems that are highlighted in this book on occasions by staff members, when the fact of them not being present all day, has as you can see, had the reverse effect i.e. (NO PROBLEMS).

1) who has the problems
2) who’s (sic) needs do we need to meet first
3) should staff be paid to have their problems resolved

Phil’

4.72 On what seems to be the next day (though undated), he wrote again: ‘everyone up with no problems, all eager to help not a cross word said by anyone, everyone to school on time, everything organised and bedrooms left ‘TIDY’. No comments by other staff followed these entries, but a few days later an incident involving separating young people at bedtime led to violence, hysterics and a woman member of staff striking an adolescent girl.

4.73 In the two weeks just before Christmas industrial action was continuing. On Christmas Day itself it had been decided that the residents of 245 Hartshill Road should spend the day at The Birches. The log book records that this produced ‘rather rowdy behaviour when semi-staffed arrived, arguments (sic) between both sets of kids’. Boxing Day was also not a very successful day and by the end of the year abscondings had begun again.

4.74 During 1983 (November and December only) 5 children were subject to Pindown at 245 Hartshill Road.

- The shortest episode was 1 day
- The longest continuous episode was 10 days.

The total time spent in Pindown at 245 Hartshill Road in 1983 by each of the 5 children was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>9 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>10 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>12 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
</tbody>
</table>
(c) County Council Financial Policies

4.75 The county council’s financial policies in social services pre-1983 had resulted in spending being almost the lowest overall in England and Wales in comparison with other county councils and in some significant areas of provision, the lowest. Paul Hudson, director of social services, who retired in 1985, had warned his committee in 1980 that reductions had evem by then made ‘a real drop in standards of service to the public’ and that taking into account the continuing rise in demand of about 8 per cent per annum ‘in a two year period the gap between resources and demand (was) about 24 per cent’.

4.76 Over the whole social services department in 1983/84 there was growth of £1.3 million, savings of £600,000, leaving a net growth of £700,000. It was possible for £197,000 of the savings to be made as a result of rate relief on homes for elderly people, but the remainder, £354,640, was saved by the re-organisation of child care services. The way in which this requirement for savings affected the service was that it could only be achieved by major reductions in the numbers of residential beds available for children in care, which in its turn would bring a major reduction in numbers of staff and other costs.

4.77 There was a reduction in the number of residential establishments and also in the number of beds in some establishments as in the case of The Birches, Newcastle-under-Lyme, where 22 beds were cut nominally to 15 although the number of children remained the same as before, or increased. The staffing establishment was related to the reduced number of beds not the number of children for whom care was provided. Even with the average reduction in the number of children, for cost reasons the number of staff allocated was considerably less than national guidelines recommended. (Castle Priory report, see Chapter 3, para. 3.9.)

(d) Social Services Re-Organisation

4.78 The re-organisation of child care residential services agreed in July 1982 and implemented on 1 April 1983 (for the details of which see chapter 3, paras. 3.40 to 3.44) had been preceded by a number of smaller changes which were an essential part of the background against which it took place.

4.79 Staffordshire had decided in 1980, with the agreement of the West Midlands Regional Planning Committee to close its former girls approved school, Rowley Hall, and to make Riverside (also formerly an approved school – then a community home with education) a co-educational establishment with an age range from 11-18 years. This involved a reduction of 30 beds: from 110 to 80 in all, 60 for boys, 15 for girls and 5 for intermediate treatment.

4.80 Although demand for residential places had been growing and the proportion of children in care in Staffordshire who were boarded out was significantly lower than the national average, residential child care beds had been reduced from 716 to 453 between 1976 and 1982.

4.81 Staffordshire had also ‘systematically withdrawn wherever possible from the use of local authority and voluntary homes providing education on the premises’. [Director’s report to the House of Commons Social Services Committee representatives 1982] Apart from children with exceptional needs the policy was to provide for the requirements of children in care within the homes in the country.

4.82 On 1 April 1983 the re-organisation of residential child care services began to be implemented. In the few months between July 1982 when the policy had been confirmed and 1 April 1983 the implementation date, it had not been possible to do as much planning and preparation as would have been desirable. To make the new family centre scheme work effectively 164 children in residential care needed to be returned to their own homes or found foster homes. Without significant additional field social work resources this objective was only partially met.

4.83 Financial policy had led to a reduction of the numbers of residential child care beds. The provision of staff for the family centres and other homes in the re-organisation was also affected by financial policy. For eleven family centres comprising 155 beds, only 149 (whole time equivalent) staff posts were
allocated. These included 39 which were either clerical, administrative, or domestic/handyman/gardener posts.

4.84 Included in the 110 social work posts were 9 area officers and 11 team leaders all of whom had work outside the family centres or managerial responsibilities within them. Of the remaining 90 social work posts half were social work assistant posts at salary levels unlikely to attract experienced or qualified staff. Taking shift work and sleeping in duties into account, the staffing ratio did not allow for more than two people to be on duty for much of the working week.

4.85 The long stay children’s homes in the re-organisation had both lower staffing rates and salary scales than the family centres.

4.86 The semi-staffed units which took the place, after re-organisation, of what had formerly been working boys and girls hostels, now had only 70 hours a week of staff time to cover all adult responsibility to a group of school leavers learning to become independent and to earn a living.

4.87 Not only had the staff in the family centres to cope with the full range of children’s problems but, in addition, they were to contribute to work with day nurseries, play groups, child minders, fostering and family support in the community.

(e) The Career of Tony Latham

4.88 Tony Latham became area officer (family centre) in Newcastle-under-Lyme on 1 April 1983. While he was a social worker in Longton he had developed a number of voluntary activities for which he continued to be personally responsible after 1 April 1983.

4.89 These activities at the 1 April 1983 were as follows:

(a) Community and Social Services Transport (commenced January 1977);
(b) Community Warehouse (commenced January 1977 – became a Manpower Services Commission Scheme 1978);
(c) Voluntary Transport (commenced January 1978);
(d) Blurton and Milton day centres for elderly people (commenced May 1979);
(e) Longton Volunteer Centre (commenced May 1979);
(f) Community and Social Services Youth Training Ltd. (commenced August 1979);
(g) Grosvenor House Community Project (commenced January 1980);
(h) North Staffs Resource Community Programme Ltd. (commenced April 1983);
(i) Playbus Project (Newcastle) – (commenced January 1983);
(j) Mobile Day Centre Project (commenced January 1983);
(k) Information and Resource Centre (commenced January 1983);
(l) Intermediate Treatment (commenced in early 1970's in Stoke).

4.90 When Tony Latham started in his post as area officer, he considered that the premises at 245 Hartshill Road were very poorly utilized: ‘the top floor of the three-storey building housed the beds and residential accommodation for the young people who were placed there. The first floor contained a large television room which was not used by the residents and two flats which had been occupied by resident staff when the building had been used as a long stay unit. I therefore developed the first floor of this building for use as an administrative centre for The Community Programme . . . (which) was designed so that the workers could be used very flexibly’. As area officer (family centre) he was responsible to the principal area officer for the children’s residential units and their staff. He also had ‘to play a major part in developing such activities as fostering, intermediate treatment, pre-school playgroups, liaison with day nurseries and child minders, and to be involved in treatment programmes’.

4.91 Some of the enterprises listed above in paragraph 4.89 provided services which were supportive of general social work with different client groups, for example, The Playbus Project serving children under
five, in particular, who were part of Tony Latham's responsibilities and the day centres serving elderly people still living in their own homes, who were not. Volunteers and youth trainees were some of those who helped to run the projects. The Community Warehouse was intended to make use of furniture and other equipment no longer needed by its former owners to help families with inadequate resources or trying to set up house again after periods of homelessness. Intermediate treatment was part of a developing national programme for children and young people at risk (see Chapter 3, paragraph 3.1).

Some of the transport projects were used to get clients, including children in care, to the services they needed. In the case of children in care they went to schools they already knew rather than having to go to different schools. A characteristic of the many projects and activities generated by Tony Latham was the way in which they were organized to inter-relate, using each others' resources with a disregard for boundaries between them, including financial boundaries. This made for great flexibility in a situation in which scarcity of resources was endemic but it also created certain problems of accountability and definition. Tony Latham indicated in his written submission to the Inquiry that he had already begun to realize in 1983 that 'the whole network which had been built up was becoming increasingly unwieldy'.

4.92 There were as many as sixty people involved in the North Staffs Resource Community Project Limited, most of them recruited from job centres. There was, before long, a movement between enterprises such as this and the child care work which the Inquiry was asked to examine. Some of those who first worked in the North Staffs Resource Community Programme Ltd. and other projects were later appointed to posts in the children's residential homes as, for example, social work assistants, or social aides, from which they were later appointed to posts as social workers, although unqualified.
Chapter 5

1984

(a) National Events

5.1 The London Boroughs Regional Planning Committee's report on secure accommodation was published during 1984 ("Secure Accommodation – Policy and Practice"). One of the issues dealt with in the report was staffing: 'secure units . . . require more staff than have been customarily provided in open establishments. . . . During the hours of sleep, the minimum is the number of staff on active duty and one sleeping in or on immediate call. The exacting nature of the work makes it particularly necessary in secure units to ensure that staff have their proper time off. Shifts should overlap so as to provide for effective handover.' This supported the views on staffing which had been expressed in a local authority circular (75(1)) issued by the DHSS in February 1975. The London Boroughs report recommended that 'a ratio of one member of staff on duty to 2 children may be appropriate.'

5.2 'Children in Care – Second Report from the House of Commons Social Services Committee Session 1983-1984' was also published in 1984 (28 March). The Committee were at pains, in paragraph 14, to make clear that in their view children in care should not be seen to constitute a group apart: 'the majority of children are in care not because of their behaviour or characteristics but because of circumstances beyond their control in their family circumstances. . . . It must never be forgotten that . . . the care system is designed primarily to provide protection for children against adult society rather than protection for society against children' (emphasis added.)

5.3 As already noted in Chapter 3, para. 3.11, the Committee had visited Staffordshire in December 1982 and there were a number of issues addressed in the report which were of particular relevance to Staffordshire.

5.4 One of these was non-school attendance. The Committee took the view that 'truancy rates represent a serious failure by schools in their primary function of ensuring that children turn up to be educated.' Whilst they did not wish to see the courts used as a first resort in ensuring school attendance, the evidence they received led them to regret the length of time which often elapsed before court action was taken. They recommended in paragraph 57 'that the education welfare service should bear in mind that a court appearance, even if not leading to any order, can in some circumstances have a beneficial effect on truants.' The Committee also concluded that 'a co-ordinated approach to non-school attendance is at present conspicuous by its absence', and argued in paragraph 58 that although there were clearly problems in the relationships between education and social services departments, 'it must . . . be recognised that an authority's prime responsibility is to see to it that a child is educated. . . . Facing up to the consequences of that truth might lead to a more co-operative spirit between education and social services departments.'

5.5 A second issue of importance in Staffordshire which was highlighted by the House of Commons Social Services Committee's report was 'the number of changes of placement which children in care undergo . . . shunted around within the system.' They believed that this 'must be regarded as gravely disturbing for the children who experience such impermanence and may well make a child's problems worse and thereby less able to settle.' The Committee recommended in paragraph 156 that 'priority in policies . . . be given to reducing the number of changes of placement.'

5.6 Two further issues addressed by the Committee which were of importance in Staffordshire were the medical care and education of children in care.

5.7 The Committee received some very critical evidence on the health of children in care from the British Medical Association, the Royal College of Psychiatrists and the British Paediatric Association. In consequence in paragraph 332 they took the view that 'a child coming into care . . . offers a positive opportunity to ensure that he is receiving the full range of medical service that he needs. That his 'parent'
is a local authority should mean that more effort is devoted to watching over his development and health, not less. Those responsible should be reminded of the positive potential for benefitting children in care.' The Committee recommended that as a minimum requirement to protect the health of children in care there should be a named medical adviser generally responsible for the oversight of their physical and mental health.

5.8 The Committee were also deeply concerned about the education of children in care. They believed that they were at a disadvantage which as 'over and above' that which they suffered from their home circumstances. Sometimes they became 'footballs of two local authority departments', an 'intolerable' situation in which 'the child concerned receives less and worse education as time goes by.' They urged in paragraph 346 that 'educational ambition on behalf of children in care should not be confined to a child's performance in school, but must also extend to . . . other activities such as sport, music or dance.' In fact they saw this as no more than 'the degree of encouragement, advice and if need be, financial support that a good parent would give, and in this and other respects a local authority must aim at being a good and not an average parent.'

5.9 Other major points the Committee made which were of particular significance in the context of the Staffordshire Child Care Inquiry were:

(a) the 'due consideration' to be given to a child's wishes and feelings under Section 18 of the Child Care Act 1980 which they concluded must be given in full on placement decisions;
(b) the benefit to children and staff from a much more open approach to sharing responsibility for the quality of life in a residential home;
(c) the statutory duty on local authorities to ascertain and take into consideration children's wishes which should be clearly understood to include a duty to procure for each review an explicit statement of a child's wishes; that older children should be encouraged to write a report for their review; and that the outcome of a review should be fully explained to children;
(d) that the training of residential child care staff is a priority in improving the long term standard of care for children, and that it must soon be recognised as exceptional to recruit unqualified staff to anything other than the lowest grade.

(b) Staffordshire and its Social Services

5.10 The first entry in the log book for 1984 for 245 Hartshill Road was on 10 January when it was recorded that a boy who had run away from school again was 'being detained - in the Special Unit.' He 'was complaining of stomach pains which (were) most probably caused by hunger' in the view of the staff member on duty. It was also recorded that Philip Price arrived and gave the boy some cereal and milk 'to bridge the gap' until supplies could be obtained. His supper was cereal again and a cup of tea because supplies arrived so late in the evening that he was in bed before a meal could be prepared. His breakfast at 6-30 a.m. was also cereal and milk and the log book records he had 'beans on toast for dinner'. He was discharged to The Birches on 12 January and there were no further entries in the log book until 17 January.

5.11 On 17 January 1984 at about 9-40 p.m. Tony Latham brought a boy into the home. The log book records that 'he was made to take his clothes off and have a bath and was put straight into bed'. The next day a member of staff, Ray Crudace, recorded that he was unable to let two boys have baths, 'dew (sic) to no towels . . . Tony ovried (sic) went to get some . . .'. The next day, 19 January, Glynis Mellors recorded that no toothbrushes or combs were available. She also set the three boys in the unit a '3 side essay on what they thought of each other - set competitive element - threat if not done PE outside for 15 minutes'.

5.12 The first recorded instance which we found of the use of the term 'Pindown' was when Ray Crudace wrote in the log book on 20 January 1984: 'Phil and Tony visited and pinned down (emphasis added) J . . . confined to his bedroom unless requested staff to come out . . . to be kept from R . . . and all times no contact . . . J. to have a restriced (sic) w/end of meditation to attempt to resolve his current attitude and feelings. 3 hours written work each day, but time to discuss his feelings with staff should be
available'. This seems to have been copied from a 'programme' drawn up for this boy although it was not produced to the Inquiry. Two days later on 22 January another member of staff recorded about this boy, 'the one thing other than boredom that seems to be getting to him is not being able to talk to anyone, and (sic) can see the benefits of good behaviour in helping him to restore his privileges and his eventual return to The Birches'.

5.13 Peter Crockett, assistant director, had meetings with the senior staff group in January, February and March 1984. Proposals were to be put to the social services committee concerning reduction of the numbers of beds at Riverside (community home with education) and the opening of a secure unit. The question of offering some staff help from Riverside to family centres was also being considered. A report was given from the Riverside Co-ordinating Committee which also met during this period. They had discussed the high numbers of residents at Riverside and the problems of 17 young people who were considered ready to leave but who had nowhere to go. Reviews had been carried out, but although there had been many recommendations for places in semi-staffed units, there had been 'no movement'. Special measures were held to be necessary to deal with the 'bulge'. Other relevant matters raised were that Eileen Robinson, principal assistant (casework), was preparing to make material on the Community Homes Regulations 1972 and measures of control available to all principal area officers; and Peter Crockett himself was conducting a review of the work of family centres for a report to the social services committee.

5.14 There were no entries in the measures of control book for 245 Harthill Road from 17 January to 26 April 1984. On 17 January Tony Latham authorised 15 hours in the special unit for one boy, 2 days and 15 hours for another, 5 days and 15 hours for a third and 2 weeks initially for the fourth. These entries were followed by the signature of an official visitor (undated) and the next entry in the measures of control book was dated 26 April 1984. From that date onwards no further details were given about the lengths of time during which a young person would be in the unit. Unlike the detailed entries of measures of control which were made pre 17 January 1984, the entries under that heading after 26 April followed, in the main, a routine pattern of 'loss/forfeiture of privileges, loss of recreation and/or simple chores'.

5.15 The log book for 245 Harthill Road provided a different picture from the measures of control record. On 23 January 1984, Ray Crudace recorded that S. was 'very upset to be back in the special unit'. On 29 January he recorded three additional residents in the unit, a total of five in all. The log book then had no further entries until 17 February after which it continued on a daily basis.

5.16 On 31 January 1984 Eileen Robinson, principal assistant (casework), had paid a statutory visit to 245 Harthill Road. The log book did not mention this visit and the report she wrote was not amongst those produced to the Inquiry. From the correspondence and action which followed, however, it was clear that the visit was a significant event. Eileen Robinson wrote about it to Peter Crockett on 16 February 1984 and also recorded a long note for the file, dated 16 February, of a meeting she had had with Elizabeth Brennan, principal area officer Newcastle-under-Lyme, and Tony Latham, area officer (family centre), at which the findings of her visit were discussed. The date of this meeting was not recorded but the file note comprised a first page commencing 'I had a meeting with Mrs Brennan and Mr Latham' which then recorded some of the discussion, and was attached to two further pages which were copies of her three page memorandum to Peter Crockett. This memorandum had followed a discussion she had with Peter Crockett and was intended as an 'aide memoire for (his) use and to place on record the factors which (she) regarded as unacceptable risks to residents and property'.

5.17 The aide-memoire listed 'the unacceptable risks' a summary of which is as follows:

**Exterior** - grass area ploughed up by car tracks, grass bank apparently used as a footway, peeling paintwork, excessive amounts of litter and rubbish, car parking area 'blatantly' used by a member of the public, broken off concrete bollard in the grass and a parked folding caravan at the rear.

**Inside** At 4.15 p.m. when Eileen Robinson had called she could get no reply. A 'community worker' was eventually found 'working' in a 'workshop'. He then locked up and went 'off duty'. No member of
staff was present. Eileen Robinson waited till 4-30 p.m. and another volunteer then rang the family centre (The Birches) and Philip Price arrived. He said that there was sickness amongst the staff and no-one had reported for duty for three or four days. He added that that night there was cover from 7 p.m. ‘by a casual’ (sic) (volunteer and care aides) but explained that the general state of the ‘hostel’ as due to no staff. Eileen Robinson continued ‘two young male residents were in the building – no sign of any food or preparation for a meal by the time I left at about 5-15 p.m.’.

5.18 She also saw a sixteen year old West Indian mother and her baby about whom she had some anxiety in that setting. She complained that ‘the bedrooms and sitting room allocated to residents on the top floor were not in an acceptable condition’. The major area of other rooms had been put into use for YTS and other training and in the grounds was a Portakabin used for the ‘paperwork of the Manpower Services Schemes’. The intermediate treatment manager had part of the building and groups were taking place several nights a week. Garages had been converted into workshops and were being used by YTS trainees. The North Staffordshire Activities Unit had been located in 245 Hartshill Road and £10,000 worth of camping and other equipment bought with the Rainer Foundation grant was stored there. Eileen Robinson reported that she had been told that daytime MSC supervisors became voluntary intermediate treatment supervisors by night. She told Peter Crockett she was also aware that ‘every volunteer and any supervisor who is involved in any of the centres (family centres) has also been approved as an “Approved Volunteer” through this office’.

5.19 In the file note of her meeting with Elizabeth Brennan and Tony Latham following her statutory visit on 31 January 1984, Eileen Robinson recorded that 97 children had passed through The Birches (presumably since it became a family centre on 1 April 1983); that there were 26 children currently in residence though numbers fluctuated a little; that young people at 245 Hartshill Road, other than the teenage mother, had been found lodgings and would be moving out. ‘In addition’ she concluded ‘the friction between the Area and the schools has ceased, every non-school attended that have resolved (sic) and the youngsters are back in school, and the relationship with Courts have improved through visits to the Family Centre’.

5.20 In response to Eileen Robinson, Philip Price had said that for some days just before 31 January 1984 no staff had been available for 245 Hartshill Road. The 245 Hartshill Road log book, however, recorded continuous occupation by boys in the special unit from 10 January to 18 February, with the exception of 13-16 January, although there was no record of them in the measures of control book.

5.21 Fred Hill, senior assistant (child care) was another member of headquarters staff involved in the Newcastle area’s child care service. He had succeeded Elizabeth Brennan when she became principal area officer in Newcastle-under-Lyme. He was accountable to Eileen Robinson and also to William Pierpoint, then principal assistant (service delivery). Their line manager was Peter Crockett, assistant director (service delivery). Fred Hill’s responsibilities included oversight of buildings and equipment in residential child care establishments, supervision of homes advisers, staff recruitment and advice on staffing. He was also concerned with capital programmes, fire prevention, staff rota and ‘cover’, disciplinary matters, implementation of re-organisations and a range of other related matters. He told us in evidence that in 1983 he had to relate his responsibilities to the whole county. He was also one of the rota of senior staff responsible for carrying out statutory visits under the Community Homes Regulations 1972.

5.22 On 16 February 1984 Fred Hill visited The Birches and the following day reported in writing to Peter Crockett. Because of the breadth of his responsibilities he told us that he would only have been likely to visit any residential establishment for a specific purpose, though after the lapse of time he was unable to identify the initial purpose of this visit. Fred Hill was known in the social services department for his careful and prompt recording of his work. On this occasion his promptness in writing to Peter Crockett was related to concern raised by a conversation with Tony Latham about ‘the transfer for short periods of persistent absconders at The Birches to 245 Hartshill Road’ and the fact that some of the

12A See appendix H.
practices outlined to him appeared ‘to be in contravention of the Community Homes Regulations on control’ (emphasis added). He thought Peter Crockett might be aware that occasionally a maximum of four children from The Birches were accommodated with a member of staff in continuous attendance in a bedroom and sitting room at Hartshill Road. ‘The facility is used when a child needs to be withdrawn from the group at The Birches following persistent absconding, to undergo a programme of behaviour modification’ (emphasis added).

5.23 He identified the features of this behaviour modification programme as follows:
(a) a member of staff on occasions slept in the same room as the children;
(b) although no one was locked in, the basic aim was to discourage further absconding;
(c) as a further deterrent to absconding each child had initially to wash his/her clothes which were not returned for periods up to 36 hours, during which pyjamas or PE kit were worn instead;
(d) additional measures included loss of privileges, loss of recreation, imposition of household chores (children did all the cooking and cleaning), withdrawal and transfer of pocket money into children’s savings and additional education and recreation, the latter in the form of physical exercises. These measures were relaxed or increased according to progress and might vary from 24 hours to a few days.

5.24 It was claimed that the unit had a high degree of success but Fred Hill felt that restriction of a child’s liberty by the almost constant presence of a member of staff was difficult to reconcile with the regulations. He also thought that holding back pocket money ‘as a punishment’ fell outside the regulations and that the domestic duties being performed by children went beyond the imposition of a minor but unwelcome chore. Removal of clothing, though used as a measure of control occasionally in other residential establishments also appeared to Fred Hill ‘to fall outside the regulations’.

5.25 Fred Hill told Peter Crockett that Tony Latham had accepted that procedures must comply with the regulations and that practices regarding pocket money, household chores and additional recreation (i.e. physical exercises) were questionable and would have to be modified accordingly. Tony Latham had been asked ‘to enter the measures taken (including withdrawal of clothes if this happened) more specifically on a day to day basis rather than the ‘blanket measures which appeared to cover the total stay of a child’. Fred Hill ended his memorandum to Peter Crockett with the words: ‘I feel that clear direction and advice is required in this case to protect both the interests of children and staff and I would recommend that further discussions take place with the area so that the activities of the unit can carry on but that they are brought into line with the Community Homes Regulations on control’.

5.26 Tony Latham’s knowledge of the Community Homes Regulations 1972 was clearly demonstrated in the document which he wrote and signed on 8 November 1983 only five days after the first three young people were taken into the special unit at 245 Hartshill Road (see appendix G).

5.27 We examined the measures of control records of children’s establishments at Moorview, The Alders, The Birches, Heron Cross, Wood Street, 245 Hartshill Road and 100 Chell Heath Road for the years 1979-1989 in relation to taking away children’s clothing and substituting nightclothes or PE shorts as a deterrent to absconding. What we found was that Moorview, The Alders, The Birches, 245 Hartshill Road, Heron Cross and Wood Street records showed no incidents or only a handful over the years. Only one establishment, 100 Chell Heath Road, showed numerous incidents during 1986, 1987, and 1988 only. However, examination of the 1986, 1987 log books of The Birches showed many incidents of removal of clothing and substitution of nightclothes or shorts which had not been entered in the measures of control record. These continued to occur and one such was on 26 February 1984 only a few days after Fred Hill’s discussion with Tony Latham. The girl involved, who was later to spend a considerable time in Pindown, was disciplined by being put into pyjamas and dressing gown. At 245 Hartshill Road, in spite of Tony Latham’s undertaking to Fred Hill and his own memorandum to ‘ALL STAFF’ on November 1983, removal of children’s clothes and substitution of nightclothes or PE shorts continued but was not identified and recorded in the measures of control book. It was, in fact, only the day after Fred Hill discussed these issues with Tony Latham, that Jaime Rodriguez made a relevant entry in the log book of the ‘special unit’. A boy who had been brought into the home by a social worker was ‘made to go in bath (sic) and change into shorts’.
5.28 One of the five boys who had been in the unit on 29 January 1984 was recorded on 17 February as entering the unit again. Two other boys appeared to have been in the unit for unrecorded periods prior to 17 February. On 19 February there were four boys in residence and Tony Latham was on duty from 9-45 a.m. – 6 p.m. He undertook a further period of duty on 20 February from 11-30 a.m. and used the opportunity, as he recorded, for ‘putting in basic organisation to the unit’, for example ‘beds and bedding with pillows organised for all boys’. He ‘explained . . . future . . . expectation of meal times to be better organised with tablecloths and tables laid’. He added that ‘basic luxuries’ such as ‘our hoover, ironing board, pots and pans etc. etc. have now been provided to the I.T.U. (Intensive Training Unit) to avoid the constant need of borrowing from the semi-staffed unit’. The log book entry ended: ‘still a lot of work to do with this little tribe if the success of this venture, this time will work’.

5.29 Entries in the next few days recorded that a schoolboy had gone to work at Duke’s Lodge, Tony Latham had been taken ill, and a worker named Chris Thomas explained how he had read riot act to the boys in the unit on 26 February 1984. ‘I said that if they wanted me to continue to show some humanity that I wanted something from them in return, otherwise I could be as big a b. . .d as they liked, the choice was theirs. I think I made some impression.’ On 27 February 1984 when he returned to duty he found the boys had all ‘bobbed school’. They were put in separate parts of the unit to await Philip Price’s arrival: ‘no food, allowed one drink for the first three to arrive.’ They were interviewed by the police at about 17-30 and given ‘the official “slapped wrist”’. Philip Price arrived at about 8-30 p.m. but could not see the boys because he was showing magistrates around the building. The boys were given sandwiches (except one ‘who didn’t like the filling’) and got ready for bed. At 9 p.m. when Philip Price was free again he told Chris Thomas he would see the boys in the morning. Tony Latham was back at work by then and the boys were taken to The Birches to be seen by him and Philip Price.

5.30 The log book for 5 March 1984 records that P. a school boy had spent the day before, Sunday, at Duke’s Lodge working and that his clothes were wet and dirty but there was no washing powder available to deal with them. The next day there were no toilet rolls available. P. was recorded as ‘throwing up. I told him to have nothing to eat for 24 hours gave him some milk of magnesia’. There was no suggestion of seeking medical advice. The next day, 7 March the milk had gone sour because, due to there being only one power point, the refrigerator had been turned off to accommodate the television and replacing the plug had been forgotten. No bread or milk were available during the day. On 8 March the boy P. was still having stomach pains (for the third day). The log book records: ‘gave him milk of magnesia’. There was still no suggestion of calling a doctor. On 9 March the midday meal for the school boys (including P.) was corned beef and meat paste sandwiches, their evening meal a cup of coffee, three slices of toast, and half a tin of cold rice pudding. Ray Crudcace, on 10 March, recorded ‘Dinner’ – sandwiches and coffee. On 11 March a member of staff ‘arrived with some washing. So D. (a boy) did the washing’.

5.31 On 12 March 1984 Tony Latham undertook another short duty at 245 Hartshill Road. He recorded it in the log book as follows: ‘took over from Bob (Sharpe). Blasted everyone out. Good tidy up and Hoover up. Tidy cupboards (sic) and bathroom. . . . Keep pressure up to keep unit straight.’

5.32 On 21 March 1984 a member of staff, Terry Kendrick recorded that a boy had absconded from the unit. He was ‘brought back at 11-25 p.m. Stripped of his clothes and in the Bath and went straight to Bed.’ Two days later the same boy absconded again and on his return, it was recorded that: ‘C. was to be kept strictly isolated with no contact at all – dressed in shorts only’. A few days later when he was seen by Tony Latham who decided his new weekend programme, the programme contained as a final item recorded by Ray Crudcace, ‘able the (sic) where (sic) his clothes’. Meanwhile, a member of staff on 24 March noted ‘C. asked for book to read as he had finished his work given to him by Mr Price. I refused to allow him this and sent him for a bath instead, telling him that reading a book was a privilege, and that he had none’.

5.33 In the last few days of March 1984 there were several log book entries which illustrated the basic problems of the unit’s environment and catering. On 24 March the ‘sideboard containing crockery and cutlery finally collapsed’; a member of staff, Carole Taylor, on 26 March commented in the log book that ‘at the moment no proper meals are been (sic) eaten and no times are set. This needs seeing to’. The next day 27 March, she recorded: ‘the lads will be allowed 2 pints of milk a day. If they want extra they are to
buy their own.' This same member of staff two weeks later was on duty with two boys, one of whom was recovering from German measles. She wrote: 'both of them refused breakfast because I told them to have one bowl of cereal only. Personally I don’t think that it (sic) unreasonable because at the moment they are getting through too much milk and cereal. Will discuss it at the morning meeting'.

5.34 Peter Crockett had been carrying out a review of family centres during the spring of 1984. His report on the review was considered at the 30 April meeting of the Social Services General Sub-Committee, just over a year after family centres were set up. It was a long report which offered a section on general matters and then a review of each of twelve family centres, with a very brief note on semi-staffed (independence) units. There was an account of the adverse effects of the industrial dispute in which residential staff had been involved. The Committee’s attention was also drawn to the inadequacy of domestic hours for cooking in many establishments and the effects of this. A number of positive outcomes were claimed for the re-organisation, and some problems acknowledged.

5.35 The Newcastle-under-Lyme family centre was the subject of a long and enthusiastic account, but one which at no point revealed that The Birches and 245 Hartshill Road were being run as a joint undertaking, nor that there had recently been anxieties raised in correspondence with Peter Crockett concerning the ‘special unit’. The short paragraph on semi-staffed units also made no mention of the special unit at 245 Hartshill Road. The only related comment was that ‘interesting schemes have been developed to cope with absconders from school’. . . . The semi-staffed unit has been used partly for that purpose.

5.36 The positive report given by Peter Crockett was one side of the coin. The other side was evidenced by the numerous log book entries written down during the first half of 1984 by staff at the special unit who were critical of the Heath Robinson, poorly organised and ‘hand to mouth’ arrangements which governed day to day life in the unit for children and staff alike. Even Glynis Mellors, a keen and loyal supporter of Tony Latham, was exasperated by the very poor provision made for meals.

5.37 On 5 May 1984 a girl was brought into the special unit, the first since it was set up. It was recorded by a residential worker that she ‘came in with a smile on her face and greeted me as though nothing out of the ordinary had happened. I made no reply to her greeting’. The girl was expecting to be interviewed by the police and wanted to be able to talk to the residential worker who wrote that ‘I ignored this’. Whilst with the policewoman the girl was very distressed and later the policewoman asked about the reasons for the special unit and how long K. would be in it. She was told that K. would be in the unit ‘for however long it takes to achieve aims of program (sic)’. When the girl asked to wear pyjamas instead of a nightdress in Pindown, the residential worker acknowledged in her log book entry that ‘it is very cold in here’. Later the girl tried again to talk to her ‘but realizing I was not going to converse returned to the bedroom saying “I will go out of my head if I stay in here”’. Shortly afterwards she was heard ‘sobbing her heart out’. Having asked if she could speak to her social worker or to Tony Latham or Philip Price and been refused all three, ‘she again threatened to commit (sic) suicide’. When she came out of her room to try again to make contact the worker recorded that she ‘told her that she would be punished further if she would not comply with the rules’. There was no information in the log book about why this girl had been admitted nor her legal status in care.

5.38 On the following day, 6 May 1984, a worker whom the girl knew and had been asking to speak to, offered to bring some items which she needed from the Birches. She was told that someone the girl did not know was to come since otherwise it would be difficult to ‘ignore her questions’. The worker in this episode finally recorded that she was putting the girl on to cleaning the unit which she described in the log book as ‘a mucky hole’. When this girl, who had had no drink in the early morning with her breakfast, asked if she could have one at noon, she was told that she would have to wait till lunch time.

5.39 Later on in May 1984 one of the boys in the special unit was visited by his father who, finding him sitting in the Pindown room in his underpants, removed him. John Aston who was on duty at the time recorded in the log book: ‘decided that physical reaction inappropriate simply OUT NUMBERED’.
5.40 In early June 1984 there were several entries in the log book which described the distress of children refused contact with parents, even on the telephone. One of these children who had been refused such contact on two consecutive days was then recorded as having been taken to Duke's Lodge where he filled 162 bags of leggs. He 'worked very hard'. He was eleven years old at the time. He and the staff member who went with him had not been able to take any sandwiches with them because there was neither bread nor butter available at 245 Hartshill Road, in the unit. Tony Latham's wife gave them something to eat.

5.41 Sleeping arrangements for the group in Pindown were difficult. One boy on 16 June 1984 was sleeping on a mattress in the hall. Further bunk beds were installed. Later on in June a female member of staff was recorded as having slept in the same room, the back Pindown room, with an adolescent girl who had just been admitted. When this girl arrived at 1-20 a.m. on 20 June all the other young people had to get up and move around so that she could be accommodated.

5.42 During June 1984 a number of log book entries indicated that staff were having difficulty in managing the group of young people. On 12 June one staff member writing about two children who were misbehaving said he 'threatened to throw a bucket of cold water over them'. On 17 June a boy was made to wear pyjamas for being aggressive to another child. On 26 June there was a two page entry giving a detailed weekend programme for a girl who was to spend a considerable amount of time in Pindown later on. Tony Latham wrote the programme: 'any staff member deviating from this programme without first checking with me will be severely (sic) dealt with'.

5.43 Two days later on 28 June 1984 it was recorded that Lord Hunt, of the Rainer Foundation, which had been entrusted with administering government funds for intermediate treatment, had visited The Birches and that the day care group there had very much enjoyed his visit.

5.44 Also on 28 June 1984 a neighbour of 245 Hartshill Road telephoned the social services department headquarters to make a number of complaints about the activities that went on there. Fred Hill took the call. The complaints made by the caller concerned:
(a) lack of supervision in general;
(b) two children on the roof on 24 June (other children it was said had been on the roof on other occasions);
(c) problems of parked vehicles;
(d) noise;
(e) lack of planning permission for the activities in the garages/workshops;
(f) a drunken teenager in the grounds on an unspecified date;
(g) unsuccessful attempts to speak to Tony Latham about the other complaints.

5.45 Fred Hill telephoned Tony Latham on 29 June 1984 and urged the arrangement of a meeting with the complainant. Tony Latham claimed to have spoken to the complainant and his wife on previous occasions but undertook to arrange a further meeting. The matter of planning permission, it was agreed, would be investigated. As far as we are aware the outcome was not recorded.

5.46 During the first half of 1984 Philip Price produced a document which was concerned with a staffing rota at the family centre which implicitly included both The Birches and 245 Hartshill Road. He wrote it as team leader without prior consultation with his line manager Tony Latham. It was untitled and we were told that it was produced mainly for staff working at the above two establishments. We have given the document the identifying number 1 and a copy of it appears in appendix F together with seven other documents (numbers 2 to 8) which came into existence between 1984 and 1989 and which we have called the Pindown Documents.

5.47 The first part of document 1 deals with sleeping in duties at both buildings, with case records, planning of working weeks, staff meetings and morning management meetings. There was then a separate section which focussed specifically on 245 Hartshill Road. It envisaged increased numbers of people involved in activities in the building and increased uses for the building. Six separate areas within
the building were identified. They were:

(1) The main landing for children who had developed to a point of self help skills but who still required firm consistent handling with a positive base to operate from, and positive relationships (this was on the first floor above the ground floor);

(2) The flat downstairs accommodating two residents who have reached ‘a reasonable stage in their development’ requiring less staff input and more decision making;

(3) ‘Special unit – to be treated separately from all other units at all times with very specially devised plans which should be adhered to at all times and not changed without approval of review. It is envisaged that all residents will receive a weekly review some with family, others with social workers etc.’;

(4) Schoolroom;

(5) Dining area – adjacent to schoolroom for all meals except for those on self help programmes;

(6) Another flat – to become a flexible resource to be used in any way seen as appropriate by the area officer or the writer of the document.

5.48 The document stated that except for sleeping in there should always be two staff on duty, one being a senior. ‘The emphasis of the unit should be on working with the clients, positively where appropriate to achieve the aims of individual programmes.’ Programmes were to include menu planning, budgeting, washing, ironing, mending, cleaning of bedroom, counselling. The ‘little office’ was not to become a ‘congregating point’ for staff. What was expected was that staff would be working ‘alongside clients achieving and striving towards the individual’s programme’. Morning management meetings would identify special cases within the special unit, involve a community programme representative (though they would remain separate) and discuss day to day running and routine needs. The document concluded with the hope that discussions would ‘help resolve many of the anxieties . . . facing the total staff team in making this work’. The writer saw ‘the move’ as ‘another exciting development’ and ‘the next stage of family centre concept’.

5.49 Prior to August 1984, Tony Latham and Philip Price produced jointly a document called ‘Routine of the Intensive Training Unit’. They could not remember precisely when they wrote it. A copy appears in appendix F as document 2.

5.50 Document 2 laid down the ‘Rules of the House’. They defined the basic characteristics of the Pindown regime. On admission a child was to ‘bath and have a hair wash’. They would then wash and dry their own clothes. If admitted overnight this might be left till the next morning. In addition, ‘at the earliest possible time residents will be explained the “Rules of the House”’.

5.51 These rules included first a series of prohibitions and then one instruction. The prohibitions were:

(a) no ‘wandering around’ in the rest of the building without permission;

(b) no smoking without permission;

(c) no television without permission;

(d) no radio without permission;

(e) no making drinks without permission;

(f) no communicating out of windows without permission.

The instruction was ‘Do as is told’.

5.52 The training element in the unit was to be linked to social and life skills, ‘behavioural and educational’. Residents were to carry out all domestic work; getting up and bedtimes would normally be 7 a.m. and 8 p.m. The role of staff would be observing and assessing; the objective of training would be to ‘slowly expand to true and responsibility’. Tony Latham and Philip Price (referred to in the document as ‘Tony/Phil’) would ‘constantly oversee’ every case and one if not both would be involved every two days in reviewing a resident’s programme. Staff would keep ‘an accurate daily log of events and observations’. ‘In cases where “punishments” are imposed these should be carried out strictly in accordance with the Community Homes Regulations and recorded accurately.’ ‘Leave’ (for residents) would be granted according to progress, co-operation and achievement and completed on a leave form included in the guidelines. A copy of this form was not produced to the Inquiry. The leave forms could only be completed and authorized by Tony Latham or Philip Price.
5.53 The next section of document 2 was addressed to all staff at 245 Hartshill Road and, in particular, those involved in the main semi-staffed building and the Intensive Training Unit. It contained a list of instructions the overall effect of which was:

(a) to separate completely residents in the two parts of the building;
(b) to control telephone calls. Calls to social workers and parents could be made at staff discretion. Residents in the ITU were not allowed any incoming calls unless previously agreed by either Tony Latham or Philip Price;
(c) to ensure the functioning of the ITU it was to be independent of the semi-staffed unit in all respects. If facilities were inadequate to achieve this Tony Latham was to be notified immediately;
(d) to recognise that passing of cigarettes, messages and other ‘goodies’ was happening but to reduce it to an ‘absolute minimum’;
(e) to provide for specifically worked out and detailed programmes for individuals. These would be created by Tony Latham and/or Philip Price and were not to be ‘deviated from under any circumstances without their prior approval’;
(f) to ensure supervision was as close as possible to reduce absconding, though joint supervision of both parts of 245 Hartshill Road was recognised as being ‘appropriate’ at times;
(g) to make specific arrangements for a teenage mother and her baby living in the semi-staffed part of 245 Hartshill Road.

The matters contained in (a) to (g) above were set against the background of a general statement that ‘the philosophy being (sic) the Intensive Training Unit is undermined if the “Rules of the Establishment” are not strictly adhered to’.

5.54 Document 2 had an appendix entitled ‘Basic Programme’. This comprised first ‘a total loss of all privileges e.g. television, radio, cigarettes, visitors (other than family and social workers) no nights out’. Visitors were to be allowed by prior arrangement. Privileges were to be earned through co-operation with staff and decided upon at specified review times. Failure to sustain co-operation would automatically lose the right to privileges and the basic programme would again be enforced. The timetable of the day shown in the appendix to Document 2 was inconsistent with the earlier part of the document i.e. an hour shorter, but it showed all meals taken in the resident’s room, bath night and morning and what were described as ‘supervised activities and individual sessions’.

5.55 The final section of document 2 was entitled ‘Daily Tasks – Intensive Training Unit’. With further inconsistency, since earlier in the document it stated that all domestic tasks would be carried out by residents, it listed work to be done daily, weekly and fortnightly/monthly ‘either by Intensive Training Unit residents or by staff on duty’. The lists were a range of mainly domestic tasks, ‘neither exclusive nor exhaustive’ and to be ‘done properly, not rushed and one (sic) to a reasonable (sic) standard’. Reviews were included as a weekly task each Tuesday. Staff expected to be present would be Tony Latham, Philip Price, a key worker and/or social worker and parent ‘where appropriate’. The last two pages of document 2 were a variant on the tasks list and a variant on the ‘instructions’.

5.56 During July and August 1984 the log book entries focussed on a girl who had arrived in the unit in the early hours of the morning in late June. At times she was on a strict regime, the staff refusing to talk to her. She tended to shout out in her sleep and had bad nights. During the day she surprised staff by the amount of interest she showed in books. The log books recorded on 28 July that she had read ‘a whole book’ and then taken two more.

5.57 On 23 July 1984 Tony Latham visited 245 Hartshill Road and made a long entry in the log book. The first part related to entries of matters pertaining to morning meetings, jobs around the building and reports of visits to children’s families. The second part began with an exhortation to staff to sign their own entries, ‘how can I know who wrote that!!!’ he asked. His own entry then continued (all in capital letters) ‘What a lot of saints we have residents!! All jobs done to perfection, no problems reported from any residents – does this mean that they please themselves, are never asked to do anything that might cause a ripple or are they all ready to move to lodgings the little darlings!! Sorry I just can’t believe our programmes are so successful.

No cheek from P.!!
Complete co-operation from G.!!
R. M. happy and smiling
P. C. full of the joys of spring
Did you not have any stimulating conversation?
No wonder the staff feel so unproductive.’
Log book entries about individual young people painted a different picture from Tony Latham’s entry.

5.58 Glynis Mellors wrote in the log book on 2 August 1984 ‘in which gold mine do you search for cups? Or is it a matter of ‘throwing’ your own each morning?’ The statutory visitor in August 1984 was P. Warren who inspected 245 Hartshill Road on 15 August when Glynis Mellors was on duty. He reported that ‘painting/furniture/tidiness (was) generally poor’; there had been only minor restrictions, for example, loss of privileges as measures of control, but there was no adequate space for an office or for staff, that ‘nearly everywhere (was) bare/uncared for,’ and ‘most of youngsters rooms (were) depressing and reflect type of youngsters accommodated – they don’t seem to care’. Another statutory visitor, David Livingstone, who inspected during Philip Price’s duty, on 31 August reported ‘generally a progressive extension of work done at The Birches family centre was in evidence’.

5.59 John Aston on 13 August 1984 recorded in the log book that the girl who liked reading had asked for school work. He ‘put J. on domestic science. Cleaning kitchen!!’ On 14 August referring to a recent admission of a working age boy, Aston wrote: ‘no smoking, radio, television etc. Week of Specail (sic) Unit rules. (See Yellow Folder with rules in.).

5.60 The reference to the Yellow Folder was the first mention of a stiff yellow ring binder which was kept in the office of the Intensive Training Unit at 245 Harthill Road. It was originally put there by Tony Latham sometime prior to August 1984. There was a white label on the front of the binder with the following message signed by Tony Latham:

‘Intensive Training Unit.
This book is to remain in the Intensive Training Unit office and all staff are asked to make themselves fully conversant with the contents.’

5.61 Various documents were put in the Folder from time to time. When John Aston first referred to the Folder it contained document 2 (Routine of the Intensive Training Unit) and probably also a document entitled ‘Code of Instructions – Enclosure to Central Office Circular No 16/79 dated 10th January 1979 – Community Homes Regulations 1972 – Regulation 10 – Control’.

5.62 The other documents which were in the ‘Yellow Folder’ when it was produced to the Inquiry were:
(a) copy letter to Elizabeth Brennan, principal area officer from the director of social services dated 22 November 1984;
(b) copy letter to the director of social services from Elizabeth Brennan dated 25 March 1985 (a follow up to the letter of 22 November 1984);
(c) copy letter from the director of social services to Elizabeth Brennan dated 9 May 1985 (a further letter concerning the fire door);
(d) copy letter from the director of social services (Circular 138/86) dated 26 June 1986 and headed ‘Restriction of the liberty of children in care’, addressed to staff in the child care section;
(e) copy letter from the director of social services dated 25 October 1986 headed ‘Community Homes Regulations 1972, Regulation 10: Control, Secure Accommodation (No 2) Regulations 1982’ (sic) and addressed to certain senior managers (child care) Riverside, Tay-y-Bryn and statutory visitors;
(f) an undated document entitled ‘Principles behind the use of the Time Out Unit at 245 Hartshill Road’, and signed ‘by Chris Walley’;
(g) letter from the director of social services to British Telecom, headed ‘245 Hartshill Road, Stoke-on-Trent – Installation of additional line’ and dated 1 February 1988.

Copies of the documents in the Yellow Folder appear in appendix F under the general heading document 3. The undated document ‘Principles behind the use of the Time Out Unit at 245 Hartshill Road’ probably came into existence in 1989. Although signed in Chris Walley’s name it was not, he told us, written by him or signed by him. Walley was an area officer (children) Stoke-on-Trent until 1988 and then Juvenile Justice C5-Ordinator, North Staffordshire. The word ‘occasionally’, however, on page 2 of
the document was written by him.

5.63 The impact of the contents of the Yellow Folder was not discussed in the log book but entries soon afterwards display some ill-concealed frustration. On 22 August 1984 John Aston came on duty and found that information he needed was missing. He wrote ‘no communication. . . . No review book filled in. Good management this’. He found himself in disagreement with the admission of a boy to the unit and after returning from some outside work for which Philip Price provided cover he left a note in the log book for Price: ‘Well Phil. Obviously you don’t read log books and programmes’.

5.64 In early September 1984 John Aston was signalling through the log book for more information, this time about weekend programmes and the use of Duke’s Lodge. He recorded a sharp toned agenda of the issues he hoped to raise at the next staff meeting. A week later he wrote to a colleague in the log book ‘have you got the report book, you sod?’ The next day he had words with The Birches because the evening meal did not arrive till 7 p.m. By 22 September 1984 he was recording that the ‘washing machine (was) in . . . a disgusting and dangerous state’. A new arrival came in on 1 October and was ‘stripped to his pants . . . and school work set’. A few days later, 6 October, he recorded that the young people in the unit were not able to have an evening drink because there were no cups. In addition there were no cereals, no milk and no bread.

5.65 On 7 October 1984 an entry was made following information from Philip Price. It recorded ‘C.I.D. (police) coming to see T. . . . because they think he should not be in here because he has not done anything’. There were further instances of pyjama discipline at this time and a boy who did not want to work at Duke’s Lodge and made this clear by leaving and returning to The Birches, later received a ‘roasting’ from Tony Latham, was put in night-clothes and sent early to bed.

5.66 Meanwhile the memorandum which Fred Hill had written to Peter Crockett on 17 February 1984 about what he believed to be breaches of the Community Homes Regulations at 245 Hartshill Road, had received no written response. In evidence Fred Hill said that although it was addressed to Peter Crockett, Tony Latham and Philip Price knew about what he was writing because he had informed them at the time. His purpose had been ‘to bring to the attention of my superiors some of the things that were going on so they then could make a decision whether this was OK or whether it needed to be limited’. No one else appeared to have put the issues in writing before, for example, the issue of wearing nightclothes as a deterrent to absconding. Hill added that although Elizabeth Brennan might have raised the matter of the special unit with Peter Crockett ‘there (was) no document’. He believed, looking back, that when he returned from his visit on 16 February 1984, he would have gone to his line manager William Pierpoint and gained his agreement that he should swiftly put the matters of concern in writing. He had done so the next day.

5.67 Fred Hill explained that in considering whether there were breaches of the Community Homes Regulations he had carried out ‘a very simple exercise’: if pocket money, for example, was able to be taken as restitution to pay for damage (but not otherwise taken) ‘they weren’t doing that’ and ‘so if it’s not there (in the regulations) you weren’t supposed to be doing it’. The regulations ought to be used in this way. ‘You’re not supposed to say, well, let’s try and find a way round that.’ He saw quite clearly that removal of a child’s clothing was a punishment and felt sure that a child would see it in that way. He had worked in residential child care himself and in 1984 was concerned that legal requirements should be respected.

5.68 The first response to Fred Hill’s memorandum came at a meeting at The Birches on 11 October 1984. Those present at the meeting were Peter Crockett, William Pierpoint, Elizabeth Brennan, Fred Hill and Tony Latham. The meeting had been convened in response to a letter from the principal area officer detailing the use of residential establishments in the Newcastle area and proposals for future developments. One of the eight main items of discussion was ‘Intensive Unit – Hartshill Road’. 14 It was
recreation. This would take the form of organised tasks outside the establishment 'usually such things as gardening or sports under the supervision of staff'. These activities, it was said, took place at weekends. The measures of control would be 'relaxed or increased according to the child's progress during the period in the unit which might vary from 24 hours to a few days. All punishments were entered daily in the measures of control book and all staff had been made aware of the Community Homes Regulation on control.'

5.75 Hill's memorandum to Peter Crockett next identified the problems which he considered needed attention. The first and most 'obvious' was the extent to which a child's liberty was restricted in the unit. He understood that at no time was a child locked in a room even if accompanied by an adult. He believed that because of what he interpreted as the 'high staff to child ratio' absconding was less likely than from the family centre where staffing ratios were lower. He quoted the DHSS circular\(^\text{16}\) on the Secure Accommodation (No. 2) Regulations in which 'control imposed or implied by staff or other responsible adults' would not be considered to constitute restriction of liberty, though 'control should always be imposed or implied in a manner consistent with good child care practice'. His view, however, as expressed to Peter Crockett was that 'we are obviously sailing close to the wind' (emphasis added) with some of the arrangements he had described; unless it was 'abundantly clear' that continued staff presence in the Unit did not have the effect in practice of restricting the liberty of a child any more than it would do in a normal small staff children's group situation in a residential setting.

5.76 After discussing the individual aspects of practice which he had examined, removal of clothing, staff sleeping in the close vicinity of children and additional recreation as punishment, staffing, education and access for statutory visitors, Fred Hill summed up his recommendations, and the conditions which should be met if, as he hoped, the activities of the Unit were allowed to continue. He saw the Unit as a 'valuable facility in the area'... which provided 'a positive approach to the problems of non-school attendance and absconding'.

5.77 Fred Hill's recommendations were that:

1. There should be no more loss of liberty in the Unit than that caused by the control imposed or implied by staff through a manner consistent with good practice;
2. The practice of removal of a child's clothes and substitution of pyjamas, PE kit etc: should be discontinued;
3. The practice of staff sleeping in the same room as children or on the landing outside the room should be discontinued;
4. The use of additional recreation when defined as a punishment should be discontinued;
5. All measures of control taken must comply with the Community Homes Regulations (regulation 10 on control (sic) and should be recorded in the appropriate book;
6. The use of the terms special or intensive in reference to the Unit should be discontinued. (Fred Hill reminded Peter Crockett that at the meeting on 11 October 1984 it had been decided that the beds at Hartshill Road could be used for short stay preventative work in addition to semi-staffed use. He took the view that the Unit was providing short stay facilities in line with the family centre concept of flexible use of resources);
7. Statutory visitors should be given access as required to the Unit and all parts of the building;
8. The minimum level of staff cover at 245 Hartshill Road should be Residential Care Officer 2 or Social Work Assistant 2. If semi-staffed staff are used in this respect they should be made fully aware that their responsibilities include supervision of the Unit from time to time;
9. Arrangements for the education of non-school attenders should be recognised officially by the department;
10. The use of a second sleeping-in member of staff at 245 Hartshill Road should be accepted and should take place when determined by the needs of the children within the Unit.'

Finally he recommended to Peter Crockett that a letter should be sent to the Newcastle area including the conditions he had outlined. He also suggested that all principal area officers should be informed that the practice of removal of a child's clothing to deter absconding should be discontinued.

\(^{16}\) See appendix M.
agreed that ‘Mr Hill should re-examine the practices within the Unit to ensure that they fall within the Community Homes Regulations on control’. The note of the meeting ended with the following statement:

‘it was further confirmed that the Area have been given a flexible brief regarding the use of the 10 beds at 245 Hartshill Road and that they can continue to be used for short stay preventative work as appropriate in addition to semi-staffed use’.

5.69 A statutory visit was paid to 245 Hartshill Road on 31 October 1984 by I. D. Cunnott whose report to the District Advisory Sub-Committee expressed satisfaction with the achievements made in the work with adolescents. On 1 November 1984 John Aston put together another list of issues he wished to raise at the staff meeting. They were outlined in the log book:

(1) Young people might get too accustomed to schooling in the unit;
(2) ‘Tension – Boredom – Frustration of living here!’;
(3) ‘Do they know their future short term/long term?’;
(4) Food: – from The Birches ‘small portions’;
(5) Need for shampoo.

On Sunday 11 November John Aston also recorded that a group of young people spent all day at Duke’s Lodge cutting and bagging logs.

5.70 On 12 November 1984 Fred Hill wrote a report\textsuperscript{15} for Peter Crockett of the work he had carried out in examining the practices within ‘the so called Intensive Unit at 245 Hartshill Road’. At that time the accommodation in use was a bedroom, sitting room, bathroom and toilet in a former staff flat. The rooms were said to be used to accommodate a maximum of four children although the average number of occupants at any one time was said to be two. Most of the children accommodated had previously been resident at The Birches though there were occasional exceptions.

5.71 In Fred Hill’s view the purposes of the Intensive Unit were:

(a) for individuals who needed to be removed from the main group at The Birches ‘so that more individual care can be offered’ or ‘whose treatment programme at The Birches breaks down’;
(b) for absconders who could not be contained within the main group;
(c) as a ‘crash pad’ for short term care and for ‘a number of children who encounter problems with non-school attendance’.

Each child was said to have a ‘treatment programme’ and a ‘key worker’.

5.72 Hill found that staff for the unit were drawn from The Birches, the semi-staffed unit at 245 Hartshill Road and on occasions from social services aides. Overall responsibility lay with the senior member of staff on duty at The Birches. One member of staff was rostered outside of school hours and an additional member of staff ‘drafted in as required’. Sleeping in ‘cover’ was provided and on occasions a member of staff slept in with the children or on the landing outside. The semi-staffed unit sometimes covered sleeping-in duties, and occasionally additional sleeping in cover was allowed.

5.73 Fred Hill understood that most children in the unit went out to their own schools. If, after consultation with the school, it was decided as part of a treatment programme that a child should not attend, alternative arrangements for education were made at 245 Hartshill Road. Children from the family centre who were not attending school were taught in a separate area of the building at 245 Hartshill Road. He was informed that school work was provided by individual schools and when appropriate children were taught by home tutors from Staffordshire education department. ‘Additional tuition’ was being provided by a community services worker who had trained as a teacher and support from the Urban Aid programme was being sought to finance her on a permanent basis.

5.74 The regime in the Intensive Unit started with a child having to wash his/her clothes on admission. They were not returned ‘for periods up to 36 hours during which time the child is clothed in pyjamas or PE kit’. If appropriate, further measures as part of a plan to modify behaviour were taken. These included loss of privileges, loss of recreation, imposition of household chores and imposition of additional

\textsuperscript{15} See appendix H.
5.78 On 20 November 1984 Fred Hill wrote a further recommendation to Peter Crockett. It was headed '245 Hartshill Road – Special Unit'. The purpose of the memorandum was to inform Peter Crockett that since the completion of Fred Hill's report dated 12 November the Newcastle area staff had transferred the unit from the staff flat to 'the integral ex-staff maisonette' in order to provide more space. There were now two bedrooms, a kitchen, a sitting/dining room and bathroom/toilet in use. It was still not envisaged that more than four children would be accommodated at any one time. A copy of Annex B to the DHSS Circular (LAC(83)18) (see appendix M) was attached to Fred Hill's memorandum and Peter Crockett's attention was drawn to the fact that it was not permitted to confine a child or children in a certain section of a home by locking internal doors even when they were accompanied by a responsible adult or adults. Permission had previously been given by the fire officer to lock one of two doors between the maisonette and the main establishment to separate the activities in the two areas. Although Fred Hill was satisfied that there were no fire risks, 'the fact remain(ed) that the locking of the internal door in question could be seen to have the effect of confining children to a particular area' and he wished to consult Peter Crockett on this point. In addition he wished to add to his list of recommendations in the memorandum of 12 November a requirement that no more than 10 children's beds should be used at any one time in total at 245 Hartshill Road and that a maximum of 4 of the 10 should be in the Unit.

5.79 Peter Crockett responded to Fred Hill's two memoranda in a letter to Elizabeth Brennan, principal area officer, on 22 November 1984. The letter was signed in the name of the director of social services as was customary but both Peter Crockett's and Fred Hill's references were on it. The letter was written with specific reference to 'the short stay facilities currently operating in the maisonette at 245 Hartshill Road'. Peter Crockett said that whilst he fully appreciated the 'positive work in progress' after 'lengthy discussion on the matter' he had decided 'to lay down a number of safeguards for children and staff which (were to) be adhered to at all times'. He described them as 'instructions', and in the main they followed the recommendations made by Fred Hill, though with two significant exceptions and one only partially met. The 'instructions' from the director of social services to the Newcastle area were:

1. Control implied or imposed by staff should at all times be implied or imposed in a manner consistent with good child care practice;
2. No more than 10 children's beds were to be utilized at any one time at 245 Hartshill Road, this number to include a maximum of 4 in the staff maisonette;
3. The use of the terms special or intensive (to describe the unit) were to be discontinued;
4. Statutory visitors were to be given access as required to the maisonette and all parts of the building;
5. The minimum level of staff cover at 245 Hartshill Road was to be Residential Care Officer Grade 2 or Social Work Assistant Level 2. If semi-staffed staff were used in connection with the activities in the maisonette they were to be made fully aware of their responsibilities in this respect;
6. In normal circumstances only one sleeping in allowance per night would be paid at 245 Hartshill Road. If circumstances arose that warranted a second person sleeping in, clearance would have to be obtained on each occasion from central office;
7. All measures of control taken had to comply with the Community Homes (Regulations), regulation 10, Control, and were to be recorded in the appropriate book;
8. The practice of staff sleeping in the same room as children or on the landing outside the room was to be discontinued;
9. The use of additional recreation when defined as a punishment was to be discontinued;
10. No internal doors in the unit were to be locked at any time, including the door leading from the maisonette to the main establishment.

5.80 These ten instructions met recommendations 1, 3, 4, 5, 6, 7, 8 in Fred Hill's memorandum. His recommendation concerning sleeping in staff was watered down. The two which were omitted entirely were the official recognition (and, therefore, need for resources) of educational provision at 2-5 Hartshill Road, and Fred Hill's proposal that the removal of children's clothes and substitution of pyjamas or PE kit to discourage absconding be discontinued, not only at 245 Hartshill Road but throughout the county's child care establishments. Peter Crockett's response to this latter issue was to tell Elizabeth Brennan that

17 See appendix H.
18 See appendix H.
the practice fell ‘outside the Community Homes Regulations’ but that before issuing ‘a final instruction’ he wished to give the matter ‘more general consideration’. Meanwhile he asked her ‘to attempt in the intervening period not to use this practice, pending further guidance’. His letter concluded by asking her for formal acknowledgment of her receipt of the instructions, and that she would ‘ensure that all staff connected with the unit (were) made fully aware of them’. Mrs Brennan eventually responded on the 25th March 1985 (see chapter 6, paragraph 6.8).

5.81 Entries in the unit log book continued to reflect what had become a familiar pattern. On 17 November 1984 John Aston recorded that one of the boys ‘didn’t have a wash till I kicked him up the back side’. He then found that the boy was wearing football shorts under his pyjama bottoms and made him remove them. On 25 November the vacuum cleaner was not working and on 29 November a female member of staff protested in the log book ‘women (are) not just here to wash and iron, hoover etc!’ A number of children at this time were recorded as talking in their sleep. At the beginning of December a new member of staff recorded that when she had to examine a child’s head for nits, she let the child examine her head in the same way. By contrast a ‘regular’ member of staff recorded that having put two girls in Pindown on 10 December he told them ‘they would stay in the room until someone came to give further direction – I added that I didn’t know when this would happen, but that Phil/Tony would probably take their sweet time as the girls had bugged them about’.

5.82 On 11 December 1984 Lynn Allsop, a homes adviser, carried out a six monthly review visit to 245 Hartshill Road. Following her visit she reported that difficulties were arising due to the building being used for ‘intermediate treatment, community service programmes etc!’. She did not refer to the special unit. Additional problems were being experienced in keeping to normal procedures in respect of building, equipment and fire precautions, and numerous site meetings had been held with the building inspector and fire officer ‘in an attempt to keep track of developments’.

5.83 Fred Hill making observations regarding her report wrote: ‘although this unit is being used flexibly in line with the family centre concept it has been something of a nightmare for Mrs Allsop to keep track of continually changing developments. However this has been done in a supportive manner although I do get concerned the safeguards are occasionally disregarded by the staff in this area’. Written underneath these comments were the words ‘I think our letters protect our position at least’. The initials beside them were GP (G. Pierpoint).

5.84 On 14 December 1984 the log book recorded that ‘Phil arrived . . . has decided that things are a little too comfortable in here for the kids . . . has written a work programme . . . for the weekend and said that staff could add any other nasty little jobs which need doing’. On 15 December the vacuum cleaner was missing, there were no bin bags, no mop and the usual equipment problems.

5.85 A statutory visit was paid by R. Pilmore to 245 Hartshill Road on 18 December 1984. The visit report was not produced to the Inquiry but the note which formed part of a report to the District Advisory Sub-Committee said that the establishment was generally in need of internal redecoration; that several measures of control had been recorded in accordance with the Community Homes Regulations; and that the Unit was fully used with numerous activities taking place, some with the help of volunteers.

5.86 From 18 December 1984 until 15 January 1985 there were no log book entries and the records show no children in Pindown.

5.87 During 1984 19 children were subject to Pindown at 245 Hartshill Road.

5.88 – The shortest episode was one day.
   – The longest continuous episode was 37 days.

5.89 The total time spent by each of the 19 children in Pindown at 245 Hartshill Road was:

50
<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>6 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>7 days</td>
<td>4</td>
<td>1 each</td>
</tr>
<tr>
<td>9 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>10 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>13 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>14 days</td>
<td>3</td>
<td>1 child – 1 episode</td>
</tr>
<tr>
<td>15 days</td>
<td>2</td>
<td>1 child – 2 episodes</td>
</tr>
<tr>
<td>20 days</td>
<td>1</td>
<td>1 child – 3 episodes</td>
</tr>
<tr>
<td>28 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>38 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>60 days</td>
<td>1</td>
<td>5 episodes</td>
</tr>
</tbody>
</table>

Four children were not included in the above figures because it was not possible to identify how long they had been in the Unit.

(c) County Council Financial Policy

5.90 In Staffordshire the Policy and Resources Committee decided budget strategy for the whole county. Individual spending committees then received allocated targets to be met.

5.91 The 1984/85 budget strategy was decided at a meeting of the Policy and Resources Committee on 12 July 1983. The director of social services reported to his own committee on 7 September 1983 that a target reduction of £7,000,000 had been set for the county as a whole. The figure which social services had to meet was £291,000, 1 per cent of its total budget. Over the whole social services department in 1984/85 there was growth of £1.7 million, savings of £300,000 and net growth therefore of £1.4 million.

5.92 The director reminded the committee that over successive years ‘savings have been made with every possible attempt to minimise the impact on the services provided to clients’. In 1984/85 he was proposing to find £262,950 by reducing the county council’s contribution to District Council’s Sheltered Housing Schemes and to meet the remaining sum of £28,950 by reducing the number of beds in a home for elderly people and using part of the building for intermediate treatment.

5.93 The overall impact of savings in 1984/85 on the child care services, therefore, was considerably less than in the previous year. Nevertheless it was not possible to do more than add a cost of living increase to boarding out allowances which could with advantage have been raised in real terms. In some other items of expenditure where inflation-proofing was also not possible, this meant in effect reductions. These had already taken place in earlier years as well, and were contributing to a continuing decrease in resources and standards.

(d) Social Services Re-Organisation

5.94 1984 was a year of consolidation and review of the 1983 re-organisation.

5.95 The next re-organisation took place in 1985.

(e) The Career of Tony Latham

5.96 Tony Latham continued to develop existing projects during 1984, and also to initiate new ones. A new day centre was set up in January 1984 and the first steps taken in what was in 1987 to become known as SHAP, the Supportive Housing Accommodation Project. Tony Latham and Philip Price had found that there was a serious shortage of suitable accommodation for young people to live in when they left
residential care. Much of what was available was unsatisfactory. They decided to negotiate with private landlords, to guarantee rent and place young people with a volunteer living in the same house initially, until after several months the young people, usually two or three together, could manage on their own. Also in 1984, in October, another new enterprise, Forest Enterprises (Staffs) Ltd. was incorporated and commenced trading in October 1985. Its purpose was to help people leaving the Community Programme and Youth Training Scheme. It provided work in gardening, clearing rubble and chopping logs.

5.97 During 1984 Tony Latham was closely involved with the development of Pindown and the overall approach to work with children and families. He told the Inquiry that 'time spent in the unit . . . was seen as a very small part of a much wider process of formulating and developing care plans or contracts with each young person'. His objectives were to develop 'individually tailored, closely supervised, well structured and controlled' care plans which would be constantly reviewed 'with the direct participation of the young person and all significant others'. These others would include, as appropriate, members of the child's family, social workers and teachers. The vehicle used for review was the 'family meeting', held both before and during periods of time spent by a child in Pindown. Family meetings were often held in the late afternoon or evening to accommodate parents in particular.

5.98 Tony Latham's view as expressed to the Inquiry was that 'the review meeting was . . . the most crucial element in the programme'. Family centres were intended to work more closely with families in the area, and it was therefore important to encourage their active involvement. He said that 'we had recognised that often when children come into care, the level of parental contact falls off dramatically'.

5.99 The children in residential care, in his view, were a low priority for area social workers because they were living 'in a safe arena'. The review meetings, therefore, also had a 'major priority of making . . . area social workers as responsible for what went on in (residential) care as in the field'. Tony Latham, therefore, decided to chair the review meetings because he was line manager for the social workers responsible for children at The Birches and the other homes for which he was responsible. He 'demanded that the area social worker should be accountable in the same way that parents were also accountable. It was not fair that Johnny should get a rollicking for failing to perform his part of the bargain if, for example, the social worker had failed to visit his parents, or on a home visit, he had been put in front of the T.V. and ignored by his parents'.

5.100 Tony Latham described part of the technique of family meetings as 'positive and negative role play, with the idea that by creating conflict, people start saying what they think'. He would play a negative role concerning the young person while another member of staff appealed to him on behalf of the young person. He would then reluctantly concede that the young person 'should be given a particular privilege or allowed to visit their parents'.

5.101 The written records for which Tony Latham accepted responsibility were log books, measures of control books, programme books, residential files and area social workers files. Although decisions from review meetings were recorded, there were seldom any written accounts of family meetings or reviews and as we understand it, there was not the kind of preparatory documentation for them which would be appropriate for a case conference or a statutorily required review. In the measures of control records there was no information concerning the reason for the measures being used.
Chapter 6: 1985

(a) National Events.

6.1 During 1985 there were two publications of relevance to Staffordshire’s residential child care service. Both were concerned with research. One was the first study for a number of years of children’s homes. The study covered twenty homes in three local authorities, three voluntary and three private organisations. Two hundred and thirty four children (59 per cent boys and 41 per cent girls) were living in them. Its findings demonstrated not only that residential provision was a positive choice for some children, particularly adolescents, but that it had an important role to play in keeping siblings together, in maintaining close links between parents and children, in providing reception functions for children coming into care and a safety net for fostering failures. The author concluded that ‘the quality of individual care offered in the homes visited was, generally, of acceptable standard and in several establishments was extremely impressive.’ He added that ‘most staff were deeply committed to their task and children were usually appreciative of their residential experience’.

6.2 The second publication was produced by the Department of Health and Social Security in order to disseminate the findings of nine research studies which were of importance to good practice in child care. The studies had been carried out in 49 local authorities and included about 2,000 children. Many free copies of the publication were sent to directors of social services for circulation within their departments. Although not specifically about residential child care many of the practical issues highlighted by the studies were directly related to the work of residential staff as well as field social workers. Examples were: planning for children in care; statutory reviews; decision making; and family contacts of children in care. The publication was also the subject of a series of national seminars in which local authority staff and others were invited to participate.

(b) Staffordshire and its social services

6.3 The records produced to the Inquiry show a gap of time in the occupation of the special unit at 245 Hartshill Road between 18 December 1984 and 15 January 1985. Two teenage girls and a teenage boy had gone out in the week before Christmas 1984. Two girls aged fourteen and one aged thirteen came in during the second half of January 1985. The thirteen year old stayed for 48 days, the other two spent 9 and 15 days respectively in the unit.

6.4 Physical conditions and catering continued to be the subject of complaints by the staff in log book entries. Problems were experienced in getting medical examinations on admission carried out. Some entries gave clear indications of staff being over stretched particularly during evenings and overnight, when supervision of both the Pindown unit and the semi-staffed unit had sometimes to be combined.

6.5 Early in 1984 the meeting of senior staff chaired by Peter Crockett had discussed the possibility of Riverside (community home with education) making additional staff available to help family centres. At that time also the opening of two secure units was being planned. These plans, however, did not materialise as the director of social services informed his committee on 19 February 1985. The secure units had not met the requirements of the Secretary of State under the provisions of the Criminal Justice Act 1982 and would not therefore be able to open. The staff who would have been working in them, instead of being deployed to help family centres, were to be involved in trying to facilitate the movement of children out of Riverside back to their own homes or into other children’s residential establishments.

6.6 During January 1985 Paul Hudson, the director of social services, had decided to take early retirement as from 28 February. His deputy Barry O’Neill was appointed to replace him from 1 March 1985 and Peter Crockett was appointed deputy director from the same date. Peter Crockett and John Spurr transferred their functions with immediate effect from mid January 1985, John Spurr becoming

senior assistant director when Peter Crockett became deputy director. John Spurr's responsibilities included chairing the group of senior staff which Peter Crockett had established before 1983.

6.7 When Peter Crockett wrote to Elizabeth Brennan over the director's signature on 22 November 1984, [see Chapter 5, para. 5.79] he asked her formally to acknowledge his letter containing the instructions concerning the special unit at 245 Hartshill Road. On 11 February 1985 he wrote again because she had failed to do so: 'whilst I appreciate the need to discuss my letter with relevant staff in your area, I would ask you to acknowledge receipt and to confirm that all staff concerned with the Unit have now been made fully aware of the instructions I have laid down'.

6.8 Due to the changes resulting from the director's retirement and Peter Crockett's promotion it was John Spurr who received Elizabeth Brennan's reply to Peter Crockett's second letter, which she addressed to the new director Barry O'Neill. Her letter was dated 25 March 1985, four months after Peter Crockett's first letter. In the first sentence she apologised for the delay in replying and then continued, 'certainly the matter has been discussed with all the relevant staff concerned with the unit and they are fully aware of the points you have raised'. The word used in Peter Crockett's letter had been 'instructions' a much stronger term than 'points you have raised'. It was also not clear whether 'the matter' referred to in her letter was the final issue about removal of clothing and substitution of night clothes or PE kit to deter absconding, or merely a general term to cover the unit and the issues concerned with it. Elizabeth Brennan did not say whether she had personally discussed the letter with her staff.

6.9 The main point of her letter was concerned with two specific issues in the ten instructions which she did not accept. The first was sleeping in allowances about which she had obtained a concession from John Spurr that she need not consult central office on each occasion that additional sleeping in duty was required. The second was the prohibition on locking at any time the door which divided the unit from the rest of the house. She asked for reconsideration of this on the grounds that because of other exits there was not a fire risk, and that the door needed to be locked, not to keep young people in the special unit but to keep young people from other parts of the house out of the unit.

6.10 When Elizabeth Brennan's letter reached John Spurr he had written a note on it. It read 'FH (Fred Hill) 2 things
1. I'm inclined to agree about the locked door
2. The whole set up is being considered closely and may well be brought to an end v. soon. JS'

Two versions of this note were seen by the Inquiry. The first was as quoted above. The second was a copy of Elizabeth Brennan's letter which had had the note written on it but had then been folded and photocopied so that only the first part of the note appeared.

6.11 The second part of the note might, in the light of the preceding correspondence about contraventions of the Community Homes Regulations, have implied that the special unit was about to be closed. John Spurr denied in evidence that this was the intention and could not, in retrospect, remember what the note meant. He thought it might have referred to the fact that the diversity of activities being carried on at 245 Hartshill Road were leading to excessive wear and tear on the premises and also to difficulties with neighbours, and therefore might need to be reviewed. Consideration was being given at this time to the future of all the semi-staffed units. On 4 March 1985 the meeting of assistant directors and principal officers had been invited by John Spurr, by this time its chairman, to discuss the matter in preparation for a report by the director of social services to the Committee on 29 April 1985.

6.12 Before that meeting took place Brendan Sullivan, assistant director (finance), had paid a statutory visit to 245 Hartshill Road on 10 April 1985. The report of his visit was not produced to the Inquiry but it had raised issues about which Fred Hill wrote on 5 June 1985 to John Spurr, senior assistant director. One of the issues was about the level of staff left in charge of 245 Hartshill Road. Fred Hill reminded John

21 See appendix H.
Spurr that the area staff had been ‘instructed’ that the minimum level of ‘cover’ should be social work assistant level 2, and that social services aides should not be left in charge at any time. He said that he had been assured by the area officer that this instruction was complied with at all times.

6.13 Brendan Sullivan raised two other issues which were inter-related and also related to the forthcoming report of the director to the Committee. The first was what was referred to as the ‘Time Out Area’ which was another name which was sometimes used for the special unit. We do not know what Brendan Sullivan had said about this, but Fred Hill’s comment to John Spurr implied that Brendan Sullivan may have thrown doubt on its future continuation. Fred Hill wrote that: ‘I am not aware that the Newcastle Area have any plans to phase out this facility, and on the contrary, they appear to regard it as an essential part of their resource. As you are aware we have laid down guidelines in respect of this facility’. The second issue was about semi-staffed facilities about which Fred Hill reminded John Spurr, who had raised the general issue with senior staff in January 1985, that it was ‘hoped eventually to phase-out the semi-staffed usage at Hartshill Road’. Brendan Sullivan may have commented on the state of the building because Fred Hill concluded his note to John Spurr by promising to ‘visit the premises once again with the Building Inspector to see what improvements, if any, can be effected on the top floor of the building’. The top floor was where children’s bedrooms were situated and where for a substantial proportion of its existence, the Pindown unit was also situated in a small flat formerly used by staff.

6.14 Barry O’Neill, the director, had reported at the General Sub-Committee meeting on 29 April 1985 that many of the young people for whom semi-staffed units had been required, had moved on elsewhere and the need was no longer so great. He suggested that this provided an opportunity for redeployment of the buildings concerned. 245 Hartshill Road provided ten semi-staffed places, only six of which were occupied and ‘in addition, these premises provide a base for a Community Services Team which organises a wide range of voluntary services in the locality providing effective support services towards preventative child care. Part of the premises is also used as an annexe to (The) Birches Family Centre for the occasional short term care of up to 4 children, and some intermediate treatment activity also takes place there’. The director told the Committee that the six young people in the semi-staffed accommodation were likely to move on and ‘whilst the premises serve as a useful adjunct to the activities of the Birches Family Centre, I would like to keep in mind the possibility of finding another locality for these mainly non resident functions’ (emphasis added). If that were possible, he would then wish to make further use of the residential facilities of the premises, ‘possibly as a residential home for mentally handicapped adults’ (emphasis added). The final recommendation to the Committee was that ‘245 Hartshill Road... continue to be used for daily activities until alternative centres can be found’.

6.15 The director’s report made no reference to the special unit although the correspondence referred to above was continuing at director and assistant director level at the time of his report. Since Elizabeth Brennan was a member of the senior staff group which met with Peter Crockett, and later John Spurr, she would have known about the possible change of use of 245 Hartshill Road. Tony Latham, however, said, in evidence, that he had no knowledge that 245 Hartshill Road was being considered for another purpose and had not been consulted about it by anyone.

6.16 The final item in the correspondence which Fred Hill had begun on 17 February 1984 and which had involved Peter Crockett, John Spurr and Elizabeth Brennan, was the director’s response to Elizabeth Brennan’s letter of 25 March 1985. It was drafted by Fred Hill and sent over Barry O’Neill’s signature on 9 May 1985.22 It only mentioned the dispute about whether a door between the ‘unit’ and the rest of 245 Hartshill Road should be locked or unlocked. The letter said: ‘I note that the only point... you find difficult is the instruction (point 10) about the door in question’. The letter thus assumes the other nine points have been accepted. It continued: ‘after further consideration... I am agreeable to the locking of this door by the use of the existing yale lock which will enable the door to be opened from the unit side as required but not from the establishment side’. Elizabeth Brennan was asked to ensure that the key to the mortice lock on the door was removed.

22 See appendix II.
6.17 There was no further correspondence and the issue of removal of clothing and substitution of nightclothes or PE kit as a deterrent to absconding was thus left unresolved. Elizabeth Brennan did not seek any decision and the director’s last words had enjoined her ‘to attempt . . . not to use this practice pending further guidance’.

6.18 Further re-organisation was going to take place in the child care service from 1 April 1985 when area officers (family centres) were to become area officers (children and families) and to be based in area offices instead of in the family centres. They also were to have responsibilities for field social workers amongst other additional work. This change was discussed in anticipation by the group of senior staff chaired by John Spurr. Principal area officers were ‘advised to use whatever means was appropriate to recruit a team of casual staff in order to fill deficiencies’ left by the withdrawal of the area officers from family centres. A list of volunteers was also to be prepared and arrangements made for clearance of their suitability for work with children.

6.19 During the early part of 1985 the senior staff group chaired by John Spurr met five times in January, once in February, twice in March and on 1 April 1985. No further records of any meetings were produced to the Inquiry.

6.20 Although the documentation of Pindown implied that children and young people would, in the main be held in the regime for short periods only, the records for 1984 showed that a significant number were involved for ten days or more and a few spent periods of time between twenty and sixty days in total. This pattern continued in 1985. It also became clear from the records of 1985 that some young people came into the regime in successive years as well as more than once in any one year.

6.21 Several young people in 1985 not only went into Pindown more than once, but were in for quite long periods and had either been in during the previous year, or were to go in in subsequent years, or both. A boy, P. E. who was admitted from The Birches on 15 February 1985 provides an example. He was just fifteen years old and had already been in Pindown for two periods of twenty-four and four days respectively in November and December 1984. The preparatory instruction in the log book about his admission in February 1985 read: ‘room to be stripped . . . of everything except sleeping bag’.

6.22 P. E. was brought in at 3-15 p.m. by Philip Price. He had absconded from school and the decision had been made to re-admit him to the special unit. The entry in The Birches log book read that P. E. had been ‘transferred to Maisie’s welcoming arms if not charms!’ The term ‘Maisie’ was derived from the maisonette in which the unit was located.

6.23 P. E. was taken straight to his room and after tea, bathed and was in bed by 6-30 p.m. The next day, Saturday, he did school work in his room all day but was described as very unhappy and crying a lot. Log book entries in the following days record that he was talking in his sleep a great deal and talking to himself when awake.

6.24 Louise Doherty (then Ogborne), the teacher at 245 Hartshill Road, described him towards the end of his first week as ‘an immature boy of below average intelligence . . . appears to inhabit a world of his own . . . unable to face reality’. A few days later in the week ending 1 March 1985 she wrote again in the log book: ‘another week of solitary confinement for (P. E.) has had some rather peculiar effects’ (emphasis added). He is talking to himself a great deal and we had tears several times during the course of the week. Sleeping in staff also report incidents of (P. E.) talking in his sleep. He admits to missing his mother a great deal and constantly asks when he will be allowed to see her . . . The pitiful part of it all is that he keeps doing silly things and blotting his copy book – but he can’t seem to tie those incidents in with not being allowed any contact, freedom or privileges’. Amongst the ‘silly things’ he had done were calling out of the window of his room and banging on the bedroom door and walls in an attempt to communicate with two girls who were also in Pindown. His school work was not encouraging but the report said he had ‘shown every willingness to do it’ and ‘obviously tries to do his best’.

6.25 Later in March 1985 he was described as ‘an affectionate child’ who ‘responds well to a degree of
care (coupled with control), and Louise Doherty commented 'I now begin to think that P's emotional progress has been affected by a lack of self-confidence, as he responds gratifyingly to encouragement and praise'.

6.26 By 8 March 1985 he had still not been allowed to see his mother, and was having tearful and hysterical outbursts, saying that 'he couldn't take anymore' and was 'terrified about his review'. After an appearance at a juvenile court on 29 March he was given a conditional discharge and allowed to go home, continuing to come for schooling to 245 Hartshill Road. On 5 April Louise Doherty once more reported, 'after his discharge P.'s behaviour changed quite dramatically. The quality of his work improved and he was bright and co-operative during the school day'. P. E. was in Pindown for forty-six days on this occasion and for a further period of fifty-five days during 1985, a total over 1984 and 1985 of one hundred and twenty-nine days.

6.27 During March 1985 a fifteen year old girl was also re-admitted to Pindown. She was described by Louise Doherty as 'co-operative ... helpful ... lively imagination'. Louise Doherty later wrote that 'she seems to me to have fallen into a pattern of coming in and going out with little meaning being attached to why'. A truant aged just 16 was admitted on 8 March. The log book recorded that 'he was immediately stripped down to his shorts, isolated in his room and put on the basic programme'. He was discharged home on 12 March but by the last week of March was in Pindown again 'depressed and resigned'.

6.28 The measures of control book for 245 Hartshill Road did not record the isolation or removal of clothes in these cases or any others. The entries were almost uniformly 'loss of privileges, loss of recreation, simple chores'. There was an occasional omission of one of the measures or a different order in the three entered. There were 1146 entries for 1985 relating to 26 children. They were entered under the headings of date, name of child, measure of control, by whom applied and by whom authorised. There was no column for information about why the measures of control were applied.

6.29 Many hundreds of entries were made by Louise Doherty. Significant numbers were made by Jane Walton, Damian Doherty and John Aston. Small numbers were made by S. Lovatt, Glynis Mallers (then Bonnic), P. Hall, C. Taylor, Janet Daniels, Peter Nicol-Harper and J. Scott. There were some gaps in the signatures. Tony Latham made four entries and Philip Price one. In the column for the name of the person who authorised the measures of control there were some gaps and Tony Latham authorized his own and twenty-nine others. Otherwise the signature throughout was Philip Price's. The impression gained from many of the entries is that they were signed in batches, probably some time after the event.

6.30 There were no records of statutory visits to 245 Hartshill Road between December 1984 and April 1985 amongst the reports produced to the Inquiry. We read reports of statutory visits to The Birches in January, February and March 1985. The impression gained by the visitors was that the children were well cared for though the physical conditions in the home showed the effects of high numbers and inadequate maintenance. There was recognition of the difficult task being undertaken. Entries under measures of control showed only four absconders in the three months and only three incidents of additional measures of control being used. By contrast the log book recorded several children being put into pyjamas for punishment or following abscending. These were not recorded in the measures of control book. One boy had been told that if his behaviour did not improve he would have to go to Duke's Lodge to work.

6.31 It was also clear from other log book entries that Philip Price and occasionally Tony Latham were being used as disciplinarians. After a statutory visit on 19 March 1985 the visitor, Peter Warren, had stated that 'staff and building' were 'very well organised'. Further admissions from The Birches to 'Maisie' took place shortly afterwards.

6.32 On 15 April 1985 a member of staff who was on night duty at The Birches expressed her feelings in the log book: 'tonight has been a total waste of time -- its not human beings you want working here but morons who don't have hearts and are without feelings'. Children had been running in and out of bedrooms and the older children (some of whose names appeared later in Pindown) were behaving in an 'unacceptable' (sic) manner. 'IN THIS BUILDING WE ARE NOT RUNNING A BROTHEL' she
wrote. 'Their language is gutterish and disgusting'. She recorded that she had had to ring Philip Price because a boy had a 'quite large dagger knife' which he refused to give her for safe keeping in the office until the next day.

6.33 The next day, 16 April 1985, Philip Price wrote in the log book: 'I accept that two female staff on duty together is not a good idea, but occasionally it has to happen to avoid any major rota changes. If staff are in a position to negotiate an alternative I would be more than willing to discuss and accept a compromise.'

6.34 John Aston warned his line managers through the log book on 2 March 1985 that the group in the unit at 245 Hartshill Road was getting too big and was 'becoming a little pressure cooker'. Shortly after this date a boy attempted suicide and was admitted to hospital where he remained for six weeks. Later in the month John Aston put another warning in the log book -- seeking to persuade colleagues to restrict access to the unit.

6.35 Janet Daniels expressed disillusionment with what she described as the 'b' treatment she had been asked to carry out with one child. It 'has backfired' she said 'the whole exercise has been a total failure'.

6.36 There were also several comments in the log book in April 1985 which gave staff reactions to Duke's Lodge and the children's involvement. On 4 April Graham Toplass took a girl to work there and later recorded that she 'worked well all afternoon cleaning out the chickens. Never complained (sic) about the smell (it was bloody awful (sic)). After the chickens, she cleaned out the rabbits'. Several days later Louise Doherty took a group of young people there and later recorded 'the girls mucked out the chickens ... D. and I cleaned the duck shed out (pooh!)' During May Louise and some children cleaned up Duke's Lodge itself, made Tony a stew and fed the rabbits. The log book in May began to refer to visits to Duke's Lodge as 'day care' and 'evening care'. It also became clear from log book entries that visits there at weekends sometimes related to shortage of staff at 245 Hartshill Road.

6.37 Most new entrants to the unit came after truancy or absconding but a girl was brought in on 18 April with the instruction 'she's not here for control. Having communication problems at foster home'. She was admitted, in fact, for assessment but she was immediately put on the same regime as others in Pindown and recorded in the same way on the day of entry in the measures of control log book. She was still retained on this basis on 3 May 1985 when John Aston wrote in the log book to Philip Price 'J. thought's and feelings what (sic) she wrote down opposite. Take the time to read them Phil!' She was still being retained on the 'loss of privileges, loss of recreation, simple chores' formula which was always entered in the measures of control log book. On 22 May she was described in the daily log book as 'very upset by what goes on in the unit' and wanting to get out as soon as possible. The measures of control log book showed that she remained on the 'loss of privileges etc.' for sixty-four days until 20 June 1985.

6.38 During the time this girl was in the unit there were variations in the regime for her and she went out to some activities, but the staff records did not discriminate throughout the period, and she was, therefore, in the position of having to 'earn' basic concessions such as going out to a youth club even though she was referred for observation and assessment which was one of the functions of the family centres after 1 April 1983.

6.39 There were two statutory visits to 245 Hartshill Road in June 1985, one by E. W. Roman, senior assistant, on 19 June and one by H. Miller, senior assistant, on 20 June. Mr Roman under the heading of control reported that there were no problems. Concerning the building he noted that 'the multi-purpose utilisation . . . put(s) an unusually heavy demand on the fabric and furnishing. . . . For this reason a much higher level of maintenance should be provided than . . . at present to keep up with noticeable wear and tear, which, quite unfairly, draws the visitors attention away from the valuable contribution the place makes to a section of young people and particularly in respect of local community collaboration'. Mrs Miller, under the heading of control reported 'numerous daily records of privileges withdrawn which involve six children. Aim of staff is to reinforce good behaviour so here is a simple reward/punishment system in operation to hopefully effect change in the children's pattern of behaviour'.

58
6.40 One of the conditions which had been included in the director's letter of 22 November 1984 had been that there was to be 'a maximum of 4 children in the staff maisonette' i.e. the unit. Numbers in the unit began to rise at the end of May when there were five residents. By 6 June there were six. June 1985 was a difficult month in 245 Hartshill Road. John Aston spelt out 'that if (MJ) was admitted someone would have to move out', to Riverside. The mother of a girl who was 'on basic Pindown' called to see her and the log book recorded: 'Mum says she's shocked (sic) at how things are here. tried to explain that all we are doing is denying privileges so she won't be bad enough to come back.'

6.41 It was also in June 1985 that Wade Rogers refused one boy contact with his mother and broke down a door behind which another boy was barricading himself. When the boy behind the door was found to be wearing his own trousers, they were taken from him. Wade Rogers recorded that 'C. said he had nothing to live for. Both children very upset (was it something I said?)'. The boy whose trousers were taken away from him ran away again the next day.

6.42 On 8 July 1985 there was a starred entry in the log book which read 'Keep tidy. Official visit in morning Mr F. Hill'. Before that note the log book recorded that two girls had been transferred elsewhere in the building and 'Unit cleaned and locked up'. No record of Fred Hill's visit was produced to the Inquiry. On 24 July a statutory visit was paid by P. A. Wall, another senior assistant from headquarters. Under the heading of control his report was 'satisfactory' and in general comment he described 245 Hartshill Road as a 'hive of activity with this establishment playing a big part in the Family Centre concept for the Newcastle Area'.

6.43 Throughout June and July 1985 there were many days when five or six residents were in the unit and by August the numbers went up to seven. They remained at five, frequently six and sometimes seven up till the second week in November when numbers dropped for the rest of the year to three or less.

6.44 On 17 July 1985 the boy P. E. who had been in Pindown for forty-six days earlier in the year was admitted again. The following day Peter Nicol-Harper recorded that 'P. E. wanted sheets and his dressing gown. I refused'. Two days later on 17 June John Astou wrote in the log book about P. E. 'well (sic) can be said about this little runt has been said. He has done exactly as he has been told. Willing to complete anything you set. Either willing or to (sic) scared to say anything'. On 26 July a fourteen year old girl W. B. was admitted for a 'reception programme' which was described as 'negative programme though not too heavy'. There was a possibility that the girl might be pregnant. She was also asthmatic. Damian Doherty recorded that: 'she... claims to have asthma, cannot get her breath, need to clarify if she does suffer or if it is attention seeking. Excuses to come out of her room'. The log book records later the same day that W. B. was 'too upset to eat'. 'The young girl broke her heart this evening and later asked about how long she would be in here for.' The following day Damian Doherty recorded about W. B.: 'asthmatic again today after having to write about the problems with her family - poss. (ibly) stress related.' Being asthmatic she found it difficult to get to sleep. On 30 June, another member of staff recorded that 'she finally got off to sleep. Around 10-30 she was transferred across the other side because there was a possibility of (a boy) being admitted'.

6.45 D. G. was brought in on 31 July 1985 by Graham Toplass who 'had to carry him to the car whilst he was screaming and... causing all the neighbours curtains to open... He finally cried himself to sleep around 11-30 p.m. A fifteen year old girl was admitted on 10 August and Jane Walton recorded in the log book 'N. Q. ... to have the “fear of God” put into her. No conversation with her at all - from us or kids'. Regarding the boy P. E. on 7 August 1985 his 'programme' refers to "punishment measures" (emphasis added)... no TV - remain in bed... not to be allowed to look through window or talk to anyone'.

6.46 D. G., who was frequently in Pindown from the age of just eleven years old, was 'very upset' on 12 August and doing 'a good deal of weeping and sobbing'. Over the next few days the following entries were recorded about him:

   'he has drove (sic) me mad... At 1-45 I lost my temper, he doesn't know how close to death he came. I don't think he likes me any more he won't answer or talk to me HA HA HA HA I will have to do it more often.'
6.47 At the end of August and in early September 1985 'everybody off to Duke's Lodge' was a frequent entry.

6.48 A fifteen year old girl, S. V., who spent many weeks in Pindown at various times and who had been described as an intelligent girl who saw little to look forward to in life, was described by Graham Toplass as 'a pain ... she needs something that we cannot give her here, like the biggest shock of her life'. The next day she cut her wrist: 'Blood everywhere, soon settled (sic) down when I told her it didn't bother me what she did to herself. As (sic) been a pleaser (sic) to be with this afternoon.' The same day the general situation in the unit could be seen through the entry Damian Doherty made before going off duty: 'I'm glad to finish today - something must be done about the ratios (of staff) + numbers + people in this unit ... its getting increasingly difficult to contain everybody here - What a bloody night!'

6.49 The staffing problem was also referred to in an entry by Damian Doherty on 30 September 1985: 'this place contains too many kids who are becoming more disruptive, rebellious, annoying, disturbed by the day. I had my worst night on duty ever. A time bomb is all this place is becoming (sic). All I seem to do is contain to (sic) many kids, in poor ratio, in a small space! Narrowly avoided a full scale rebellion last night.' (emphasis added). The evidence in the log books sometimes indicated that staff were carrying out night sleeping in duty alone.

6.50 In October 1985 John Aston asked for 'programmes to be written out -- is a must! Lots of confusion around the place'. A girl L. C. was coming in for 'solitary' to do 'lots of very boring school work ... to remain isolated till she goes home at 9 p.m.' D. G. was brought back to Pindown 'screaming' again, having tried to dive out of a window to escape. He was put back on 'full Pindown' and work at Duke's Lodge in between. Damian Doherty stated in the log book concerning a thirteen year old girl, C. A., 'Pindown is doing her no good ... I feel that it further upsets a deeply disturbed young lady and also confuses staff roles with her'. This girl, coming in for Pindown during the day only, graduated to residential Pindown. In the log book Jane Walton wrote: 'Be nasty to her'.

6.51 Duke's Lodge was being used a great deal. A social worker complained to Peter Nicol-Harper that a boy for whom he was responsible was working too late at night at Duke's Lodge to get to college on time the next morning. The same evening that this was recorded Tony Latham telephoned The Birches to say the boy would not be back from Duke's Lodge till after 11-30 p.m. The programme for another boy, during October 1985, read: 'Pindown -- no -- contact -- schooling in his room or Duke's Lodge if Tony requires him' (emphasis added). By November this boy was working at Duke's Lodge three evenings a week ('evening care') and all day Sunday ('day care') in spite of still being a schoolboy.

6.52 During the last few weeks of the year one child was prevented from going on a visit home as a punishment, and also had to go to Duke's Lodge though very unwilling to do so. Another child was referred to a psychiatrist, but she and another girl both took overdoses on the same day before there had been time for her appointment. Because of insufficient staffing someone on the staff had to be fetched from their home to stand in with one girl while the other was taken to hospital. The second one went later.

6.53 At The Birches Peter Nicol-Harper who had worked there since 1983 and was later to return as team leader, left in September 1985 to undertake professional social work training. Jaime Rodriguez who in 1984 had been seconded for training returned, not to The Birches but to the area office. Numbers of children at The Birches had been falling during 1985 and there were no entries in the measures of control record when statutory visits were made on 30 September and 22 November 1985. On 20 December 1985 Mr. D. Layton, a principal assistant, reported that 'the general appearance both internally and externally has changed out of all recognition. ... The policies followed by the Family Centre have resulted in a considerable reduction in the large number of difficult to place children which the centre was left with when it opened under its present function'.
6.54 No reports of statutory visits to 245 Hartshill Road between 18 June and 31 October 1985 were produced to the Inquiry. The visitor on 31 October, D. J. Livingstone reported under 'Control' – 'Nil' absconders since the previous official visit and 'several entries of loss of privileges and recreation in line with Community Homes Regulations'. During the period between June and October 1985 there were 633 entries and even between the end of September and the end of October, there were 154 entries. D. J. Livingstone signed the book recording these entries on 31 October, the last entry for October. On 15 November I. D. Cunnett also paid a statutory visit and under 'Control' recorded 'no attempted absconding since last statutory visit'. During the interval between D. J. Livingstone's visit and I. D. Cunnett's one boy had in fact absconded. I. D. Cunnett also recorded 'numerous' additional measures of control, 'but all appear within guidelines'. The measures of control book had not been signed. The final statutory visit during 1985 was made by A. J. Brookes on 17 December. He recorded 'none' in relation to abscondings since the last visit.

6.55 Also on the 17 December 1985 Jane Walton made an entry on a young boy, J. V., who was coming into Pindown daily because he was a problem at school. He was nine years old. She wrote: 'No problem. Did exactly what he was asked. Stayed in his room only coming out when given permission. However he was smiling on his way out to go home, so I had words with him and threatened to make him stay and do more jobs. He went home crying. Damian gave him a rollicking earlier on, and set him tasks. Consistent, firm, negative approach maintained'. Another day, this little boy was set to clean windows and polish woodwork. He was 'caught ... playing with the spray ... few choice words. Set him on writing the alphabet which he couldn't write (sic) it out. He can recite up to 'f' with difficulty'. Jane Walton took him home and was concerned that his mother did not put him to bed at once. She was warned 'to make it quick'. Following this, on another day, he managed to recite to 'k' but whilst cleaning the bathroom and dishes he was smiling again so Jane Walton gave him 'a few words about Santa forgets to call in the Pindown room. Look worried. Taken home. Mum sharp with him i.e. supper/bed soon'.

6.56 During 1985, 22 children were subject to Pindown in 245 Hartshill Road. Some had been in Pindown in previous years and some returned subsequently. The figures below relate to 1985 only.
- The shortest single episode in Pindown was 1 day.
- The longest continuous episode was 84 days.
The total time spent by each of the 22 children in Pindown at 245 Hartshill Road was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>Number of children</th>
<th>Number of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 days</td>
<td>3</td>
<td>1 each</td>
</tr>
<tr>
<td>3 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>6 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>7 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>8 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>9 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>10 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>11 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>21 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>23 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>41 days</td>
<td>1</td>
<td>4 episodes</td>
</tr>
<tr>
<td>44 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>48 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>101 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>108 days</td>
<td>1</td>
<td>3 episodes</td>
</tr>
<tr>
<td>117 days</td>
<td>1</td>
<td>6 episodes</td>
</tr>
</tbody>
</table>

(c) County Council Financial Policies

6.57 The Finance and Development Sub Committee in Staffordshire met on 18 May 1984 to consider a
report on the county council’s financial position for 1985/86 disclosing the ‘serious situation which would develop in that year unless special efforts were made to curtail expenditure’.

6.58 In preparing 1985/86 revenue estimates spending committees were to be asked to
   - (a) make substantial reductions in their base budgets; and
   - (b) limit the amount requested for development growth.

6.59 At the social services committee meeting on 10 January 1985, the director of social services and the county treasurer presented a joint report concerning base budget reductions and limitation of new developments.

6.60 Over the whole social services department in 1985/86 there was growth of £1.2 million, savings of £600,000 and net growth therefore of £600,000.

(d) Social Services Re-Organisation

6.61 Paul Hudson, director of social services, took early retirement in February 1985 and Barry O’Neill, his deputy, was appointed as director.

6.62 A major re-organisation within the social services department coincided with this change. There was no tradition of consultation with staff regarding re-organisations and very little, if any, took place in 1985.

6.63 At headquarters Peter Crockett, who as assistant director from 1982 had combined the work of three assistant directors pre-1982, became deputy director. John Spurr, who in 1982 had become senior assistant director, remained in that post until 1986. Responsibility for individual client groups which in 1982 had been unified under Peter Crockett, in 1985 was divided again into disability services, services for the elderly, and children and family services, each under an assistant director. This specialisation corresponded with similar divisions into specialist groups outside headquarters. The direction of residential services, with the exception of family centres, remained at headquarters in the specialist groupings. Responsibility for family centres remained at principal area officer level. The assistant director for children and family services was Audrey Williams. Assistant directors had senior assistants responsible to them. One of these posts was filled by Fred Hill in the children and families group.

6.64 At area level principal area officers had three area officers corresponding to the client group divisions at headquarters, and each of these specialist area officers was responsible for groups of social workers comprising a senior social worker and field social workers. There was also a juvenile justice co-ordinator responsible for a team of juvenile justice social workers.

6.65 The area officer posts which from 1983 had been based on family centres were removed from the departmental structure. The area officers for children and families who took their place continued to have responsibility for the family centres and other children’s residential care units, but were based at area offices and held the wider responsibilities described above. Elizabeth Brennan continued to be the principal area officer for the Newcastle-under-Lyme area. Tony Latham, formerly area officer (family centre) became area officer (children and families). Philip Price remained, until he went away for social work training, as team leader in the family centre.

6.66 The way in which the department was being re-organised resulted in what was described in the notes of a meeting of assistant directors, principal area officers and senior assistants on 25 February 1985 as a ‘wide overlap between the problems of individuals and the pattern of care established within an establishment which function was the function of central office staff’. This overlap was the subject of considerable discussion and potential difficulty. Central office remained responsible for appointments of staff, emergency cover and the emergency duty team. Areas were responsible for social work with clients, but expected to offer ‘interest and associated involvement’ in residential establishments, and similarly in the appointment of staff by participating in interviews.
6.67 Training matters were to remain the responsibility of the senior assistant director in liaison with the training officer. Area officers were to consult with the senior assistant director who would initiate agreed courses.

6.68 Riverside (a community home with education) had had some further reduction in numbers of beds from 75 to 50. It had also been intended to open two small secure units within it. In 1985, at the 19 February meeting of the Social Services General Sub-Committee, it was decided not to do this because of lack of funding to bring them up to the standards required by the Secretary of State for approval. Two of the posts which had been allocated for the secure units 'as a consequence of the re-organisation of the department' were to be used to establish 'posts of Rehabilitation Co-Ordinator to develop services for children moving back into the community from Riverside or other residential homes'.

6.69 The semi-staffed residential units in Stoke-on-Trent and Newcastle-under-Lyme were reviewed for the Social Services General Sub-Committee on 29 April 1985. A number of changes were made in the use of units no longer needed for young people and further possible changes were recorded for review at a later date.

(e) The Career of Tony Latham

6.70 During 1984 further re-organisation of child care services was planned and eventually implemented on 1 April 1985. Area officers (family centres) were to cease to be based in the area offices taking on at the same time increased and more widely based responsibilities. Their title was to be area officer (children and families). Tony Latham had received a letter from the director of social services on 16 November 1984, offering him the new area officer's post for the Newcastle-under-Lyme area. If he accepted the post his new duties were 'to participate in the management of the department's activities in the area...to take a particular responsibility for the service to families and children...to be a member of the principal area officer's management group and...to establish a management group involving officers in charge of residential and day care establishments and senior field work staff in your special field of activity'. He was also to be involved in conjunction with the principal assistant responsible for health service contacts in social services central office, in liaison with health authorities in the Newcastle area in relation to family and children's services. In due course Tony Latham accepted the post which took effect from 1 April 1985.

6.71 The responsibilities of Tony Latham's new post were much wider than his previous one, and involved areas of work in which he had no experience. It required not only the full-time commitment expected in a full-time post but until new experience had been gained to match new demands, it required extra commitment. At the same time the range of staff expecting leadership and supervision was both wider and more senior than in his previous post.

6.72 By 1985 Tony Latham's own house, Duke's Lodge, had become 'almost entirely turned over to projects'. He described what took place: 'the vehicles were largely kept there and repairs carried out there...various equipment was moved (there)... When the Longton Volunteer Centre closed, the people working there - The Clerical Group and The Task Force were divided between Duke's Lodge and Hartshill Road. There was a big increase in the YTS operation in 1984, 1985 and 1986.' His 'front room' was used for daytime meetings, an upstairs bedroom was occupied by a team of five people running YTS schemes who came in at 7.30 a.m. Another bedroom was used for papers and filing cabinets. Downstairs there were five desks, and training sessions for YTS and The Community Programme took place, and the kitchen was a 'free for all'. A portacabin and a mobile caravan were in the garden. Tony Latham worked very long hours and he carried out his 'voluntary' work at home, both before and after his paid employment for Staffordshire.

6.73 During 1985 Tony Latham increasingly involved children and young people from 245 Hartshill Road with Duke's Lodge. Log book entries record this on many occasions. It is also clear from some of the entries that boys and girls were working to a significant extent though the terms 'day care' and 'evening care' were used. Some received payment; some received small sums of pocket money; some
received no money. It is also clear from log book entries that there were occasions, particularly at weekends, when parties of children went to Duke’s Lodge at least in part because the staffing situation at 245 Hartshill Road was not viable for them to stay there. The hours they were there, some of them undoubtedly for work, were a minimum of three hours in the evenings and six hours on Saturdays and Sundays, sometimes longer.
Chapter 7: 1986

(a) National Events

7.1 Accompanying the Secure Accommodation (No. 2) (Amendment) Regulations 1986 was a publication, 'Secure Accommodation for Children and Young Persons – Guidance for Local Authorities' -- Department of Health and Social Services Inspectorate 1986: CI(86)8.

7.2 Although focussed on practice in relation to the use of secure accommodation, the contents of the Guidance for Local Authorities contained much that was directly relevant to the care of children and young people in Pindown in Staffordshire.

7.3 Within the physical security of an approved secure unit for example the document made clear the importance of the following: an adequate quality of life; the damaging effects of isolation; and the developmental needs of children for companionship of other children, for education, recreation, choice in their environment as far as possible, personal possessions and interesting food attractively presented.

7.4 It was also stressed that active intervention in terms of counselling should be available so that the child is 'helped to make sense of his experience'. Other important issues discussed were the quality of social work practice in assessments and decision making; joint decisions between field and residential staff adequately monitored by senior specialist staff; the need for practice to be child focussed avoiding a rigid, punitive and impersonal approach; the importance of understanding that a child's view of his behaviour may be very different from an adult view, combined with 'adequate knowledge of human growth and development' and 'normal' behaviour.

7.5 In relation to emotional needs the guidance drew attention to 'the sense of loss, isolation and powerlessness which accompanies placement in a secure unit',... which combined with 'pre-existing emotional difficulties and the feelings engendered by being closely confined may lead to an overwhelming sense of despair and a lack of trust in others'.

7.6 The NHS Health Advisory Service also published a report in 1986 on services for disturbed adolescents. ['Bridges over Troubled Waters' – March 1986] The group responsible for the report represented health, education and social services. They consulted widely, took evidence from many organisations and individuals and visited centres of various kinds in England, Scotland and Wales. Amongst the many issues relevant to the care of adolescents which they discussed, three in particular were relevant to the subject of the Inquiry. They were punishment and control, complaints procedures and information. In Paragraph 5.21 in relation to punishment and control they argued that in all institutional settings for children and young people there should be a general prohibition on 'inhuman and degrading treatment' as well as specific prohibitions on such 'inappropriate sanctions' as physical punishment, deprivation of food and drink, limitations on access to parents, relatives and friends, imposition of particular dress codes or uniforms, the use of drugs as a restraint, physical restraints or seclusion'.

7.7 The report argued also in Paragraph 5 in relation to complaints procedures and information that in all institutional settings for children and young people there should be 'well publicised complaints procedures, containing an independent element'; and that all young people should be given 'a handbook setting out clearly their rights, any specific rules of the institution, and how they should set about making a complaint'.

(b) Staffordshire and its Social Services

7.8 The first entry in the measures of control book for 245 Hartshill Road was on 14 January 1986 when two fifteen year old boys were admitted to the unit.

7.9 On 16 January when a statutory visit was paid to The Birches there were only seven children resident.
7.10 Organisational problems were continuing at 245 Hartshill Road, and there were log book entries, as in previous years, calling attention to shortages of many staple commodities.

7.11 Early in January there was the first mention of provision of a home tutor, for a boy, P. E., in constant difficulties in relation to education. She gave him a calendar for his room. A staff member wrote 'he's so pleased. It's sad that he can be so chuffed over such a little thing, poor kid'. The same boy was reluctant to go to Tony Latham's home, Duke's Lodge, to work so he locked himself behind the doors to the boiler room. When he refused to open the doors they were kicked in by one of the residential staff, and he then had to go to Duke's Lodge. The log book recorded 'HE HAD NO CHOICE!' His programme stated 'To go to Duke's Lodge as and when required.' In addition he was put on 'a heavy chores programme' to 'continue indefinitely (sic) until Glynis Mellors decided otherwise.

7.12 Although Glynis Mellors was taking a major role in relation to some children at this time, she was asked by Elizabeth Brennan to move to Duke's Lodge in January 1986. The North Staffordshire Voluntary Project which oversaw the running of nineteen voluntary projects set up by Tony Latham needed work to be done on its accounts and organisation. From January 1986 for most of the year Glynis Mellors was less involved in Pindown, but she continued to do residential work at The Birches for several months and her name or signature appeared on various programmes for children at 245 Hartshill Road.

7.13 In February 1986 more than two years after the 'special unit' started, a cook was appointed at 245 Hartshill Road and daily deliveries of milk and bread were at last arranged.

7.14 John Spurr reported to the director of social services on 27 February 1986 following a statutory visit to The Birches. At that time there were nine children accommodated, four adolescents in the main building and five younger children in the former staff house. He wrote that: 'the splitting up of the age groups (has) given the staff an opportunity to work more positively with the separate groups of children.'

7.15 By contrast the wear and tear on 245 Hartshill Road was considerable and in March 1986 a homes adviser had spent 'Christmas shopping money' to replace seating in the TV lounge, to buy some bedroom furniture and extra laundry equipment. Commenting on her report Fred Hill, senior assistant, wrote that 'this building continues to take quite a hammering because of the extensive use ... despite the total lack of domestic hours conditions appear to have improved.'

7.16 The same month, on 20 March 1986, Brendan Sullivan, assistant director (finance) paid a statutory visit to 245 Hartshill Road. Since his last visit redecoration work had been carried out and it was 'not the slum it was this time last year'. He thought that the home gave a favourable impression in terms of level of activity and the use to which it was being put.

7.17 Brendan Sullivan commented particularly on two aspects of the residents at the home though he said he 'did not enquire other than with superficial comments as to what was going on'. The first aspect was 'the use of what was described as a 'pindown' unit. Essentially this was one room in which one child was kept isolated (but the room was not locked) from the rest of the establishment to give him time 'to consider'. When I called the one boy in this room was working quite happily it appeared on homework. A member of staff is stationed in the office adjacent to this room and can keep an eye on any visits to the boy or his movements out of the room' (emphasis added).

7.18 The other aspect on which he commented was 'a mother and baby (who) were resident at the Home'. At the time the mother was out at work and the baby was being minded by a volunteer. Brendan Sullivan commented that 'I am not clear about the exact status'. His overall impression of the home was 'favourable' though 'some of the activities did appear to be none-routine!! (sic)' When the report of this statutory visit reached the District Advisory Sub-Committee there was no mention in it of 'Pindown'. Brendan Sullivan had also commented that on measures of control: 'a considerable list of detailed loss of privileges were recorded'. The report to the District Advisory Sub-Committee stated that 'the control over the children at the establishment again seems to have improved since my last visit children seem to be taking more care of their surroundings.'
7.19 Admissions to the unit at 245 Hartshill Road continued during 1986. In mid February there were eleven young people in all, some in the unit itself, and others in the rooms on the landing nearby. A boy whose foster home had broken down was brought in; an eleven year old boy who had been on a form of daily Pindown, returning home at night, was brought into residence for a 'contemplation retreat ... in Pindown room.' Two adolescent girls, one asthmatic and the other with the instruction 'not to be treated harshly' were admitted in March 1986. The second girl was described by a member of staff only a day later: 'this place is really cracking her up so I relented and joined the softly, softly approach.'

7.20 In early April 1986 a boy who was almost thirteen was admitted at his own request according to the record. The log book instructed 'start Pindown ... no calls, no visits, allowed clothes and shoes, no school work, to have a few days to think about things.' He had a history of absconding and was weepy on admission ... obviously re-thinking his ideas of care. MR LATHAM SAYS 'FIRM PRESSURE.' A week later he was recorded as 'not enjoying a "negative" approach.' After another week the log book recorded about this boy 'still shell shocked. I think he will be glad to get home.'

7.21 A thirteen year old boy who had already been in the 245 Hartshill Road unit before was there again in May 1986. He ran away and was to be put on 'STRICT PINDOWN' when he returned. He telephoned wanting to know if he could return and what would happen to him if he did. He was told that this was not known but that it was all right for him to return. The log book entry continued, 'HA HA HA. He returned 5:05 put him in back bedroom. He had a temper tantrum throwing things about (soon put a stop to that) Dose (sic) not know what he's done wrong. IS HE THICK?' The same day two hours or so later the log book recorded, 'asked for a drink - but sleeping brats don't need drinks - (therefore) guess the reply?'

7.22 In early June 1986 the same boy was in Pindown again 'until further notice'. His Sundays were spent at Duke's Lodge. In July he was still at 245 Hartshill Road and one of the staff recorded that 'he is at times very trying. If he was a horse we would have shot him by now.'

7.23 The fourth Pindown document, a copy of which appears in Appendix F as number 4, originated some time after July 1986 as part of a report entitled 'Intermediate Treatment in Newcastle, Staffordshire - Evaluation Report'. The report covered the period from August 1983 to July 1986 and was written by Glynis Mellors (then Bonnie), intermediate treatment manager. She told the Inquiry in evidence that she was asked by Tony Latham to prepare the report for Elizabeth Breman. 'I wrote it and then it would go for approval to Tony Latham.' She did not remember whether he had amended it but she agreed she had approved of the final version.

7.24 Tony Latham, in evidence, said that the report was written 'if I remember rightly, because we were at a point where we were ... fighting for resources in the Newcastle area ... it was a ... document which was used to try and increase that resource provision, ... it was designed to give Liz a full picture of the overall intermediate treatment resources, and that means how we were using Glynis as well ... part of Glynis's role ... was in the Pindown type of regime.' He agreed that he had approved the document.

7.25 A section of the main report was headed 'Intermediate Treatment - Preventative and Rehabilitation Work'. It first relates intermediate treatment to the re-organisation of the child care system in Staffordshire and to 'the ethos behind the Family Centre concept'. Arguing that in the past aspects of the child care service had been looked at 'in too much isolation' the document goes on to explain that a 'decision was made to treat both cause and effect simultaneously, not only from within the Community but also from within the residential setting'. It asserted that 'each child had similar problems giving rise to similar effects but the causes were identified as being different'.

7.26 It explained that complex individual programmes and contracts were drawn up 'to re-introduce both child and family into an acceptable environment from which both could operate effectively. To do this the programmes had to be removed to a setting 'equipped (sic) and designed to cater towards a resolve, as opposed to operating from a general base where specialist work was omnipotent'. The reasons why specialist work was 'impotent' in a general base were held to be:

(a) lack of uniformity of approach;
(b) demands and interruptions of other children’s needs;
(c) adverse effect of more difficult children on others.

7.27 To achieve the objective outlined above ‘a unit was set up detached from the main part of the residential building based at 245 Hartshill Road’. Initially it was referred to as ‘the special unit’. At the time when Document 4 was written it was known as the ‘Intensive Training Unit’. The instruction in Peter Crockett’s letter to Elizabeth Brennan of 22 November 1984 that the terms ‘special’ or ‘intensive’ were to be discontinued seemed to have been either not known or overlooked.

7.28 The unit in 245 Hartshill Road, the report continued, ‘soon became recognised as the place where problematical children were placed. Being totally isolated and self contained it enabled its residents to be observed, assessed, appraised and programmes developed. Above all, it enabled at times hard-line punishment and reward tactics to be adopted without influence, prejudice or inconsistency (sic)’ (emphasis added).

7.29 The report claimed that as the ‘radical’ practice of preventative and rehabilitative work was acknowledged, demand for it grew. Sometimes a family would be catered for, if interaction between parent and child needed to be assessed. Sometimes the unit was used as a ‘crash pad’. The report stated that: ‘it was and still is a pliant and very important tool to use in many cases’.

7.30 Contracts and programmes for children were ‘devised as a result of combined expertise and experience from the area officer, team leader and intermediate treatment manager’. [Tony Latham, Philip Price and Glynis Mellors.] The term ‘contract’ was defined as ‘a framework of criteria laid down by which the individual needs to operate to succeed’.

7.31 The report argued that preventative and rehabilitative work should not be used ‘solely at the point of crisis’ but that ‘steps should be taken well before this point to enable problems to be nipped in the bud’. ‘Contracts and programmes would denote punishment and rewards, immediate courses of action, specific goals, specific expectations, specific sanctions, time limits and controlled disciplines to be enforced by the appointed person. This enabled sanctions to be exercised . . .’ (emphasis added).

7.32 An essential element in the work described in the document was that ‘care is presented as a totally negative experience’ (emphasis added). It was linked in the argument with ‘negative I.T.’ Intermediate treatment, it argued, offered positive or negative experiences. Positive intermediate treatment was ‘all the “nice” things – holidays, camps, visits to places of interest etc.’ Negative intermediate treatment was ‘ensuring the participant clearly identifies, comes to terms with and works through his problems and is not allowed to take the easy way out.’

7.33 Examples were given in the report of ‘Intermediate treatment residencies’. One girl admitted to the Intensive Training Unit had a ‘programme . . . structured on what was called a “heavy pin down”, her only privilege being that of being allowed to attend school’. Another girl was in ‘intensive Pindown as a result of constant absconing from the Birches Family Centre, expelled from school, permissive (sic) behaviour and theft’.

7.34 In order to promote understanding of what the author of the report and her colleagues were offering, the report stated that meetings had taken place with local magistrates, and that not only were individual children’s contracts and programmes drawn up for juvenile courts, but also for the social services department, the probation service, parents and schools.

7.35 ‘Weekly reviews with the family and/or the individual appraised and evaluated progress and if necessary new criteria were introduced.’ Many meetings were held in the evenings to enable parents to participate. Children ‘earned’ benefits and privileges ‘away from the scenario of care’ which at times of dispute at home, it was suggested, could appear to be a ‘glamourous (sic) option’. To counteract this, as stated above, ‘care is presented as a totally negative experience’.
7.36 The programmes were recorded in duplicate note books with a page for each child. A number of these books were produced to the Inquiry. Programmes from 7 August 1985—end of December 1986 were examined. There were 272 programmes, or revisions or confirmations of existing programmes. They had been produced as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tony Latham</td>
<td>none</td>
</tr>
<tr>
<td>Philip Price</td>
<td>34</td>
</tr>
<tr>
<td>Glynis Mellors</td>
<td>17</td>
</tr>
<tr>
<td>John Aston</td>
<td>52</td>
</tr>
<tr>
<td>Louise Doherty</td>
<td>18</td>
</tr>
<tr>
<td>Damian Doherty</td>
<td>8</td>
</tr>
<tr>
<td>Jane Walton</td>
<td>3</td>
</tr>
<tr>
<td>Janet Daniels</td>
<td>1</td>
</tr>
<tr>
<td>Ican Scott</td>
<td>1</td>
</tr>
<tr>
<td>Unsigned</td>
<td>138</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>272</strong></td>
</tr>
</tbody>
</table>

7.37 A number of the unsigned programmes included decisions to put a child in 'basic pin down' which involved isolation, and on occasions substitution of night clothes or PE shorts for the child's own clothes.

An example of an unsigned programme was one on 11 February 1986: 'A very negative experience of care required for D.'

1. Rise at 7 a.m. Bath
   Bed at 7-30 p.m. after a bath
2. No contact with other residents
3. No privileges
4. No smoking
5. No phone calls
6. Not allowed out of room
7. To knock on his door if requires staff attention
8. Will not go out to school for the rest of the week possibly.'

For the same boy on 3 March another unsigned programme states 'Total pin down procedure. Not allowed out of room even to complete any chores. A hard lesson is required for this young man.' Another unsigned example dated 25 September 1986 states

'Basic programme
Bedtime 7 p.m.
Rise 7 a.m.
Bath — morning, night
No other contact with other residents
All meals to be taken in room
No visitors
No phone calls.'

7.38 The document gave examples of reports to juvenile courts on children who had been involved in the programmes and contracts. One of these related to a boy who had been in 245 Hartshill Road in 1984. The magistrates were told that 'at the beginning of the programme T. was schooled in our Education Department' (emphasis added). At the time this boy was at 245 Hartshill Road, Louise Doherty (then Ogbourne) was facing the problem of setting up a schoolroom. She told the Inquiry that 'when I started off it was made clear to me that there was no budget for it at all, and there certainly wasn't... I didn't have a pen. There were... a few textbooks, but they were very antiquated... I had no resources at all. So it was very, very difficult for me to work'. She said that there was no communication with the education department concerning the classroom: 'because it (the unit) wasn't recognised'.

7.39 During the summer months of 1986 statutory visitors reported that The Birches remained under-populated to the benefit of the children who were there. Discussion however, was going on about the relationship between The Birches and 245 Hartshill Road. Fred Hill visited 245 Hartshill Road on 29 July 1986 and reported that there was still heavy wear and tear at this establishment. Under general
comments he said 'most of the Family Centre work is still based at Harthill. Apparently following recent contact between Mrs Brennan and Mr Spurr, Mr Spurr has agreed to discuss with the Director on his return from holiday'.

7.40 Eileen Robinson carried out the August statutory visit to 245 Harthill Road and reported as follows: 'pending a decision at Central Office this establishment is continuing to operate as the “headquarters” of the Family Centre, with the staff house at The Birches providing for younger children'. Some rethinking was going on and she suggested that 'it may be that alternative proposals will emerge which will involve bringing The Birches back into use for younger children.' A note was written on this report by John Spurr saying that since Eileen Robinson's visit Elizabeth Brennan had confirmed that The Birches 'is reinstated as the Family Centre and the former staff house is not at present being used for residents. There are still some details to settle about some of the uses made of 245 Harthill Road, but its primary use has reverted to semi-staffed for older children' (emphasis added). Written in a different hand and unsigned there is also a note in capital letters saying 'The Birches is the Family Centre.' The reports of these statutory visits which went to the District Advisory Sub-Committee contained none of this information. There was also no mention of the 'Intensive Training Unit' in any of the reports.

7.41 In September 1986 Philip Price was seconded to undertake social work training in Wrexham. He was not then involved with 245 Harthill Road or The Birches for the next two years. It had been intended that he should commence his training in 1985 but he believed there was 'too much to be done' at that time and it was deferred. When he finally went he told the Inquiry he felt he was 'burned out' by the excessive hours of work which he had done in the preceding three years.

7.42 The statutory visit to 245 Harthill Road on 30 September 1986 was carried out by M. D. Willis, a senior assistant, who in noting '18 instances of children losing privileges and suffering minor sanctions' since the last official visit, pointed out that 'the measures of control book has no column in which to record the reason'. In this instance the report to the District Advisory Sub-Committee added new comments. It said 'that a widely used resource is the provision of family meetings to examine the tension of family dynamics. In conjunction with contractual work, these resources have been key factors in helping to prevent children from coming into care.' This visitor had also noted that the staff day room was 'no more than a broom cupboard'. This comment did not reach the committee.

7.43 The last statutory visit in 1986 of which a report was produced for the Inquiry was carried out by Mrs M. Jupp, a senior assistant, on 20 November. She noted under measures of control that since the last visit sixty measures had been recorded as 'all loss of privileges and entered each day imposed (sic).' Only five of the statutory visitors during 1986 signed the measures of control book. The signatures were in April, May, August, September and November.

7.44 Glynis Mellors had been moved to work at Duke's Lodge in January 1986. In her written statement to the Inquiry she indicated that she knew Duke's Lodge through her job as intermediate treatment manager. By 1986, she said that it had 'turned into a dilapidated area. A variety of equipment was stored there, YTS trainees, Community Programme trainees and volunteers were accommodated... Social workers would borrow minibuses to transport kids every day of the week... the phone never stopped ringing.' She often worked there at weekends as well as long hours during the week. She said that she got very frustrated at the conditions of work '...I had to go through pools of mud to get to my office and frequently had chickens flying at me'. She wrote to Elizabeth Brennan on 31st October 1986 and in consequence was moved back to The Birches, initially for six months.

7.45 Glynis Mellors was upset by the way in which her request was considered. She felt that it was seen as an opportunity to reduce costs whereas she herself had put in 'literally hundreds of hours of overtime with no thanks or recognition'. She believed that the social services department was happy to benefit from the additional resources which she and Tony Latham were making available, but 'were not prepared to make more than a token gesture to fund those resources'.

7.46 Glynis Mellors moved back to The Birches on 10 November 1986 where she continued to run the...
YTS scheme and also the accounts of all the nineteen companies within the North Staffordshire Voluntary Project. She remained at The Birches until she moved back to Duke’s Lodge in May 1987.

7.47 During October 1986 the log book at 245 Hartshill Road was used as a means of proposing the conversion of a sleeping in room into an office for the staff. Jaime Rodriguez, who by this time had returned to residential work again, promised to take the idea to Tony Latham.

7.48 The Birches still had a very small group in residence, but 245 Hartshill Road was so full that residents were subjected to more than usual bed moving, room changing and consequent lack of security. A member of staff wrote about one boy, ‘this poor lad does not know if he is coming or going. We will have to find him a bedroom. The times I had to disturb him during the night because he is sleeping on the landing floor is past a joke.’ The next day another member of staff was also moved by his plight: ‘very fed up with the isolation bit and very down about sleeping in the corridor’.

7.49 John Aston, on 1 November 1986, referred in the log book to the arrival of a new boy on 2 November. It was not clear at that point whether he would be residential or coming in by the day. His future activity, however, was already decided. It was reported that Tony Latham required him ‘to wash, scrub clean 1000 plant pots. To be done in middle laundry. . . . D. can go home when they are all done perfect. Restacked in the hall ready for collection.’ In the middle of this log book entry the following sentence appeared ‘If he (D.) doesn’t come in then T. to do them’.

7.50 Two more boys came in during the next few days and by 7 November the log book contained a complaint about high numbers and the need for more support. The following day, a Saturday, the member of staff telephoned Tony Latham ‘to see if he could send some work to keep T. and D. fully occupied. He suggested boxes of nuts, bolts and screws to be brought up from The Birches to be sorted out into appropriate piles.’ The same day the log book also recorded that a boy C. had not gone to Duke’s Lodge because ‘Tony does not need him’ (emphasis added).

7.51 On 11 November 1986 a boy who was in Pindown on a number of occasions was in again: ‘here for tea and punishment. To eat in front pindown – no contact with any other lads. Dirtiest, messiest jobs, he is not to stop until 7-30 p.m. (except for tea)’ (emphasis added).

7.52 Early in December 1986 two teenage girls were admitted to Pindown. A member of staff recorded about one of them, ‘this young lady came in on her high horse she soon climbed down when she found out what was in store for her’.

7.53 During 1986, 27 children were subject to Pindown in 245 Hartshill Road.
- The shortest episode was 1 day.
- The longest continuous episode was 37 days.

The total time spent in Pindown in 1986 at 245 Hartshill Road by each of the 27 children was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>2 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>3 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>4 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>5 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>6 days</td>
<td>3</td>
<td>1 each</td>
</tr>
<tr>
<td>7 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>8 days</td>
<td>2</td>
<td>2 each</td>
</tr>
<tr>
<td>9 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>10 days</td>
<td>2</td>
<td>2 each</td>
</tr>
<tr>
<td>11 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>12 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>Length of time in FIndown</td>
<td>No. of children</td>
<td>No. of episodes</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------</td>
<td>------------------------------------------</td>
</tr>
<tr>
<td>16 days</td>
<td>3</td>
<td>{</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 child – 1 episode</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 children – 2 episodes each</td>
</tr>
<tr>
<td>18 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>20 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>21 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>35 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>37 days</td>
<td>2</td>
<td>1 each</td>
</tr>
</tbody>
</table>

(c) County Council Financial Policies

7.54 The director of social services and the county treasurer again presented a joint report to the Social Services General Sub-Committee on 29 November 1986/7. The county council Policy and Resources Committee had set financial guidelines for spending committees. Over the whole social services department in 1986/87 there was growth of £1.2 million, savings of £300,000 and net growth therefore of £400,000.

7.55 In the development proposals put to the committee the only item specifically relating to child care was the appointment of clerical staff in relation to a child abuse review. In the 1986/87 estimates, compared with 1985/86, field social work showed some increase; family centres, long stay community homes and semi-staffed units showed either no increase or a slightly lower figure than the previous year; and intermediate treatment showed a very small increase. Boarding out expenditure remained almost the same as the previous year and preventive and support services were identical.

7.56 The savings which had to be made were eventually achieved 'for the most part by transferring responsibility for the payment of individuals in private and voluntary residential homes from the county council to the DHSS.' A witness told the Inquiry that it was fortunate that this opportunity was available; otherwise the situation would have meant not standing still but making substantial cuts.

(d) Social Services Re-Organisation

7.57 A major departmental re-organisation had taken place in 1985 and no further large scale re-organisation was currently being planned in 1986.

7.58 Changes likely to affect the rest of the residential child care service were, however, being considered in relation to Riverside (community home with education). The director of social services presented a report to the Social Services General Sub-Committee on 24 September 1986.

7.59 Staffordshire had, before 1981, had three community homes with education on the premises, totalling 186 beds in all. In 1981 two were closed and Riverside was adapted to provide 75 community home with education places, and a 25 place observation and assessment unit. In 1983 the community home with education was reduced from 75 to 50 places and observation and assessment increased from 25 to 28 places.

7.60 Since 1983 there had been a steady decline in numbers of residents in the long stay part of Riverside. During 1986 numbers had fallen as low as 20 and were 27 at the time the report was written. In the observation and assessment unit, however, there had been continually full occupation and greater demand than could be met. At the same time, the director reported, 'there are a number of children and young people who cannot be managed in the family centres, or in the community, and who need a period of residential care in a structured, controlled setting.'

7.61 Riverside was 'at a crossroads'. It cost almost £1,000,000 a year to run and field social workers had expressed a preference for its functions to be carried out in small units located in centres of population.
7.62 The director, however, felt its extensive facilities would be difficult to replace and was therefore proposing that it should be retained but operate on a different basis. His proposal was for a 50 place residential unit for girls and boys ‘requiring assessment, care and treatment which the area child care services may be unable to provide. ‘The purpose of the unit will be to give comprehensive assessment, care and treatment on an individual basis to delinquent anti-social and disordered girls and boys in the 11-17 years of age group who cannot be managed in more open settings.’ A decision had been made in 1985 not to open the two secure units formerly planned for Riverside: see Chapter 6. para 6.68.

7.63 The aim of the unit, according to the director, would be ‘to achieve stability and progress in the behaviour of children and young people’. The staff structure for 50 children and young people in such a unit was to consist of six teachers and twenty-eight residential staff of whom one was on a high salary grade and would be in charge but sixteen would be on salary scales which were unlikely to attract either experienced or qualified staff. A relatively small domestic staff and a small office group were to complete the establishment.

7.64 In recommending this re-organisation of Riverside the director told the committee that it was intended ‘that the proposed changes will provide the foundation for creating a skilled source of help for difficult young people and their families, which the area social work staff will find positive and imaginatively responsive, while also producing considerable savings on current costs’. He did not explain how the observation and assessment demand, ‘greater than (Riverside) can meet’ would be provided in conjunction with the kinds of care outlined above, particularly taking into account that the full use made of the observation and assessment unit was due to the numbers of children and young people remanded by the juvenile courts.

(e) The Career of Tony Latham

7.65 Tony Latham had worked closely with Peter Crockett, currently deputy director of social services, when he was a social worker in Longton and Peter Crockett was the principal area officer for Stoke-on-Trent. During that time Peter Crockett had actively encouraged Tony Latham’s promotion of intermediate treatment and associated activities. When Peter Crockett became assistant director (service delivery) he continued to take an interest in Tony Latham’s work.

7.66 Elizabeth Brennan, principal area officer, was Tony Latham’s line manager in Newcastle-under-Lyme from 1 April 1983 and he was one of her most senior members of staff. Particularly when the changes were made in the responsibilities of area officers, Elizabeth Brennan and Tony Latham worked closely together.

7.67 Peter Crockett as assistant director (service delivery) had an overview of what was going on at field level throughout the department and admired what he saw as Tony Latham’s initiative and energy. Elizabeth Brennan told us that ‘Mr Crockett was the one who used to suggest to the other area officers that they should be as enterprising as Mr Latham.’ Tony Latham was aware of the differences between his own situation and others in relation to senior managers. He told the Inquiry that whilst it was unusual for staff at his level to have access to senior managers, the sort of work he was doing constantly brought him into touch with them. When, for example, he was asked to develop intermediate treatment all over the Stoke-on-Trent area he became involved with managers other than his own and he told us that he got ‘sucked into the next tier of management’, partly because of the ‘conflict between areas and divisions, and not a lot of working together between one area and another.’ He added that ‘as soon as somebody crosses that border, which is what my work invariably did . . . then somebody else over and above them used to have to intervene to sort out my position, which is where I got involved with Peter Crockett.’ Later, he believed that, ‘there was always a lot of confusion between John Spurr’s role and Peter Crockett’s role’, and he was aware that this caused frustration to some senior managers. With reference to tasks he undertook at the request of senior managers both before and after 1983, he told us that he never received even a temporary upgrading nor any additional status to handle the people and problems involved.

7.68 Elizabeth Brennan became anxious and critical regarding the conflicts created by the demands on
Tony Latham. His new area office post had increased his responsibilities considerably and separately he was personally involved and playing a key role in the decision making in a large network of diverse activities, projects and businesses. She was aware that he was working extremely long hours. She and Peter Crockett had a discussion with Tony Latham about this and she expressed the view that his area responsibilities were suffering as the result of his other enterprises. After the meeting she decided to write to Peter Crockett. The letter dated 11 July 1986 was marked strictly confidential at the time but it was the subject of discussion at the time of the Inquiry.

7.69 Elizabeth Brennan’s letter stated that she could confirm that Tony Latham had mainly carried out the work of his various projects in his own time. Because, however, of the very close relationship between the projects and the work of the family centre he still got directly involved in matters at the family centre which she ‘would not normally expect an area officer to get involved with’.

7.70 Elizabeth Brennan explained to the Inquiry that there had been a direct overlap between the work of the family centre in Newcastle and Tony Latham’s Community Programme Scheme. This was because staff shortages in the residential units had led her and her colleagues to use people from the Community Programme Scheme as social services aides who then worked as temporary staff in residential child care.

7.71 She went on to write that although Tony Latham was spending more time managing the area office child care team than he had been formerly, ‘it is still far from satisfactory’. Too much responsibility was being left to senior social workers particularly in relation to child abuse. It has to be noted that the proportion of qualified field social workers in Staffordshire even at the time of the Inquiry was very low by comparison with other local authorities. In 1986 the proportion was even lower in this particularly demanding area of work.

7.72 Elizabeth Brennan wrote to Peter Crockett ‘I am aware that Mr Latham works many more hours than he should for the department, but a lot of this is of his own making. Because of the hours he works he gets extremely tired and it is having a serious effect on his health. He is also asking to take more time off in lieu so that he has more time during the day to do his project work’. She told us that she received no reply to the letter.

7.73 In strict line management terms John Spurr was Elizabeth Brennan’s line manager, but Peter Crockett had been concerned with Tony Latham’s enterprises and had wished to be involved in the discussion which preceded her letter. This was not the only occasion when we observed departmental lines of communication and accountability being bypassed.

7.74 Elizabeth Brennan’s perception that her line management role in relation to Tony Latham was not as clear as she would have liked, was due to her feeling that his work outside his area responsibilities was being ‘sanctioned at a high level’. This put her in a dilemma as his line manager. She was also not sure that the full implications of the developments for which he was responsible were clearly understood by those, whoever they were, who were lending him their support.

7.75 Tony Latham told the Inquiry that during the latter end of 1986 he had been to a meeting with Roy Hudson (a Deputy Clerk), Brendan Sullivan, assistant director of social services (finance) and Peter Crockett, deputy director of social services. At that time, acting on advice he had been forming companies in some of his enterprises. At the meeting those present had discussed ‘at some length’ what Tony Latham was doing and the risks which he and other social workers in his position were taking in acting as members of executive committees or directors of companies, and what protection, if any, might be offered to them by the local authority. Nothing, in fact, subsequently materialised according to Tony Latham. He told the Inquiry that ‘as everything was up and running at the time . . . I just carried on’.

7.76 Some changes began to take place, however, and Longton Volunteer Centre and Longton Resource Centre Community Programme closed in November and December 1986 respectively.
Chapter 8: 1987

(a) National Events

8.1 In 1987 Staffordshire was one of six local authorities invited to participate in an inspection of family centres by the Social Services Inspectorate.

8.2 The previous year a national survey of family centres had been carried out prior to the selection of a sample of centres for more detailed study. The inspections in 1987 were concerned with the use of family centres run primarily as an alternative to the more traditional means by which local authority social services departments have provided services.

8.3 The 1986 survey had identified eight categories of family centres which were divided into residential and non-residential ones. There were two residential categories: converted children’s homes and ‘special’ residential family centres.

8.4 Because the House of Commons Social Services Committee in its second report on children in care in 1984 had been concerned, as noted before in Chapter 4, paragraph 4.4, that family centres based on ‘re-cycled children’s homes’ might become ‘an unhappy mish-mash of family centre, playschool, crisis intervention centre and residential home’ the Inspectorate decided to concentrate exclusively in its 1987 inspection on residential family centres based in converted children’s homes. Staffordshire County Council, having been invited to participate, chose ‘The Alders at Tamworth and The Birches at Newcastle-under-Lyme to be inspected. The report of the various inspections was eventually published in 1988 entitled ‘Family Centres – A Change of Name or a Change of Practice’. Insofar as the inspection of The Birches is relevant to the Inquiry it is dealt with below in paras. 8.33 and 8.40 to 8.45 and in chapter 12 para. 12.74. The visit to The Alders has no relevance to the Inquiry.

8.5 During 1987 the DHSS published practice guidance to social workers under the title ‘Reports to Courts’. In a section under the heading ‘The Child Away from Home’ attention was drawn to the importance of involving residential child care staff in the preparation of reports.

(b) Staffordshire and its Social Services

8.6 The practice of Pindown was in its fourth year when 1987 began. A 14 year old boy who was already in the unit on 6 January was described by John Aston as ‘very quiet, lonely and bored. Need to find something that we can occupy him with.’

8.7 A thirteen year old girl was admitted on 19 January 1987 ‘very upset’. The boy described above, on 29 January ‘spent a good deal of time sobbing his heart out . . . grieving. Very co-operative and well mannered.’ The girl who had come in on 19 January was described as ‘quiet – still looking shocked at being here – but well behaved’. The following day one of the regular staff working with these two children recorded in the log book, ‘in my infinite wisdom allowed them a book’.

8.8 A statutory visit was paid to 245 Hartshill Road on 21 January 1987 and the visitor noted that some of the measures of control used since the last visit were related to non-attendance at school. Although Elizabeth Brennan had told John Spurr in autumn 1986 that 245 Hartshill Road’s ‘primary use has reverted to semi-staffed for older children’ the Pindown group continued with school age children as well as older ones.

8.9 On 10 February 1987 a boy of just fifteen was brought in and then jumped out of the bathroom window and ran away. Later in the day he was brought back. The log book recorded: ‘collected him from home what a performance that was. He just did not want to come back to Hartshill Road, I wonder why? L. and I convinced him that it was the only place to be. We put him in the Royal Suite it is the nicest room in the building. Stoke police have been informed that he’s back at the Hotel del Doss.’ The next day Pyjamas had to be borrowed for him and at 8 p.m. he absconded in the pyjamas through the bathroom window.
again. The following day his parents decided to keep him at home.

8.10 Two more boys went into Pindown on 20 February 1987 and a third on 25 February. A statutory visitor on 26 February 1987 recorded in her report that there had been 58 measures of control used since the last visit. There was no other comment except that they were 'within guidelines'. The member of staff on duty when the visitor came recorded in the log book that the 'statutory visitor called short and sweet no problems.'

8.11 At The Birches the numbers of residents had been rising again and a statutory visitor on 18 February noted that 'recent rise in admissions to Rivers from the area had been necessary because of lack of vacancies at The Centre.'

8.12 In April 1987 Tony Latham began a period of six weeks' sick leave. Before that he had signed the measures of control book for several days authorizing loss of privileges and other routine measures of control. The signature authorizing these measures of control had otherwise been illegible since Philip Price went for training in autumn 1986. It continued to be illegible until almost the end of 1987 when Peter Nicol-Harper's signature began to appear regularly.

8.13 In April a fourteen year old boy was admitted to Pindown. The log book described how he felt: 'got very upset and angry at first - he hit the wall and cried . . . he clearly is very confused by life and cannot seem to see any way out of the trap he feels he's in.' The next day another member of staff recorded that there were 'no problems, such a shame. He is a nice lad. Just needs a family'.

8.14 The statutory visit to 245 Hartshill Road on 24 March 1987 was carried out by Mr I. D. Cunnett, a senior assistant at headquarters. Under 'Control', additional measures since the previous official visit, the comment was 'J. T. Planned programme of continuous negative care - under review by Officer-in-Charge weekly' (emphasis added). The report to the District Advisory Sub-Committee under 'control' said 'appears within guidelines'.

8.15 One of the very young children who experienced Pindown, a ten year old, came in on 7 May 1987. He was described in the log book: 'he's just a little boy EDT (Emergency Duty Team) delivered him at 12-40 . . . still crying at 2-30 a.m.' The next day this child was so distressed another member of staff recorded that he was trying everything to get out. He had attempted to abscond three times 'then tried to bite himself to death, made himself sick and finally tried to open his tummy up with his finger nails . . . when everything failed finally went to sleep at 12-00.' Another member of staff the next day recorded that he was still trying desperately to get out 'he cannot understand . . . why he can't a) see mum b) watch television c) go outside and play.'

8.16 During May 1987 Glynis Mellors moved back from The Birches to Duke's Lodge. At central office Audrey Williams, formerly principal area officer, Stoke-on-Trent, was appointed assistant director. Philip Owen was appointed to take her place in Stoke.

8.17 At The Birches a 'training flat' had been established and a statutory visitor in April 1987 commented that the group of children living there seemed to be getting younger. The statutory visit on 25 June 1987 was at a time when two children had an illness for which they should have been able to be isolated in one bedroom but this was not possible. The visitor commented that pre-school children and teenagers were having to share sleeping accommodation which was not desirable.

8.18 On 1 June 1987 Louise Doherty (then Ogborne) wrote in the log book: 'it would be difficult to give any reader an adequate idea of the atmosphere here tonight. 245 is ticking away like a time bomb. The majority of residents, notably (then followed a list of names) are demanding, ignorant, selfish, thoughtless people. I think I would like to work with animals . . . they're much nicer.' The next day Graham Toplass drew up a list of 'new rules and punishments' which were discussed with 'all residents'. It was recorded that after some initial resistance they were accepted 'well'.
8.19 Early in June 1987 the ten year old boy was again in Pindown, so upset that Graham Toplass wrote, ‘I am getting very concerned about this little chap, he’s off his food, feeling sick all the time. Dr S. came to give him his medical, I asked his opinion, he says it could be nerves.’ The child’s mother did not come to his review and he was very upset again and said she had let him down. A member of staff reminded him how many times he had let his mother down and how bad it feels.’ Three days later he was discharged to his home.

8.20 The statutory visitors to 245 Hartshill Road for June and July 1987 called when Jaime Rodriguez was on duty. The report of 9 June noted under measures of control, ‘pages of loss of privilege recorded’. The one in July noted one absconder and forty-one measures of control since the last visit. The District Advisory Sub-Committee was told in statutory visit reports for June and August 1987 about the work being done in intermediate treatment and with family meetings but there was no mention of the many measures of control or the special unit.

8.21 In July 1987 there was a dysentery infection amongst the children at The Birches. By this time there were thirteen children most of whom were under thirteen years of age.

8.22 In July 1987 a girl of mixed race was in Pindown at 245 Hartshill Road. A member of staff recorded in the log book that ‘this girl talks as if she requires a 5 STAR HOTEL - requesting food that West Indians eat c.g. swordfish.’ Also in July, a schoolboy, D. G. who was in Pindown on a number of occasions, ‘decided not to work at D/L (Duke’s Lodge) today’. The log book records ‘I have put him in the Back Pindown room, moved B . . . to the front, R . . . schooling on the landing’. D. G. remained in Pindown till school on Monday.

8.23 The report of the statutory visit of 25 August 1987 was much fuller than usual. It was critical of physical conditions in kitchens, bathrooms, and toilets, and maintenance in other parts of the building. It also commented on matters concerning the children: ‘this home deals with a small number (one or two) of children with behavioural problems who stay for a short assessment period. 2 such children have had privileges withdrawn - one for 4 days, one for 5 days e.g. no television, confined to premises, no late nights.’ The report continued, ‘the aim of this unit is to prepare youngsters who are about to leave care for independence. Facilities are not ideal for this and the building in general is not in good repair. Its rambling nature makes supervision with limited staffing rather difficult.’ In the report to the District Advisory Sub-Committee there was no reference to these matters. The general condition of the establishment was noted: ‘Some areas are in need of redecoration and will be dealt with in the current financial year.’ Under the heading of ‘Control’, the comment was ‘satisfactory’.

8.24 In August 1987 Peter Nicol-Harper, who had been seconded for social work training in 1985 returned to work in The Birches. At 245 Hartshill Road there was another new rule, that residents of the establishment were not to visit residents of halfway houses (SHAP) a number of whom were likely to be former residents.

8.25 Peter Nicol-Harper was taking a more senior role after he returned from training and began to organise reviews and staff meetings. He also sorted out regular fire drills, began to promote staff development opportunities and discussions about difficult issues such as cannabis smoking. Jaime Rodriguez was also promoting staff development on racial issues.

8.26 In September 1987 one of the girls at 245 Hartshill Road was being transported on Sundays by John Aston to Duke’s Lodge to work at the snack bar there. On 11 and 12 September two staff matters were recorded in the log book, Tony Latham’s leaving party on 18 September on the occasion of his going to headquarters to work and the marriage of two staff at The Birches and 245 Hartshill Road, Louise Ogborne and Damian Doherty.

8.27 From September 1987, 245 Hartshill Road and The Birches had, for the time being, lost all three of the team who had worked together so closely initially in 1983 and later, namely Tony Latham, Philip Price and Glynis Mellors. Tony Latham had become the Voluntary Projects Co-Ordinator, Philip Price was
away at a training course and Glynis Mellors was working at Duke's Lodge on accounts and administration. Jane Taylor succeeded Tony Latham as area officer (children and families). Jaime Rodriguez, as Team Leader and Peter Nicol-Harper, as acting team leader for a time were working at The Birches and 245 Hartshill Road. Elizabeth Brennan was able, at this point, to hand over a significant amount of child care work to Jane Taylor who did not play the same kind of role in relation to the residential units as Tony Latham had done.

8.28 Statutory visitors to 245 Hartshill Road commented in September 1987 on the staff being 'enthusiastic and caring', and in October on the setting up of 'counselling rooms' and a 'semi-independent living flat' which needed furnishing. Pindown was continuing and two adolescent girls came in during September. One was described on 24 September in the log book as having no change of underwear and 'keeps asking for her clothes'. There was also no spare dressing gown. Two days later she was 'not coping with pindown at all'. The same day she ran away but did not get very far before she was caught and brought back. The log book recorded: 'the place is getting to her. She has no power of discrition (sic) i.e. Discribe (sic) your room at home answer “my room is nice”'!

8.29 The provision of education in the unit had deteriorated and in late September 1987 a child who needed special education was recorded as 'being schooled' in pyjamas by a Community Project worker. He had run away from The Birches with two girls. He was taken straight to Pindown after being seen by Jaime Rodriguez. One of the girls was sent to Riverside. The other remained at The Birches.

8.30 In early October 1987 the log book was again used for trade union communications at The Birches, this time informing staff that they should not co-operate with the piloting of a new departmental filing system. There was an announcement in the 245 Hartshill Road log book of a staff meeting at which future policy in relation to the home was to be discussed. There was no record of what took place.

8.31 On 7 October 1987 a girl who was almost fifteen and who was to spend, in total, one of the highest number of days in Pindown was recorded as coming voluntarily to 245 Hartshill Road to meet her social worker 'and admit herself to Pindown'. It was clearly a very important event in her life and she wrote a story about herself entitled 'Decision Time' in which she as the author described what happened to a small girl' who was herself. It portrays the insecurity of a child in an adult world in which changes happen which she cannot control but as a result of which 'her heart was broken'. The end of the story was when after losing 'all she ever lived for', she was 'put into care' and realized a 'choice has to be made – her life rests on her decision'.

8.32 A parent telephoned on 5 November 1987 asking for his ten year old daughter to be admitted to 245 Hartshill Road. The log book recorded that a member of staff 'informed him we were not an HOTEL and did not take bookings'. Also in early November Louise Doherty who had previously been employed as a social services aide was appointed as a social worker. She wrote a message on 3 November 'IMPORTANT – EVERYBODY. Tues 10 Nov. 87. DHSS Inspection takes place. Please ensure:
(1) The building is clean and tidy (Marg. is coming in at 11a.m. on that day to clean)
(2) All files are tidy and up to date
(3) Filing cabinet is tidy
(4) The office is clutter free and as “professional” looking as possible.
(5) Fire book up to date and easy to read
(6) Measure of control book up to date.'

8.33 At The Birches on 2 or 3 November 1987, it is not clear from the entry which date is correct, a member of staff had used the log book to alert colleagues to the Social Services Inspection on 10 November. The entry read 'DHSS Inspection. Files need to be tidy and up to date. Building to be clean.' Someone else had written beside it 'Why?' In fact as contemporary correspondence shows the visits by the Social Services Inspectors on 10 November were arranged 'simply to have seen' the centres and 'met the officers in charge before December' when the inspection was to take place. Neither log book at 245 Hartshill Road or The Birches mentioned the visit on 10 November. The two weeks which had been agreed for the inspection were 7-11 and 14-18 December 1987.
8.34 In late November 1987 a note was written in the 245 Hartshill Road log book, *Riverside situation*—No child admitted from Riverside to Hartshill Road without permission from Jaime, Jane (Taylor) or Liz (Elizabeth Brennan). Children from the Newcastle area who would normally be admitted to Riverside will be admitted here.

8.35 During November 1987 The Birches transferred three of their group to 245 Hartshill Road. A child being given a ‘fireman’s lift’ by a member of staff had her eyebrow gashed and had to have stitches in it in hospital. One of the older girls attacked another girl at school and was suspended. She later ran away again and after being picked up was placed at 245 Hartshill Road.

8.36 Mr I. D. Cunnett the statutory visitor to 245 Hartshill Road on 20 November 1987 noted in his report, though it was not included in the report to the District Advisory Sub-Committee, that ‘the same young person since 10.11.87 (was) confined to house in evenings but as a result of absconding from school is now confined to bedroom (in pyjamas) at time of visit. Family meeting arranged for 23.11.87.’ This entry appeared under the measures of control heading. The boy concerned appears from the records to have been one who was in Pindown on a number of occasions. Although the visitor recorded ‘2 residents at time of visit’ and ‘2 young people receiving intermittent care’ he wrote ‘none . . . were seen on this occasion.’

8.37 Two important entries in relation to records were made in the log book at 245 Hartshill Road on 14 and 15 November 1987. On 14 November Graham Toplass drew Peter Nicol-Harper’s attention to the need to enter admissions and discharges to and from 245 Hartshill Road in the register at 245 Hartshill Road ‘as numbers will (otherwise) be wrong when totalled up.’ The next day Peter Nicol-Harper recorded in the log book, ‘Graham – Jaime says it is not necessary to admit Birches kids to Pindown here – they should stay on The Birches register.’ The Social Services Inspection took place at The Birches between 11 and 17 December. On 24 December a note was written in the 245 Hartshill Road log book all in capitals, ‘ADMISSIONS TO CARE WILL NOW TAKE PLACE AT 245 UNTIL FURTHER NOTICE.’

8.38 On 2 December 1987 Peter Nicol-Harper recorded in the log book at 245 Hartshill Road, ‘5 in Pindown.’ The next day he added that he had ‘forgotten to put the saucepan on the doorhandle’ in Pindown. On 9 December Peter Nicol-Harper recorded that a letter had been sent to the families who were to be involved in family meetings which the Social Services Inspector hoped to observe. At just after midnight on 11/12 December a teenage girl was brought into Pindown by the police having run away from The Birches. A member of staff wrote on 13 December that she ‘must work her short and curries off and not stop till she drops’. A boy was moved into the front Pindown room on 13 December. On 14 December 1987 Peter Nicol-Harper recorded about the teenage girl ‘L. wants to wash her clothes – is this a privilege she still has to earn?’

8.39 The Social Services Inspectors had started their visits at The Alders in Tamworth on 5 December 1987. On 11 December they paid their first visit to The Birches to meet all the staff. The same day at 245 Hartshill Road the log book has an entry ‘Mike Thomas (a social worker) rang. He will be bringing a boy on Monday afternoon to show him the pindown. Would you lay it out a bit please.’

8.40 The programme of the Social Services Inspectors’ visit which was produced for the Inquiry began on Monday 14 December. The team leader at The Birches, Jaime Rodriguez had drawn it up after discussion with Elizabeth Brennan. A general discussion was planned on ‘philosophy, staffing, rota, procedures etc., child care practices, work loads, case work, shared programmes etc., files.’ At 2 p.m. a ‘general discussion at 245 Hartshill Road (similar to The Birches)’ was arranged. At 4 p.m. there was a meeting with Jaime Rodriguez and Bob Sharp, manager of the community programme, about transport, intermediate treatment and day care. At 5 p.m.-7 p.m. the Inspectors were invited to attend and observe family meetings. These took place at 245 Hartshill Road and the Inspectors, in evidence, said they attended only one. One of the two families did not want observers to be present.

8.41 On 15 December a boy was admitted to ‘basic pindown’ with ‘a member of the Stoke team’ who was
to spend the night there 'to babysit him'. A boy who had already been in Pindown was warned that if he made any contact with the newcomer 'he would be in trouble'. A teenage girl was described in the log book: 'no problems in her behaviour, but her room smells, I hope she's not up to her tricks again.' She was a bed wetter.

8.42 The Social Services Inspectors' programme for Tuesday 15 December was 'observation of establishments' routines' in the morning and at 2 p.m. 'general discussion Supportive Accommodation – Visit to Houses'. This was the Supportive Housing Accommodation Project which was formally launched in 1987. From 5-30 p.m. the Inspectors were to observe the activities of an intermediate treatment group. The Birches log book recorded on 15 December: 'DHSS – Jim and Ian stayed from 5 p.m.–7.30.' Later on the same day there was another entry 'DHSS men returned at 10-15 and were impressed by the QUIETNESS'.

8.43 On Wednesday 16 December 1987 the Inspectors' programme included a visit to Duke's Lodge at 10-30 a.m. and a discussion of 'weekend I.T.' The afternoon was for observation and further discussion with the family centre team leader if necessary. On Thursday 17 December there was a feedback session with family centre staff before the inspection ended. No formal record was made of this session.

8.44 Elizabeth Brennan told the Inquiry that although she had met the Inspectors briefly at the beginning of their visits in the Newcastle area she had left the main organisation and contact to Jaime Rodriguez.

8.45 The Social Services Inspectors had a meeting with the director of social services following the inspection. No formal record of this meeting was produced to the Inquiry.

8.46 The inspection by the SSI is further considered in Chapter 12, para. 12.74.

8.47 A final statutory visit for the year 1987 took place at The Birches on 15 December. It was carried out by Peter Warren who was received by Alf Werner, a social worker. Peter Warren's report recorded that two children had absconded since the last official visit and '21 recorded measures of control where youngsters lost privileges'. In fact 20 of these referred to one child. No reference to the measures appeared in the District Advisory Sub-Committee report. The visitor noted that the outside yard was in a dangerous condition and that the county council could be liable if there were an accident.

8.48 In December 1987 Jaime Rodriguez who had been temporary team leader at The Birches returned to the Newcastle area office and Peter Nicol-Harper took on responsibility for The Birches and 245 Hartshill Road. Arrangements for Christmas at The Birches included receiving some of the children at 245 Hartshill Road. There was then a gap in the log book for 245 Hartshill Road between Christmas Eve 24 December and 4 January 1988 when Pindown began again.

8.49 During 1987, 30 children were subject to Pindown in 245 Hartshill Road:
- The shortest episode was one day.
- The longest continuous episode was 25 days.
The total time spent in Pindown in 1987 by each of the 30 children was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>2 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>3 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>4 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>5 days</td>
<td>1</td>
<td>4 episodes</td>
</tr>
<tr>
<td>6 days</td>
<td>3</td>
<td>1 each</td>
</tr>
</tbody>
</table>
(c) County Council Financial Policies

8.50 Over the whole social services department in 1987/88 there was growth of £1.7 million, savings of £500,000 and net growth therefore of £1.2 million.

8.51 A proposal for the closure of Riverside (a community home with education) was included in the social services budget in a joint report by the director of social services and the county treasurer. The estimated saving was £237,600 in 1987/88 and subsequent years.

8.52 Amongst developments proposed for 1987/88 were additional staff for Tamworth family centre (£7,730) and additional cooking hours for family centres (£10,260).

8.53 Within the overall budget of the county council the social services budget in 1983/84 had represented 8.8 per cent. In 1987/88 the social services budget represented 10.15 per cent.

8.54 A comparison of Staffordshire’s personal social services net spending per head of the population with the average for shire counties showed that in 1983/84 in a ranking out of 39, Staffordshire was 35. In 1987/88 Staffordshire was 33.

8.55 A comparison of the proportion of gross social services expenditure spent on child care in Staffordshire compared with the average for English counties showed the following:

<table>
<thead>
<tr>
<th>Year</th>
<th>Staffordshire</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1983/84</td>
<td>12.3</td>
<td>16.9</td>
</tr>
<tr>
<td>1984/85</td>
<td>13.4</td>
<td>16.1</td>
</tr>
<tr>
<td>1985/86</td>
<td>12.5</td>
<td>15.7</td>
</tr>
<tr>
<td>1986/87</td>
<td>12.4</td>
<td>15.6</td>
</tr>
<tr>
<td>1987/88</td>
<td>11.9</td>
<td>15.6</td>
</tr>
</tbody>
</table>

8.56 In the Audit Commission’s county council profile for Staffordshire, its personal social services expenditure was compared with a ‘family’ of similar local authorities. These were South Glamorgan, Cleveland, Humberside, Durham, Gwent, Mid Glamorgan, West Glamorgan, Derbyshire, Nottinghamshire and Lancashire. Expenditure per head was then shown under the headings of elderly, children, disability, other clients, field work and administration. Comparisons started in 1984/85. In this comparison child care expenditure in Staffordshire was as follows:
<table>
<thead>
<tr>
<th>Year</th>
<th>Staffordshire</th>
<th>'Family' average</th>
<th>Staffordshire as % of 'family' average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984/85</td>
<td>4.6</td>
<td>8.6</td>
<td>53.5</td>
</tr>
<tr>
<td>1985/86</td>
<td>5.2</td>
<td>8.6</td>
<td>60.5</td>
</tr>
<tr>
<td>1986/87</td>
<td>5.3</td>
<td>9.3</td>
<td>57.0</td>
</tr>
<tr>
<td>1987/88</td>
<td>5.5</td>
<td>10.4</td>
<td>52.9</td>
</tr>
</tbody>
</table>

8.57 A similar comparison made by the Audit Commission for expenditure on administration was as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Staffordshire</th>
<th>'Family' average</th>
<th>Staffordshire as % of 'family' average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1984/85</td>
<td>3.4</td>
<td>6.2</td>
<td>54.8</td>
</tr>
<tr>
<td>1985/86</td>
<td>3.4</td>
<td>6.0</td>
<td>56.7</td>
</tr>
<tr>
<td>1986/87</td>
<td>3.7</td>
<td>6.9</td>
<td>53.6</td>
</tr>
<tr>
<td>1987/88</td>
<td>4.4</td>
<td>7.5</td>
<td>58.7</td>
</tr>
</tbody>
</table>

8.58 Some small re-organisational changes took place in 1987 associated with the work which until then Tony Latham had developed outside the social services department.

8.59 On 6 February 1987 a confidential report was put to the General Sub-Committee of the Social Services Committee proposing that an existing post at headquarters should be re-designated to take over, maintain, develop and co-ordinate the voluntary activities which had been developed by Tony Latham. These were:

- (a) **The Community and Social Services YTS Ltd.** involving 9 centres and projects and 120 young people;
- (b) **North Staffs Resource CP Ltd.** which catered for 60 adult staff wanting to enter community or social work, some disadvantaged adults and some young people. There were 23 projects involved;
- (c) **North Staffs Voluntary Projects Ltd.** the major function of which was to obtain and manage resources for the other projects;
- (d) **Community and Social Services Transport Ltd.;**
- (e) **Forest Enterprises Ltd.**

8.60 The director's report on 6 February 1987 told the committee that these enterprises, which it was no longer possible for Tony Latham to combine with his post as area officer (children and families) for the Newcastle area, would be 'a considerable loss to the county if (they) . . . were to fold because of absence of direction and leadership.' The new post to be known as Voluntary Bodies Co-Ordinator was required to enable the activities to continue.

8.61 The director also acknowledged that 'a more co-ordinated approach to the development of links with voluntary bodies in the county' was required. Discussions with voluntary bodies in Staffordshire were taking place which it was hoped would achieve this.

8.62 The post of Voluntary Bodies Co-Ordinator was established and advertised. Tony Latham was appointed on 1 July 1987.

8.63 On 27 November 1987 the director made a further report to the General Sub-Committee of the Social Services Committee. He explained that the 30 or so companies and projects currently being co-ordinated by the Voluntary Bodies Co-Ordinator had been regrouped. Because of the scale of the
responsible for the social services department during 1987. Riverside (a community home with education) was being gradually run down but did not close until 1988.

8.65 An important report entitled 'The Way Forward' was written in 1987 at the director's request by Audrey Williams, assistant director. It was discussed at a meeting of the social services committee in the autumn of 1987. The document is undated but internal evidence indicated that it was post August 1987 and it is understood to have been given to the Social Services Inspectorate as background information for their visits in December 1987.

8.66 It was a review document which provided a detailed overview of the child care service currently provided and a number of major conclusions and recommendations pointing to the need for development 'for the next 5/10 years.' It did not affect services during 1987.

(e) The Career of Tony Latham

8.67 By the beginning of 1987 Tony Latham and Elizabeth Brennan, principal area officer, had agreed that he could not maintain his role of area officer (children and families) in Newcastle combined with the management of so many different voluntary activities and projects. Tony Latham became ill in April 1987 and was away from work for six weeks. There had been other periods of sick leave leading up to what Elizabeth Brennan saw as a crisis requiring assessment of the whole situation. She told the Inquiry that after Tony Latham's protracted period of sick leave in April and May 1987 she decided that he should begin to wind down the enterprises for which he was responsible outside of the social services department and told him that he must do so.

8.68 As described previously in paragraphs 8.58 to 8.61 Tony Latham was then appointed Voluntary Bodies Co-Ordinator on 1 July 1987. In his statement to the Inquiry he indicated that 'at the time I recognised that I was ideally suited to this job although in some ways I felt that I was manoeuvred into it . . . (it was) more an administrative and policy making job than one involving individual social work skills and I was quite reluctant to take it.'

8.69 Also during 1987 SHAP (Supportive Housing Accommodation Project) was formally founded, having been started by Tony Latham and Philip Price in 1984.
Chapter 9: 1988

(a) National Events

9.1 The Wagner Committee report, 'Residential Care – A Positive Choice', was published by H.M.S.O. in 1988. The report sought to improve the public’s perception of the residential sector. It stressed in particular the importance of the following matters: residential care being a positive experience; adequate provision of residential accommodation for children; staff being trained and qualified; and the availability of well-publicised complaints procedures involving independent advocacy. Also the report emphasised the importance of guidelines on staffing ratios.

9.2 The importance of a formal and well understood complaints procedure was also indicated during 1988 in a report of the Social Services Inspectorate on Youth Treatment Centres.

9.3 The House of Commons Social Services Committee published in 1988 memoranda placed before it which laid emphasis on the training of residential staff, on family centres clarifying their goals and on the need for more careful attention to the education and health of children in care.

9.4 An important Home Office circular, 101/1988 entitled ‘Protection of Children: Disclosure of Criminal Background of those with access to children’ was issued: see also Chapter 16, para. 16.22.

(b) Staffordshire and its Social Services

9.5 In January 1988 Pindown was still in continuous use at 245 Hartshill Road although the staff who initiated it were elsewhere. As noted in the last chapter Tony Latham had moved into a headquarters post as Voluntary Bodies Co-Ordinator, Philip Price was away at a social work training course and Glynis Mellors was carrying out an administrative role at Duke’s Lodge. The successors to Tony Latham and Philip Price were Jane Taylor, as area officer (children and families) and Peter Nicol-Harper, who was acting team leader at The Birches until Philip Price returned. Many of the child care staff, however, were the same as those who had been working at 245 Hartshill Road and The Birches in 1987. A small difference in the overall staffing arrangements was that, in the main, there were two overnight staff on duty in 245 Hartshill Road during 1988.

9.6 Peter Nicol-Harper had had a long association with The Birches, first as a social worker there from 1 April 1983 to Autumn 1985 and then on his return from social work training in autumn 1987, as a social worker again for a short period. He stood in as team leader briefly while Jaime Rodriguez was away in the autumn of 1987 and then when Rodriguez went to a headquarters post in December 1987 he took on the leadership of both The Birches and 245 Hartshill Road until Philip Price’s return from his training course in July 1988. He had qualified as a teacher before working in social services.

9.7 Since 1983 the staff of the two establishments had worked at either of them according to need, so Peter Nicol-Harper had had experience of the Pindown regime on occasions. He was an enthusiastic supporter of the family centre concept though he said in his evidence to the Inquiry that he was less enthusiastic about Pindown.

9.8 Jane Taylor had worked in Staffordshire social services since 1980 as a senior social worker in Bucknall and then from 1985 in Hanley in the Stoke-on-Trent area. During this period she had no contact with the family centre in Newcastle. When Tony Latham left the area she took his place in September 1987 and became responsible for field and residential child care work in the Newcastle area. She said in evidence that at the time of her interview for the post: ‘there was no mention of what I later found out to be a controversial system of child care. Until I walked into 245 Hartshill Road, I knew nothing about the system known as Pindown.’ She was interviewed for the post of area officer by John Spurr, senior assistant director and Elizabeth Brennan, principal area officer.

9.9 In December 1987, soon after she was appointed as area officer, Social Services Inspector from the
Department of Health carried out an inspection of two family centres in Staffordshire, of which The Birches was one. Jane Taylor said she was involved in taking the Inspectors round, showing them resources and in the feedback session afterwards. She did not receive a copy of their report but understood that it had been positive in relation to what they saw. See Family Centres: A Change of Name or a Change of Practice – Paras. 6.7.8 – 6.7.11; Appendix O.

9.10 Jane Taylor was questioning in her approach to Pindown and made this clear to Elizabeth Brennan, her line manager. She was also critical of the inadequate resources provided to the family centre and other aspects of the child care service. She found that 'The Birches provided care for a large number of sexually abused children, the youngest of which was a 4 year old who had been horribly sexually abused.' In the 15-bedded unit they also 'had to provide care for acting out teenagers of 14 or 15 who also had been sexually abused, and who were promiscuous and demanding.' In the area there was only one social worker responsible for family placement and the resources for fostering in her view were negligible: 'Most of the children at The Birches had no real prospect of rehabilitation.' In these circumstances she thought that the staff 'who were asked to cope with too much', saw Pindown as a chance for a child to 'cool off', as 'an ultimate sanction'.

9.11 A factor which was influencing the residential child care service in Staffordshire in 1988 was the gradual run-down of Riverside (community home with education) which had traditionally received a number of the most difficult adolescents who needed care as well as those on remand from juvenile courts. Although Riverside was still open in 1988 it was experiencing major difficulties due to internal re-organisation and the number of beds available had fallen steeply over recent years.

9.12 Shortly after Peter Nicol-Harper took on the leadership role at The Birches family centre which was inclusive of 245 Hartshill Road for this purpose, he wrote a message to the staff in the log book on 28 January which is quoted in full: 'Will all staff be aware that a new even harder Pindown can operate from Sunday. I do not want anyone but the immediate staff group to know where it is. I want the kids to understand that enough is enough and that we have the resource to pin kids down outside of this building. If the kids think it is Riverside let them. Will staff be extremely careful to let residents retain ignorant. Fear of the unknown is better than fear of the known. New Pindown will hopefully make admitted absconders 'disappear' but the whole effect will be lost is (sic) non Pindown kids find out where new Pindown is, who works it and what it is like. So do not feel hurt if you are not directly involved and therefore kept somewhat in ignorance yourself. Your job is to indicate to kids that you do not know who is pinned down, where and by whom. The longer they are kept in fear of new Pindown the better' (emphasis added). The 'new Pindown' was to operate in a house in the grounds of The Birches.

9.13 On 8 February 1988 bedtime under the 'old Pindown', 7 p.m., was confirmed by Peter Nicol-Harper in another log book entry and on 10 February he dealt with the issue of admissions to 245 Hartshill Road in a way which indicated greater pressure than formerly. The entry said that Jane Taylor and he had sorted a policy for admission of: (a) non-Newcastle residents in supportive housing accommodation; and (b) non-Newcastle 'kids' not in supportive accommodation. Tony Latham and John Aston were the only people who could request admission, normally to Peter Nicol-Harper. If Pindown beds were occupied, an alternative was to be made available, files to be brought, entries made in the admission and discharge register, and 'once admitted no discharge to occur until authorised by a family meeting'.

9.14 In between the notice to all staff on 28 January 1988 about the 'new Pindown' and the admissions policy statement outlined above on 10 February, the 'new Pindown' had commenced on 1 February in a house in the grounds of The Birches called The Laurels, but known also as the 'other house' or the 'little house'. Over the years it was used for many purposes but between 1 February and 28 March 1988, 29 May and 7 June 1988 and 8 and 28 November 1988 it was used for Pindown with ten children. Six of those children also spent periods of time in Pindown in 245 Hartshill Road during 1988.

9.15 A set of Pindown rules, written by Louise Doherty early in 1988, appears on the front cover of the 'Pindown – Other House' log book (see appendix F, document 5). The entry begins with the words 'it is
essential that each child is made aware of these rules at the time of their admission. The rules then cover removal of the child’s clothes on arrival along with all personal possessions; bathing and hairwashing on arrival; wearing nightwear or underwear and dressing gown but no footwear; all meals in the child’s room; no exit without knocking and waiting for permission; no communication with other children; no television, music, books, magazines, cigarettes, telephone calls or visits except by permission of the team leader; school work in the child’s room, materials removed afterwards; get up at 7 a.m., bath and wash hair; bed by 7 p.m. after a bath.

9.16 Of the first sixteen staff names which appeared in the log books as on duty with the children in Pindown at the ‘other house’ eleven were experienced in the 245 Hartshill Road regime. The tone of the entries in the first month was immediately recognisable as the tone which was habitual in the 245 Hartshill Road log books. In addition the same unfriendly environment was reproduced. On 2 February 1988 locks were put on the Pindown rooms’ windows and the children’s clothes and shoes locked in the cupboard under the stairs. Dishes and cutlery were removed immediately after meals, ‘nothing for self mutilation’ was to be left. There was an instruction in the log book that the girls who were the first residents were not to be given any information, and that staff should ‘not let them lie in bed during the day, make them sit on the chair’. In addition the log book said ‘give them a drink when you decide, not when they request – otherwise they’ll request a drink to know that you are downstairs so that they can communicate.’

9.17 The rooms were not warm enough and the girls had to wrap blankets around themselves or ask for warmer dressing gowns. Materials used for school work were taken away immediately after they had been used. The meals, recorded in detail, were similar in their inadequacy of interest and content to those which the residents of Pindown at 245 Hartshill Road were served. Ventilation was a serious problem and the rooms rapidly became very smelly. There was an instruction to staff to put pots and pans on the door handles of the rooms at night. Advice to tie door handles together was accepted until someone recognised the fire risk and counselled against it.

9.18 Peter Nicol-Harper in evidence to the Inquiry explained that ‘there were times when the programmes we were operating with the child . . . meant that one choice . . . (1) had to face as a manager, was either to speed up or slow down or alter programmes to create a move on and a bed space . . . and I took the decision that rather than prematurely alter family meeting decisions . . . as and when needed I would set up the possibility of a third or, in fact, fourth bedroom which could be used as part of the family meetings that we were operating with non residents . . . children in the community. The staff house within The Birches grounds had been already cleared for residential use, so I used it.’

9.19 A decision was taken that the measures of control for the ‘other house’ at The Birches should be entered in the 245 Hartshill Road record. In consequence The Birches measures of control book contained no entries from 12 December 1987 until 14 July 1988. Six signatures of statutory visitors or other official visitors were entered one after the other with no comment in their reports. There was then one entry on 14 July 1988 followed by seven signatures of statutory visitors again one after the other with no comment. These included three senior members of the social services department. The next entry was 8 May 1989.

9.20 During February 1988 Audrey Williams, assistant director (children and families) requested admission of a girl to 245 Hartshill Road. This girl presented a major management problem. She spent several periods in Pindown.

9.21 A feature of the use of Pindown was the ‘£1’ and ‘£5’ tours which were laid on for social workers and children whom they were finding difficult to manage. These were intended to make children behave better at home and thus avoid coming into care. An entry in the log book of 245 Hartshill Road on 25 February 1988 recorded an appointment for a social worker to ‘bring a young lady . . . for £1 tour of the building. She’s to be given a full tour plus the full treatment.’ The staff member who would be doing this was asked to ‘allow (the social worker) to see how its done, so that she can do it by herself the next time.’ A similar entry appeared on 10 March and another on 17 May 1988.
9.22 The log book at 245 Hartshill Road continued in March and April 1988 to have entries such as the one about a teenage girl whose family meeting on 7 April had been inconclusive as a result of which she was going back into Pindown: 'please make things really uncomfortable for her' and a teenage boy on 11 April 'to be given a really hard time, isolated and perhaps a nasty job to do.' A twelve year old was to be dealt with on the basis of 'Jaime (Rodriguez) to be the good guy. Peter (Nicol-Harper) to be Mr Nasty.' On 21 April a boy not yet in care was to have 'either £1 tour or pretend admission.' A member of staff clearly was critical of some arrangements when he wrote 'N. collected by the level 2 (social worker) skip driver in central office 9-43 no idea what time he will be returned. What we social workers have to do to make a living.' Other entries have a variety of concepts of Pindown: 'basic Pindown', 'stage 2 Pindown', 'nasty Pindown' were examples.

9.23 Although Tony Latham in 1988 was in a different role in the social services department from his former responsibilities, a number of entries in the 245 Hartshill Road log indicated that he was still involved in decisions about some children. These were separate matters from the Duke's Lodge activities in which children were involved. An example of this involvement appeared in the log book for 245 Hartshill Road on 24 May 1988. A girl P. was to be reviewed by her 'social work centre worker' and the team leader. It was made clear that 'T.L.' did not want a certain outcome for the girl i.e. to go 'back on landing' the alternative to which was discharge to 'Supportive Accommodation'. The entry continued 'will staff please put it in T.L. pigeon hole as to what should happen P. wise'.

9.24 For a short time in May 1988 an attempt was made by Peter Nicol-Harper, supported by Jane Taylor, to establish a positive form of Pindown. The log book on 7 May records that 'Therapeutic pindown kicks in.' The log book records are not sufficiently explicit to identify clearly what 'therapeutic pindown' was, but in evidence Peter Nicol-Harper told the Inquiry, that 'we attempted to create a positive version of the negative pindown, in other words all the extra resources, without the taking away of children's rights. I called it 'Maisie' which was short for maisonette because there's a maisonette opposite part of 245, basically a flat, in which we theoretically wanted to set up a, for want of a better word, therapeutic community, for the children using positive re-inforcement. The problems were that whereas Pindown can be operated by one member of staff, 'Maisie' needed three members of staff on shift' (emphasis added).

9.25 Peter Nicol-Harper also made the point that not only were more staff needed, but 'we also wanted to use our best, most experienced, most caring, rather than controlling, members of staff, but we couldn't afford to take them away from... other parts of 245.' It was not in his view an effective way of running a positive programme to use the least experienced staff, and as a consequence positive Pindown only lasted two or three weeks 'and... was a disillusioning experience for both of us.'

9.26 During May 1988 entries appear in the log book about one boy N. who although still of school age was having to spend a lot of time at Duke's Lodge: 19 May, 'N. working for Tony returned 9-45'; on 25 May, 'N. out working till 8-30'. Although not yet sixteen, by July N. was being charged rent at 245 Hartshill Road and on 15 July there was an entry in the log book 'Where is N's rent money for last week?' The reply was 'No wages, could not pay'. By 9 September when N. was just over sixteen years old another member of staff wrote 'N. Bill picked him up. Isn't there a law about the amount of hours a child can work.' On 12 September (a Monday) another entry notes 'N. work before 7 a.m., Check on return if he's been paid extra for weekend.' On 23 September N. was taken to see a ½ way house' and by 26 September he had moved into it. The log book recorded 'N. to be collected for work in future from 245 at 8-30 a.m.'

9.27 A statutory visit was made to 245 Hartshill Road on 27 May 1988 by Mr M.D. Willis who noted under 'control' that one girl had absconded for two weeks from 26 March and that there had been 124 instances of loss of privileges recorded since the last statutory visit on 31 March. He also made the following comments: 'Measures of control system seems very odd, with young people starting their sojourn there with a loss of privileges. The measures of control book does not state the reason.' He thought the establishment 'bewildering... to visit with its separate units and kitchens on different floors... general condition... rather poor, most things having the appearance of being well worn and the decoration looking shoddy.' However he was 'impressed with staff/resident relationships and the
politeness, warmth and trust shown.' In the report to the District Advisory Sub-Committee under 'control' was the one word 'satisfactory'.

9.28 On 3 June the rules for two young people in 'Maisie' were defined in detail: nights out at staff discretion; 'help' staff to cook; clean whole maisonette; visitors from landing by invitation only; on video night they may visit landing from 6-30 – 10-30 p.m.; to remain in Maisie till 245 Hartshill Road went on holiday unless either changed their mind meanwhile' A new Maisie log book was started a few days later. This was not produced for the Inquiry.

9.29 The traditional Pindown continued separately.

9.30 Statutory visitors to residential child care establishments had special forms on which to write their reports. Other official visitors, such as county councillors were asked to sign a visitors book. The Birches visitors book dealt with fifteen years in eighteen pages because most visitors only signed their names.

9.31 In July Peter Nicol-Harper decided to revert to being a social worker again. He told the Inquiry that 'Maisie' had not, in his view, been successful and Philip Price was returning from training. He was ambivalent, if no more, about basic Pindown as it had been and still was being practised. It was being used, in his opinion, at least on some occasions, as a form of secure accommodation. He regretted its use, for example, for a boy who was remanded on a number of occasions and who spent sixty-four days in Pindown. He said that he had expressed his views to Jane Taylor, his line manager, and to Elizabeth Brennan, the principal area officer.

9.32 The measures of control book for 245 Hartshill Road has an undated press cutting stapled to the page recording loss of privileges and other measures taken from 3 July to 20 July 1988. The press cutting states: 'Care 'Breakthrough' – A Newcastle Centre for families has been singled out for praise in a report by The Social Services Inspectorate. The Birches in Sidmouth Avenue has been commended for its success in helping problem families to stay together. The report said that the family centre was improving the quality of child care in Staffordshire by helping to contain problems which might result in a child being taken into care. Social services official John Spurr said the former children’s home represented a ‘major breakthrough’ in child care. 'The idea is to try to nip problems in the bud' he said. 'The centre is used as a resource to help families to learn to cope with problems' explained Mr Spurr.'

9.33 Philip Price completed the academic part of his social work training in July 1988 and began to take up the reins of his job in Staffordshire again. At some stage in July or a little later in 1988 he renewed the Pindown documentation for staff working in the Pindown unit. (see appendix F, document 6) The document is undated and consists of eight pages of which all except the first page had been drawn from other documents contained in Document 3 in appendix F and then re-typed. The first page headed 'Introduction' was new.

9.34 The first sentence of the 'Introduction' acknowledges that 'most people working in the arena of social work may have difficulty in coming to terms with the working practices of a pindown unit i.e. possible infringements of rights, civil liberties etc' (emphasis added). The establishment of such a unit, however, was argued to be necessary within the structure of the '245 Community Unit', 'Community Unit' was to be the new name for 245 Hartshill Road under the Juvenile Justices scheme which was being extended to include residential units. The Introduction continued by explaining that 'past experiences have led us to believe that if (Pindown) offers a platform to begin some positive work with individuals and is a resource continually used and requested by other agencies for initial observations of the more difficult individuals' (emphasis added).

9.35 It was also in July 1988 that Chris Walley, who had previously been principal area officer for the Stoke-on-Trent area, was appointed Juvenile Justice Co-Ordinator (the post had originally been called Project Co-Ordinator and was later changed again to Young Persons Service Co-Ordinator). There were three such posts in the county and the one Chris Walley held related to the principal area officers for Leek, Stoke and Newcastle. Leek had no residential units which were to be part of the juvenile justice
scheme, Stoke had two, 100 Chell Heath Road and 245 Hartshill Road, and Newcastle, as the area formerly responsible for 245 Hartshill Road although it was in Stoke-on-Trent, shared 245 Hartshill Road. Penbridge Road also became part of the scheme. The residential units remained the responsibility of the principal area officers at this time, in the case of 245 Hartshill Road this was Elizabeth Brennan.

9.36 The juvenile justice scheme developments were directly related to the closure of Riverside (community home with education on the premises) as soon as practicable, and with the development of locally based schemes for young offenders which would combine the use of field and residential work resources.

9.37 Philip Price came back to 245 Hartshill Road as team leader, but because of the juvenile justice scheme was then accountable to Jane Taylor as line manager and also Chris Walley as juvenile justice co-ordinator. Jane Taylor visited 245 Hartshill Road regularly and developed training opportunities for staff, but she did not take the role in family meetings that Tony Latham had. Before Philip Price's return this had been carried out by Peter Nicol-Harper as acting team leader.

9.38 During September 1988 Tony Latham's responsibilities as Voluntary Projects Co-Ordinator ended and he was appointed a senior assistant (children and families) at headquarters. This brought him formally back into the child care service within the department.

9.39 A combination of the rundown of Riverside and the lack of alternative resources was leading to difficulties in a number of family centres, one of which was The Alders at Tamworth. During September 1988 it began to experience major problems with a group of teenagers.

9.40 Throughout 1987 statutory visitors' reports regarding The Alders commented warmly on this homely, clean, tidy, busy and 'child centred' establishment. Few absconders and very few entries of additional measures of control were recorded. Foster parent meetings, day care and day nursery work appeared to be going on in a well-organised manner and in a good atmosphere.

9.41 During the autumn a group of very difficult teenagers, about eight to ten in particular, began to become unmanageable. The family centre was not especially well staffed; it was carrying cut substantial day care for older children and the day nursery occupied a significant part of the premises which were not adapted for family centre purposes. The presence of many tiny children in a centre in which aggressive teenagers were present made it more difficult for the staff to manage a deteriorating situation. A call for help from the family centre to headquarters led to two workers coming from Burton and Stafford to help. They agreed with The Alders' staff that the group of teenagers needed to be split up. Two of them were placed elsewhere for a few weeks but when they returned the difficulties began again. One of the girls, who the centre admitted on little advance information, proved to have been in prison for offences which involved violence. Other young people with very serious problems, including remands awaiting court, had to be admitted because The Alders served the whole Tamworth area and was expected by senior management to cope with its own problems. Staff at the family centre doubled their shifts voluntarily to help each other but became over-tired and demoralised.

9.42 By October 1988 Philip Price was fully involved in 245 Hartshill Road again. Peter Nicol-Harper had been appointed team leader at The Birches. The statutory visitor's report on 12 October was written by Patrick Phillips. Under the heading of control he noted that two children had absconded together on three occasions since the previous official visit. He then wrote the following: 'A daily record "Loss of Privileges..." is made for each young person placed in the "pin-down" accommodation amounting to 102 entries since 22 August 1986. Otherwise each resident's level of privileges etc. is determined at each case review and recorded on a case sheet, together with special measures of control' (emphasis added).

9.43 When this report was presented to the District Advisory Sub-Committee the wording was: 'Control - A strict regime here for young people who have become beyond control of their parents and other residents are also subject to careful programmes of care and control, using family meetings as part of the process.' The general comments said that the establishment was 'in a transitional stage of staffing
and function as a result of the introduction of the new Juvenile Justice System but seems to be coping with a continuing residential group of young people.°

9.44 From mid-October a few written contracts were made with children and these continued into the following year when a few children from other family centres in difficulties were brought to Pindown at 245 Hartshill Road.


9.46 The measures of control book for 245 Hartshill Road had 752 separate entries for 1988.

9.47 During 1988, 40 children were subject to Pindown in 245 Hartshill Road.

- The shortest episode was 1 day.
- The longest continuous episode was 64 days.

The total time spent in Pindown in 1988 by each of the 40 children in 245 Hartshill Road was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>5</td>
<td>1 each</td>
</tr>
<tr>
<td>2 days</td>
<td>3</td>
<td>2 children - 1 each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 child - 2 episodes</td>
</tr>
<tr>
<td>3 days</td>
<td>3</td>
<td>2 children - 1 each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 child - 2 episodes</td>
</tr>
<tr>
<td>4 days</td>
<td>3</td>
<td>1 child - 1 episode</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 children - 2 each</td>
</tr>
<tr>
<td>5 days</td>
<td>2</td>
<td>1 child - 2 episodes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 episodes</td>
</tr>
<tr>
<td>6 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>7 days</td>
<td>1</td>
<td>2 children - 1 each</td>
</tr>
<tr>
<td>8 days</td>
<td>3</td>
<td>1 child - 2 episodes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 each</td>
</tr>
<tr>
<td>9 days</td>
<td>2</td>
<td>1 child - 3 episodes</td>
</tr>
<tr>
<td>13 days</td>
<td>2</td>
<td>1 child - 4 episodes</td>
</tr>
<tr>
<td>14 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>16 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>19 days</td>
<td>1</td>
<td>5 episodes</td>
</tr>
<tr>
<td>20 days</td>
<td>2</td>
<td>4 episodes each</td>
</tr>
<tr>
<td>21 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>22 days</td>
<td>1</td>
<td>3 episodes</td>
</tr>
<tr>
<td>24 days</td>
<td>1</td>
<td>4 episodes</td>
</tr>
<tr>
<td>25 days</td>
<td>3</td>
<td>1 child - 2 episodes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 children 3 each</td>
</tr>
<tr>
<td>27 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>44 days</td>
<td>1</td>
<td>5 episodes</td>
</tr>
<tr>
<td>55 days</td>
<td>1</td>
<td>5 episodes</td>
</tr>
<tr>
<td>64 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
</tbody>
</table>

9.48 During 1988, 10 children were subject to Pindown in The Birches:

- The shortest episode was 1 day
- The longest continuous episode was 29 days. The total time spent in Pindown in 1988 by each of the 10 children in The Birches was:
### Table:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>2 days</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>3 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>4 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>5 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>11 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>21 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
<tr>
<td>34 days</td>
<td>1</td>
<td>4 episodes</td>
</tr>
<tr>
<td>47 days</td>
<td>1</td>
<td>2 episodes</td>
</tr>
</tbody>
</table>

9.49 6 of the 10 children who were subject to Pindown at The Birches were also subject to Pindown at 245 Hartshill Road during 1988. They are included as well in the figures for 245 Hartshill Road for those episodes.

(c) **County Council Financial Policies**

9.50 The guidelines set by the county council for the social services committee in its preparation of estimates for 1988/89 did not require savings to be made.

9.51 The net growth for 1988 was £1.3 million. The social services budget represented 10.34 per cent of the total county council budget compared with 10.15 per cent in the previous year.

(d) **Social Services Re-Organisation**

9.52 Re-organisation was a major issue in social services in 1988.

9.53 The future of Riverside (a community home with education) was under consideration. A revised form of organisation at Riverside had already been operating since 1 April 1987 when numbers were reduced to 50. There had, however, been substantial problems in the high rate of absconding and threats of violence to staff by young people.

9.54 The director acknowledged in a confidential report to the social services committee on 12 January 1988 that Riverside was still unsettled following changes made in 1987 and that placing young people on remand in the same groups as other children had caused difficulties of control. Two senior members of staff, Bernard Ramsay and Tony Latham, had been asked to go into Riverside and advise. Meanwhile admissions had been curtailed.

9.55 A further confidential report 'Alternatives to Care and Custody through Community Social Work' was presented to the Social Services General Sub-Committee by the director on 30 March 1988. The proposals entailed the closure of Riverside and redeployment of its staff, as well as changes of use in some other existing residential establishments.

9.56 The 'more effective alternative' proposed was to use the staff resources available from closing Riverside in conjunction with intermediate treatment officers and area social workers to create 'teams of community social workers' throughout the county. Three main projects would integrate field and residential workers in North, Mid and South East Staffordshire. Each would have a project co-ordinator who would relate to a senior assistant at headquarters responsible for advice, policy, direction and monitoring. The senior assistant would be responsible to the assistant director (children and family services).

9.57 The elements within the projects would include an intermediate treatment centre and education unit, a community unit with residential facilities, a support unit providing a 'high degree of residential supervision', fostering placements, independence units and family centres. 'Secure accommodation in
the sense of facilities to lock up young people' would be sought outside the county. The details of the proposals were fully described. It was estimated that overall a net saving of £30,000 could be made.

9.58 Two of the residential establishments affected by the proposals were 245 Hartshill Road, described in the report as a semi-staffed unit, and 100 Chell Heath Road, a family centre. Both would become 'community units' under this scheme.

9.59 The proposals were agreed and minuted, and described as 'exciting, decisive and major new initiatives in the development of community social work and crime prevention.' It was also noted that 'in relation to secure accommodation ... the county council did not, and had never had, any secure accommodation ... where (it) was required the situation would continue as at present i.e. use would be made of units operated by other local authorities.'

9.60 The director reported to the Social Services General Sub-Committee on 21 July 1988 on the re-organisation of the YTS scheme and other related activities of the Voluntary Bodies Co-Ordinator. There had been considerable difficulties in consequence of changes in Manpower Services Commission funding and although the scheme and related activities were regarded as valuable the original proposal to absorb the scheme into the social services department might need to be reviewed.

9.61 The Social Services General Sub-Committee received a further report from the director on 25 November 1988. This dealt with the termination of the Community Programme Scheme and the impact of that on the services managed by the Voluntary Bodies Co-Ordinator.

9.62 The Employment Training Scheme which had replaced nationally the Community Programme made it impracticable to continue to provide staff for a range of services after Christmas 1988. Those which had to be urgently reviewed included intermediate treatment in the Newcastle area and the Supportive Housing Accommodation Project.

9.63 The major re-organisation proposals in 1988 were contained in a report to the Social Services General Sub-Committee on 25 November 1988, 'Looking forward to the 1990s – a Design for Service.' The proposals set out by the directors would, he wrote, 'create a structure which will absorb strains, incorporate new requirements and allow growth and flexibility.'

9.64 The main proposals were:
(a) to discontinue nine principal area teams;
(b) to discontinue central management of residential and day care services;
(c) to establish 19 social services districts with a district manager responsible for residential and day care services, and social work and community care services;
(d) to group the 19 districts under 3 social services divisions, each of which would have district teams of social workers for hospitals and clinics and team managers at family centres/juvenile justice projects.

9.65 The advantages of the new structure would be:
(a) a comprehensive team approach to integrated local services;
(b) maximum authority for district managers in operational decisions and use of resources;
(c) freedom of headquarters staff to concentrate on strategic planning, development of services, policy formulation and performance monitoring and control.

9.66 The director advised that the earliest date for implementation of these proposals would be July 1989.

(e) The Career of Tony Latham

9.67 Toward the end of 1987, as indicated above in paragraph 9.54, Tony Latham was carrying out work related to problems of control at Riverside (community home with education). Following the completion
of this work he wrote, at the beginning of 1988, as we understand it, a report for the director of social services making proposals for the future use of Riverside as a county resource.

9.68 Changes in Manpower Services Commission funding created major problems in supporting a number of the projects during 1988 and subsequently.

9.69 The work of Tony Latham and his team was warmly acknowledged by the director of social services. When, however, he reported to the social services committee in July 1988 he had to warn them that reductions in funding might lead to the necessity of bringing some schemes to an end.

9.70 Tony Latham was appointed to post of senior assistant (children and families) at headquarters in September 1988.

9.71 By November 1988, the Community Programme having ended two months earlier, it was necessary for the director to tell the committee that staff could not be provided for a range of services after Christmas 1988.

9.72 As a consequence of ending a number of projects because of loss of funding, Fundwell Ltd. no longer had the same justification, and it was agreed that it would be wound up over the next few months.
Chapter 10: 1989

(a) National Events

10.1 The Children Act 1989, major reforming legislation, received the Royal Assent on 16 November 1989. A few of its provisions are already in force. The remaining provisions of the Act will come into force on 14 October 1991: see The Childrens Act 1989 (Commencement and Transitional Provisions) Order 1991 (S.I. 1991 No.828). Part VI of the Act, sections 53 to 58, deals with community homes. Paragraph 4 of Schedule 4 to the Act empowers the making of regulations in respect of community homes. These may provide, for example, for the ‘control and discipline of children in such homes’. (see also chapter 12 paragraph 12.50)

(b) Staffordshire and its Social Services

10.2 In 1989 plans for the re-organisation of the management structure of the social services department came to fruition and changes within the child care service also took place, particularly in relation to provision for young offenders and adolescents with special problems.

10.3 Riverside (community home with education) finally closed in January 1989. This resulted in there being pressure on the family centres to take almost all the children, including those remanded from juvenile courts, who would normally have gone to Riverside.

10.4 In the north of the county 100 Chell Heath Road and 245 Hartshill Road had been redesignated ‘community units’ in the juvenile justice re-organisation but their facilities were limited and did not absorb the full impact of the loss of places at Riverside. In Tamworth, after Riverside was closed, the area only had The Alders as residential provision for all purposes.

10.5 Problems had already been experienced at The Alders during the winter of 1988 and John Spurr, deputy director of social services, had been involved. The statutory visitor on 22 December 1988 had noted that ‘teenagers who have recently disrupted the family centre have now been moved and the centre is now back to normality. . . . The day nursery was a hive of activity.’ The next statutory visitor a few days later on 6 January 1989, however, thought the overall physical conditions had deteriorated since a previous visit eighteen months earlier.

10.6 It was not only the lack of places in residential establishments which was a problem in 1989 but also the lack of social work time, continuity and team collaboration. Residential staff were frustrated at not receiving adequate information themselves to do their work effectively, but also complained of having to watch the young people in their care suffer from the uncertainty, anxiety and frustration caused by insufficient information, lack of planning and lack of consultation with them about plans for their future. The residential staff believed that some of the bad behaviour of young people could legitimately be attributed to their anger and fear of the future caused by unco-ordinated and poor quality work on their behalf.

10.7 There had also been signs of trouble in late 1988 at Heron Cross House, Stoke-on-Trent, due to having to accommodate children from other units on a temporary basis during departmental changes in connection with the juvenile justice re-organisation. Peter Wall, the statutory visitor for November 1988 had attributed difficulties to ‘remands from courts and detention centres’. The residents of Scotia House, another residential home, had also temporarily had to be accommodated. The physical environment at Heron Cross House had been deteriorating and the last visitor of the year had used the phrase ‘there was no feeling of warmth or happiness’. By 10 February 1989 K. Templest, another statutory visitor, reported that ‘Heron Cross (was) badly in need of repairs following destructive behaviour of offenders recently accommodated at the home. General atmosphere of despondency . . . flat roof, lot of rubbish thrown through windows by children.’ Changes were understood to be in hand.

10.8 Philip Warrilow had been appointed area officer for Tamworth in March 1988 and had been involved in the problems of The Alders as they developed. He told the Inquiry in evidence that he had
been asking for assistance for the home from October 1988, particularly that they might have some redeployed Riverside staff. When Margaret Spooner had been appointed principal area officer in November 1988 he had complained to her about the needs of The Alders and she had communicated with headquarters in the social services department.

10.9 The juvenile justice co-ordinator responsible for the Tamworth area, Mark Roberts, was not in post until March 1989. Philip Warrilow saw this as another factor in The Alders' problems because not only were the former resources of Riverside no longer available, but the new resources were not either. A group of young people were increasingly challenging staff and acting together to intimidate other children. Six of them had run away after an outburst of aggression on 19 February. They returned on 20 February. Philip Warrilow had a meeting with them and they agreed to stay in and gradually earn back evenings out by good behaviour; but such co-operation was short-lived.

10.10 Staff at the family centre were being called upon to carry out work for which they had received no training and staffing levels were so poor that they were 'reduced to one at times'. The regular rota sheets which at The Alders were stuck into log books never showed more than two people on duty at a time.

10.11 The Inquiry was told that when The Alders team leader had telephoned asking for help, a senior manager had responded 'that now we know what Riverside had to put up with'. A letter which a group of staff wrote expressing their concerns was intended to go to central office but they were told they could not send it and were very frustrated.

10.12 The log book at this period contained entries about incidents inside and outside The Alders which gave cause for serious concern.

10.13 Various meetings took place about the family centre during March 1989. It is not clear exactly who was involved but by 9 March the team leader at The Alders, Sylvia Dennis, left a message in the log book for 'All Staff. There is a meeting 11 a.m. Monday — with Tony Latham (sic) and Co.' — This was to be on 13 March. There is no record of the meeting in the log book, or in any other papers produced for the Inquiry.

10.14 On 15 March 1989 the log book carried an instruction to staff that if two adolescent girls who had run away, returned they were not to be admitted 'until next week, not for food, washing, are (sic) anything at all. All staff are to stick to this there his (sic) no backing down.' The next day Margaret Spooner, principal area officer, was reported in the log book as having said 'we must let them in they are on care orders and cannot be turned away'.

10.15 Meetings then took place involving Chris Walley, Tony Latham and Philip Price after Philip Warrilow, area officer, had asked for help. John Spurr was telephoned. A meeting also took place with the team leader at The Alders, Sylvia Dennis. Members of the staff met Tony Latham. It seemed to be commonly agreed that eventually Peter Crockett, deputy director, had asked Tony Latham to go to The Alders 'to assist and advise wherever necessary'. Philip Warrilow who had been working closely with The Alders told the Inquiry he was not part of the decision making process, but was told that Tony Latham was coming.

10.16 The name Glynis appeared in the margin of the undated log book entries just before 20 March 1989 with no comment. Glynis Mellors had been working at Duke's Lodge, Tony Latham's home and projects centre, during 1988, carrying out administrative office work. By February 1989 she was no longer required there because the enterprises concerned had ceased or been transferred.

10.17 In her written statement to the Inquiry she said that Tony Latham had been asked to go to Tamworth 'and identify the problems . . . there and he asked Phil Price and myself to form a task force to do this. I spent all my time from March 1989 to July 1989 at the Centre.'

10.18 The Latham team came in on 20 March 1989 and held a family meeting about a girl who was subsequently put in the Pindown unit they established on the top floor of The Alders. Some of the details
of how the first resident in the unit was handled and how the unit was operated are described in Pindown Profile No. 7 in Chapter 11.

10.19 The Inquiry received evidence that the staff of The Alders felt pushed on one side by Tony Latham's team. The team were said to have described themselves as 'senior representatives on behalf of headquarters'. The team leader at The Alders told the Inquiry in evidence that it was suggested to her she should go on holiday, but she was not prepared to do that. After a few days she decided, however, that it might be in the children's interests to take them on holiday and took them to Clacton with another member of staff on 23 March for about a week.

10.20 A specific Pindown log book was started at The Alders on 20 March 1989. It contains records of seven children having been put in the Pindown unit between 20 March and 2 October 1989. Two of them, both boys, absconded within hours of being in the unit and did not return to it. Three boys and one girl were there for four days each. The first girl was in Pindown, apart from two days when she absconded, from 20 March to 12 April 1989.

10.21 The area social workers were not happy about the Pindown unit. They found that decisions were made about children for whom they were responsible with no consultation and that their role in relation to the children was not taken into account. The social worker for the first girl in the unit found her attempts to visit the girl blocked. Glynis Mellors described her in the log book as 'sulky' with the family centre staff concerning a meeting arranged at very short notice about one of the other children on her caseload.

10.22 One field social worker who had spent a significant amount of time working in The Alders, told the Inquiry that the area social workers were so concerned they tried 'to find out what the rights that prisoners were allowed to have as a basic right for either getting out of a room or having exercises because initially they (the children in Pindown) were there twenty-four hours a day'.

10.23 Another area social worker told the Inquiry that in March 1989 'we heard from a member of staff that there was going to be such a thing as Pindown introduced because of the behaviour of the children . . . the family team know nothing of what this Pindown was or what it entailed or who it was going to be . . . who was going to be actually in it'. At a team meeting Philip Warrilow had told them it was going to happen. They expressed their concern. He had explained 'this room was going to be used to control the children . . . and (one girl) was going to be put into this room because she was seen to be the culprit, the big trouble causer who led the other children astray'. The room that was used was a former storeroom. When the social worker had worked at The Alders and had asked if it could be converted into another bedroom: 'they said no because the floors were unsafe. . . . There was no fire escape and the only way down was down one set of stairs to the fire exit on the lower floor. The window was very small and later after the girl who was put into this Pindown room got out of it, it was nailed up with perspex and there was then 'no ventilation . . . and . . . hardly any light.'

10.24 The family meetings which were held at The Alders were also a cause of concern among the social workers in the Tamworth area. A social worker said that she 'used to go in with butterflies in my stomach and feeling really worried and I really don't know what the child felt.' She described to the Inquiry the role play: 'they would have one person who would play big baddy and would be still carrying on being critical whether the child had done nothing wrong or not . . . another member of the group would play Mr Nice Guy.' She found it 'very difficult not to get angry with the team during the meetings'. This perception was supported by other social workers. One who had worked in a secure unit under another local authority described the family meetings as 'brutal', for parents and children.

10.25 A further social worker remembered that 'nothing positive was said about the child, all the bad things . . . he had been naughty but every single thing he had done badly was brought up and it was brought up in totally derogatory terms, the language was appalling'. When asked what language was used the example he gave was 'You're fucking useless.' Philip Warrilow confirmed in his evidence that social workers 'did not like some of the language used in meetings.'
10.26 During March and April 1989 the log books for 245 Hartshill Road and The Birches showed no exceptional events. Fred Hill visited Heron Cross House at the end of March 1989 and reported that the situation was more settled though there were still signs of damage and vandalism.

10.27 The statutory visitor to The Alders for March 1989 recorded that he spoke to 'Mrs Mellors who is the former manager of the Social Services Youth Training Scheme and who is helping out at the Centre for a temporary period until she is offered permanent alternative employment' (emphasis added). The report to the District Advisory Sub-Committee said 'There have been problems of control with some of the children but the staff are working through the difficulties and the Centre is operating satisfactorily'.

10.28 In April 1989 Laurence Pountney who had been principal officer, child protection, at headquarters since leaving Tamworth in September 1988, was promoted to assistant director (children and families). Elizabeth Brennan was appointed to his former post and left Newcastle after six years as principal area officer. Chris Walley, juvenile justice co-ordinator showed Laurence Pountney round 245 Hartshill Road soon after he was appointed assistant director. During April and May 1989, as far as can be seen from the records, there was only one child at a time in Pindown and for relatively short periods of time.

10.29 On 5 April 1989 Peter Crockett called in briefly at The Alders in the course of visiting the residential establishment next door which was being used for accommodation of mentally handicapped adults. During April 1989 the area social workers tried on a number of occasions to arrange a meeting with Tony Latham. Meetings were arranged and then cancelled. On one occasion the staff were sitting together waiting when Philip Price told them Tony Latham was not coming as arranged. On 15 April the meeting was cancelled again. There were further cancellations but eventually a meeting took place on 9 May with the area staff, family centre staff and Tony Latham. Staff witnesses recalled the critical attitude taken towards them.

10.30 In May 1989 Jane Taylor who had been area officer in the Newcastle area was appointed a child protection co-ordinator at headquarters. The statutory visitor for The Birches on 3 May was Fred Hill, senior assistant, who reported that he had had a long discussion with the team leader Peter Nichol-Harper and that the centre was still feeling the effect of withdrawal of the back up facilities formerly provided by Tony Latham’s enterprises, particularly transport. The statutory visit reports provided for the Inquiry on 245 Hartshill Road did not include any from October 1988 to April 1989. The report for 12 April 1989 described it as 'a unit... for young people on remand or who have recently been through the courts, with some longer term cases.'

10.31 The statutory visitor for May 1989 at Heron Cross House found there were still signs of damage to furniture and fittings. He commented 'the design of this unit is not conducive to the creation of a homely environment. Rooms are hexagonal, walls are bare, there are too many open passages, and not enough carpeted areas to create a softer 'lived in' atmosphere.'

10.32 There were gaps in the statutory visits reports produced to the Inquiry for The Alders and there was no report for May 1989. At 245 Hartshill Road an entry on 21 May 1989 records the admission to Pindown of an eleven year old boy. In the handwriting of a member of staff who had been working at the unit for a long period there was a note 'How on earth do we implement Pindown with an 11 yr. old', although children as young as eleven had been there before.

10.33 On 30 June 1989 the log book at 245 Hartshill Road recorded a note to staff that they would be on strike from midnight one day to midnight the next, although two members 'per session' were exempt, except in relation to manning the office. Glynis Mellors was still at The Alders but there was no record of any child in Pindown. The official visitor at The Alders in June 1989 reported that the children were present when he was there: 'fair relationships with staff were evident... efforts had been made to retain a reasonably comfortable physical environment with personalised bedrooms etc. A shortfall of domestic staff was evident... staff on duty when I visited appeared weary.'
The departmental re-organisation took place in July 1989. Amongst some of the many changes of personnel which took place as well as structural changes, Tony Latham became senior assistant (children and families); Philip Owen became the new divisional manager for the north of Staffordshire; Philip Warrilow, area officer for Tamworth, became district manager for Lichfield; Margaret Spooner, who had been principal area officer in Tamworth since October 1988, became district manager there.

Many witnesses heavily criticised the re-organisation which took place. Communication seemed less clear than previously. Small district teams felt isolated and were too small in some instances to be viable. Some people found themselves accountable to more than one line manager.

A feature of the re-organisation was that management of all residential facilities devolved to district officer level which, whilst providing local accountability and concern, also meant that as far as children’s residential services were concerned, a service in crisis was in the hands of relatively inexperienced managers.

In July 1989 we were told that 100 Chell Heath Road ‘had a bout of one week where basically anarchy ruled . . . where the residents were totally out of control’. A meeting about the situation then took place attended by amongst others: Peter Crockett (deputy director), Philip Owen (divisional general manager), David Heath (assistant divisional general manager), Laurence Pountney (assistant director), Philip Price and Tony Latham. Philip Price told the Inquiry that before this meeting he had been asked to take on the management of 100 Chell Heath Road; he was at the time managing 245 Hartshill Road. He declined but agreed to ‘work alongside’ the team leader, Morris Lyons. The meeting then decided that as from 1 August 1989 Philip Price and Glynis Mellors would join the Chell Heath Road Team ‘in an effort to resolve some of the problematic areas’.

In the event Tony Latham and Glynis Mellors were primarily involved for several weeks during August and early September 1989. The team leader of 100 Chell Heath Road at that time described what happened: ‘They operated a way of setting up family meetings, centering these . . . around a powerful personality Chairman’. Those which took place in 100 Chell Heath Road were chaired by Tony Latham and minuted by Glynis Mellors. Morris Lyons, the team leader, thought they were ‘conducting a kind of in-service development as they saw it’ for him and other staff.

The most intense meetings took place in relation to one boy who was moved from 100 Chell Heath Road into Pindown at 245 Hartshill Road where Dave Allen, Glynis Mellors and other staff provided twenty-four hour contact. David Allen, in particular, spent many hours working with this boy whilst he was in Pindown. The boy had a quite different experience from the established pattern because he had so much personal attention.

Witnesses from 100 Chell Heath Road acknowledged the value of some new ideas and help from Tony Latham’s team in tackling their problems. They did not appreciate the lack of consultation, which they regarded as typical of the department’s manner of operation, and they were strongly opposed to Pindown as a method of confronting the problems of young people. We are satisfied that Pindown was never operated at 100 Chell Heath Road. We were told however that it was suggested to staff that they might want to use it. They firmly declined. The Latham team left 100 Chell Heath Road in early September because they apparently had other priorities.

During August 1989 Peter Nicol-Harper, who had worked at The Birches and 245 Hartshill Road and trained as a social worker on secondment from Staffordshire, completed his two years subsequent service requirement and went to work elsewhere. Sally Rees had become district manager responsible for The Birches in the re-organisation.

On 10 August Philip Price wrote an internal memorandum to Chris Walley, Fred Hill and Dave Heath. He described it as his ‘personal views of residential child care practice at the present time’. It was written from a ‘constructive viewpoint’ and he hoped he would have an opportunity to discuss its contents. Some of the issues raised in the paper were as follows:
(a) disillusionment through lack of direction in policy and effective gatekeeping;
(b) no clear statement on development of alternatives to residential care;
(c) no clear direction for individual units;
(d) disjointed and individual management approaches in areas;
(e) little concept of client need.

10.43 The memorandum urged:
(a) development of clear structure and line management systems on divisional, not district, bases;
(b) an effective staffing policy with encouragement of a professional approach;
(c) management of units in negotiation with clients;
(d) skills development, especially in handling aggression;
(e) care plans for individual clients;
(f) specific management structure for children and residential services.

Currently the service was seen to be expensive but at times counter productive in relation to the client. Major problems were:

(a) inappropriate distribution of resources;
(b) inadequate staffing;
(c) lack of sense of direction;
(d) no forward plan;
(e) ill defined management structures;
(f) poor understanding and acceptance of residential work in the overall social work process.

10.44 Philip Price wrote that consultation with those responsible for the work was needed and a system of supervision and staff appraisal. He believed that other team leaders shared his views and warned that the department was ‘taking a backward step into the 90s under our current structures and that unless some major change takes place there will be no one left prepared to even go into the 90s’ (emphasis added). It is not known whether any discussion of this paper took place.

10.45 Heron Cross House was continuing to experience difficulties. A statutory visitor on 30 June 1989 had found that ‘at present a group of disruptive children are causing problems, particularly for night staff sleeping in. Staff are woken during the night to deal with problems, resulting in them being exhausted when on duty the next day... Staff morale appeared low.’ The report carried a handwritten note by John Spurr saying that urgent assessment and remedy was being sought. The report to the District Advisory Sub-Committee under the heading ‘Control’ stated ‘satisfactory’. On the back of the visitor’s report were notes dated 24 July from David Heath, assistant divisional general manager, saying that the problem of waking night staff had been resolved but that disruptive children were causing some problems.

10.46 The following month the statutory visitor at Heron Cross House was A. Carney. His report went further than the previous report. Five girls had absconded since the last statutory visit and although there were no entries in the measures of control book, two children had recently been transferred to ‘support units’ (the name for juvenile justice units) one for vandalism, the other for ‘uncontrollable’ behaviour. In his general comments the visitor reported ‘the very poor standards of decoration, furnishing, tidiness and preservation of the interior living space, create a sad and worrying impression of this family centre. Its treatment by past and present residents has been severe and its maintenance and upkeep lacking in urgency. This must have a disconcerting effect on staff morale, and a cumulative effect on vandalism by residents’. The report to the District Advisory Sub-Committee on this occasion indicated that there were considerable problems in this establishment.

10.47 A residential worker at Heron Cross House told the Inquiry that the closing of Riverside ‘was the beginning of the loss of the family centre... because we had to take children on remand and they had to mix the children who were there who had problems at home... They had to be in the same building as the boys from Risley (remand centre).’
10.48 Peter Crocket, a deputy director, after a series of meetings then asked Tony Latham and his colleagues to intervene at Heron Cross House in early September 1989. A witness described what happened when the Latham team arrived: 'They moved everything about and moved into that wing, into what they call a structured unit... it may sound funny but they just came in and we were... taken over and swamped'.

10.49 The pattern of intervention by the Latham team seemed to have been similar to the process at 100 Chell Heath Road. Initially there were family meetings, reviews and attempts to confront problems through discussion. We were told that after about two weeks, however, a boy who had been difficult to manage earlier ‘was still not conforming... and that was when the ‘Pindown’ unit was set up’. Three children were put in it during the short period it operated. One of them went out to school but when she returned each day changed into night clothes. The Pindown unit operated from 26 September to 2 October 1989.

10.50 The unit was set up in a wing of the hexagonal building, with an intervening glass panelled door screened with brown paper to prevent children on either side seeing each other. All meals were taken there; there were daily meetings with each child; and the other Pindown rules about bathing, bed times and night clothes, subject to personal variations at staff discretion, were carried out. No education was provided by a teacher but some occupation was allowed and the general atmosphere of the unit appeared to have been more relaxed than at 245 Hartshill Road.

10.51 A girl at Heron Cross House refused to co-operate, or to stay at Heron Cross House. In consequence she was taken to 245 Hartshill Road where she jumped out of a window. She became a ward of court.

10.52 While the Latham team was working in Heron Cross House in September 1989 social workers in the Tamworth area were drawing attention to the ‘dangerously low level of social work cover presently in operation’. Seven members of the area team jointly signed a letter to Margaret Spooner on 21 September headed ‘Staffing levels in Children and Families Team, Tamworth’. They identified the following problems:

(a) for several months no social workers had been able to be allocated to children on matrimonial supervision orders, some care orders, or voluntary supervision preventive work;
(b) because no ongoing support was possible crises were more severe leading to avoidable family breakdown;
(c) there was no time for planning long term for children or for assessment.

Team members were exhausted, were ‘lurching from one crisis to another’ and there was a real danger of grave mistakes being made.

10.53 Staffing levels in the Tamworth area team had been reduced from the full time equivalent of 9 posts on 1 January 1989 to 5 on 18 September 1989. At this level ‘the team is barely functioning’, the letter said. Professional standards in report writing, reviews, preparation of care proceedings, assessments, counselling, spending time with children and parents were having to be lowered. On 6 October 1989 two more staff were to be lost. Details were provided of the impact of these losses and it was made clear that the directive to involve members of other teams was impossible to act upon in Tamworth since there was only one other qualified worker, ‘dangerously overloaded’, in the building. The letter ended with an appeal to management to recognise:

(a) that Tamworth was a high risk area on a par with Birmingham and Telford; and
(b) that there was a serious staffing problem.

10.54 Margaret Spooner sent this letter to Reg Saunders, divisional general manager, on 21 September 1989. On 16 October she wrote again requesting an early reply. She referred to more losses in staffing, to telephone calls explaining their difficulties and ended by saying ‘this level of service is hardly carrying out the Director’s aim which, I understand, was to provide better services for the local community. At no time
in my social work career have I been in such a situation for disaster (emphasis added). I would welcome your views.'

10.55 Subsequently, a senior social worker and a senior colleague wrote to Barry O'Neill saying that a service was not being offered to Tamworth because staff were not available to provide it. The response to that, the senior social worker told the Inquiry, was that a meeting took place with the social workers and decisions were made on what cases they should close, and what work did not need doing. The social workers did not support a number of the judgments made. Since then the situation had, in their view, deteriorated.

10.56 After the Latham team had left The Alders, Tamworth, in August 1989 Tony Latham had had a meeting with the staff and children asking for information as part of the background to providing the director of social services with a report on the team's intervention at The Alders. The final report was signed by Tony Latham on 12 September 1989: see appendix F, document 7. In evidence Tony Latham told the Inquiry that he handed the report to senior management shortly after 12 September 1989. Nobody could recall seeing it until at least October 1989.

10.57 This long report broadly dealt with:

(a) an analysis of problems leading up to the use of Pindown at The Alders;
(b) problems and issues identified in meetings in March 1989 with residents and in meetings with staff members before and after the presence of the headquarters team at The Alders;
(c) recommendations for improving the role of team manager at The Alders;
(d) individual care plans and programmes for residents and available resources to promote family centre concepts;
(e) individual children's reviews and client centred approaches;
(f) the use of 'the special unit';
(g) supervision of family centre workers.

10.58 During September and October 1989, 100 Chell Heath Road reverted to being a family centre; Heron Cross House ceased to be a family centre; 245 Hartshill Road ceased to be a community unit and began to become a centre for child protection and fostering. Also in September 'juvenile justice schemes' were renamed 'services for young people'.

10.59 On 28 September 1989 the statutory visitor for The Birches noted under the heading of 'Control' that there were 'numerous recorded instances of minor punishments' since the last statutory visit; 40 in all. This number was without precedent in the measure of control book for ten years. At 245 Hartshill Road the statutory visitor for 5 October 1989 recorded that six young people had absconded on a total of ten occasions. There were also numerous entries in the measures of control book 'but none refer to any breach of discipline. This record is more in keeping with maintaining a record of privileges earned and there is no conventional measures of control book.' At The Alders although the central office team had departed, the measures of control book records for 25 September 1989 one boy on 'full Pindown' for continually absconding from the centre. The only other Pindown entry was in the special log book from 28 September to 1 October when a girl was in the Pindown room following a number of incidents involving alcohol. An official visitor in September expressed concern at staff shortages and pressure on staff, but found them to be giving 'the loving care to the children for which they are noted.'

10.60 The end of Pindown came in early October 1989. On 2 October as noted already in Chapter 1, paragraph 1.1, while John Spurr was in the Newcastle divisional office a local solicitor, Kevin Williams, telephoned to say that he had been appearing in court on behalf of a girl in care about whom he was very concerned. She had been in Pindown. He was proposing to take wardship proceedings. Over the course of 3 and 4 October further discussions took place between John Spurr and Kevin Williams and it became clear that the Pindown unit was seen by Kevin Williams to be 'a matter of public concern'. John Spurr had already heard from the director of social services that the chairman of the social services committee knew of Kevin Williams' concern about the unit.
10.61 There was a meeting of the North Staffordshire divisional management group on 4 October 1989. The minutes of this meeting, Minute 14(b) recorded that ‘Mr Owen (divisional director) said that with effect from last night (3rd October) there is no ‘pin down’ facility at Hartshill Road and Heron Cross’. Subsequently the girl who was the subject of Kevin Williams’ telephone call on 2 October and a boy were made wards of court and High Court injunctions were obtained on 13 October to prevent any further use of Pindown and any employment of a child in care of school age in school hours other than in circumstances agreed in consultation with the Education Welfare Service.

10.62 On 13 October 1989 the 245 Hartshill Road log book contains the following communication from Philip Price: ‘Note to all staff pending meeting – High Court on Friday. – Will discuss in more detail at special staff meeting with C. Walley A.S.A.P.
1. No more Pindown operations to take place on any child.
2. Normal regulations within Community Home Regs 10
3. Restriction of Liberty not to take place outside such regulations
4. Children working with Bill not allowed without approval of Education Welfare Service as from today
5. Bill’s role to be defined
6. Other issues but mainly of a legal nature

Will hold a group meeting on Monday when all children are here.
Well done everyone for working through this. I am confident at the end of the day an official approval and improved staffing regime throughout residential will come out of this. Phil.’

10.63 Two further documents relating to Pindown were produced during the period October/November 1989. The first was entitled ‘Principles behind the use of the Time Out Unit at 245 Hartshill Road’. It appears in Appendix I document 3, at page 223. The origin of the document was a request to Chris Walley, Juvenile Justice Co-Ordinator responsible in that capacity for 245 Hartshill Road, by a member of the legal department to provide information for the court in the wardship applications in October 1989 about the principles and practice of the special unit. It gave a description of the unit, the philosophy behind the concept of ‘Pindown’, the alternatives, and the framework of operations which included information about ‘sanctions and rewards’, confrontation methods, meetings, and the routine of bathing, knocking on a door to obtain exit, wearing of night clothes, meals in the young persons room, tasks, and earning of privileges. It concluded with a note about family meetings and the role play of negative and positive relationships. At the end of the document the words ‘by Chris Walley’ appeared but they were not in his writing. A note against the item of information on wearing of night clothes said ‘specifically not allowed’ and was identified by Chris Walley as his writing, as were two other words correcting the typing of the draft document.

10.64 The other document (see appendix I, document 8) was written by Tony Latham and much of it is identical in wording with the Time Out document referred to in paragraph 10.63.

10.65 At the meeting of the Social Services General Sub-Committee on 30 November 1989 the director presented a report on 245 Hartshill Road. It was ministered under exempt minutes. It reported on the court cases concerning two young people and ‘a system, developed within the home as a means of responding to and dealing with young people in care who were not amenable to ordinarily accepted means of control. The system was to use part of the unit as a crisis intervention unit, variously described as a “time-out unit” or a “pin down unit”’. The main weakness of the project was said to be that it had never been incorporated into the department’s approved practices i.e. as an additional means of control under the Community Home Regulations 1972. The system, the Committee was told, had been discontinued at the beginning of October 1989 having been operating since 1983. The director stated that in his view ‘it has not been harshly repressive and has not entailed ill-treatment. It has been aimed solely and directly for the good of the young person.’

10.66 Barry O’Neill, the director of social services, also on 30 November 1989, wrote to Philip Owen, divisional general manager for North Staffordshire. The letter was headed ‘Department’s involvement with Fundwell and Skip Hire’. Referring to past ‘legitimate involvement of the department with these companies’, he made the policy for the future clear. This was that:
(a) staff should not be involved in any capacity with private commercial enterprises during working hours, and only outside working hours with the consent of the chief officer;
(b) children in care or under supervision should not be involved with the private sector, unless they were on approved training schemes;
(c) Mrs Mellor and Mr Tomlinson, formerly legitimately involved in the companies were no longer authorized to be so involved and placement of young people was also no longer approved.
The divisional general manager was asked to monitor the situation and advise the director accordingly.

10.67 During 1989, 18 children were subject to Pindown in 245 Hartshill Road. (No children were put in Pindown at The Birches.)
– The shortest episode was 1 day
– The longest continuous episode was 27 days.
The total time spent by each of the 18 children in Pindown at 245 Hartshill Road was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>4</td>
<td>1 each</td>
</tr>
<tr>
<td>2 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>4 days</td>
<td>5</td>
<td>4 children – 1 each</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 child – 2 episodes</td>
</tr>
<tr>
<td>5 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>6 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>9 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>11 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>14 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>17 days</td>
<td>1</td>
<td>3 episodes</td>
</tr>
<tr>
<td>21 days</td>
<td>1</td>
<td>3 episodes</td>
</tr>
<tr>
<td>27 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
</tbody>
</table>

10.68 During 1989, 7 children were subject to Pindown in The Alders.
– 2 children were in for a few hours and then absconded
– The longest continuous episode was 21 days
The total time spent by each of the 7 children in Pindown at The Alders was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 day</td>
<td>2</td>
<td>1 each</td>
</tr>
<tr>
<td>4 days</td>
<td>4</td>
<td>1 each</td>
</tr>
<tr>
<td>21 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
</tbody>
</table>

10.69 During 1989, 3 children were subject to Pindown at Heron Cross House
– The shortest episode was 4 days
– The longest continuous episode was 8 days
The total time spent by each of the 3 children in Pindown at Heron Cross House was:

<table>
<thead>
<tr>
<th>Length of time in Pindown</th>
<th>No. of children</th>
<th>No. of episodes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 days</td>
<td>1</td>
<td>1 episode</td>
</tr>
<tr>
<td>8 days</td>
<td>2</td>
<td>1 each</td>
</tr>
</tbody>
</table>

One of the 3 children was also subject to Pindown at 245 Hartshill Road during 1989. The child is also included in the figures for 245 Hartshill Road for that episode.
(c) County Council Financial Policies

10.70 The revised revenue estimates for 1988/89 and the draft estimates for 1989/90 were again presented to the committee in a joint report of the director of social services and the county treasurer. Over the whole social services department in 1989/90 there was a growth of £2.3 million, savings of £1.3 million and net growth therefore of £1 million.

10.71 We were given information that indicated that the county council were aware that additional income was likely to be generated by transferring residents in homes for the mentally handicapped to hostel benefit status rather than Part III minimum charge status and this accounted for the bulk of the savings in this year.

10.72 The social services net budget for 1989/90 was £50.3 million. This represented 10.94 per cent of the whole county council budget compared with 10.34 per cent in the previous year 1988/89. A comparison of Staffordshire’s net spending on social services per head of the population with the average for shire counties showed Staffordshire spent £48.73 against an estimated average for other counties of £57.05 and ranked 32 out of 39 counties. Expenditure on children within the social services budget as estimated for 1989/90 showed that English counties on average spent 15 per cent of the social services budget on children. Staffordshire spent on average 11.6 per cent.

10.73 Within the Audit Commission’s ‘family group’ the ‘family’ average spending on personal social services was £67.20; Staffordshire’s was £48.70. Spending on children by the ‘family group’ averaged £11.90; Staffordshire spent £6.70, 56.8 per cent of the ‘family’ average.

(d) Social Services Re-Organisation

10.74 There had been fears in 1988 that national changes in funding for the YTS schemes due to the change from the Marpower Services Commission to the Training Agency might lead to the schemes having to be discontinued.

10.75 On 10 January 1989 Barry O’Neill, the director of social services, put a report to the committee ‘Review of the Youth Training Scheme’. He explained that, in spite of negotiations, the MSC, later to be replaced by the Training Agency, would not be able to assist the Staffordshire County Council YTS scheme to continue; that the social services department would not be offered an opportunity to run an Initial Training Scheme; and that while the MSC would welcome social services assistance in YTS Initial Training Schemes because their skills and knowledge were recognised, they would not be able to contribute towards the cost of such involvement.

10.76 At the Social Services General Sub-Committee meeting on 2 May 1989 the director of social services recommended a change of use of the Voluntary Bodies Co-Ordinator’s post. The Social Services YTS Scheme had ended in February 1989 and the complementary voluntary initiatives managed by Tony Latham, the post holder, had been run down or were being managed by the social services department. The director therefore proposed that in view of Tony Latham’s previous experience and the ‘very positive comments about the Newcastle-under-Lyme family centre’ made by the Social Services Inspectorate in their study of family centres, he should be re-designated Senior Assistant to work in the children and families headquarters section. There he could ‘help to plan and monitor the development of the family centres and the ... juvenile justice packages/intermediate treatment.’ This was agreed and Tony Latham’s new post commenced from 1 July 1989.

10.77 The director also reported to the General Sub-Committee on 2 May 1989 on the report of the Social Services Inspectors’s survey of family centres ‘A Change of Name or a Change of Practice.’ The inspection of The Birches and The Alders had taken place in December 1987. A short version of the national report had been placed in the members’ library.

10.78 On 1 July 1989 the new departmental structure was put into operation. There were two deputy directors: Peter Crockett, responsible for research, development and monitoring at headquarters, and John Spurr, for operational services in three divisions. Audrey Williams, formerly assistant director
(children and family services) at headquarters, retired and was replaced by Laurence Pountney. In each
division there were two or three assistant divisional general managers, each with special responsibilities.
District officers had team managers accountable for client group teams of social workers. Each division also
had a principal administrative officer, a juvenile justice co-ordinator and a child protection co-ordinator.

10.79 At a meeting of the Social Services General Sub-Committee on 30 November 1989 exempt
minutes of a meeting on 29 September were confirmed. They contained the following decisions:
(a) that following questions from a member of the committee the director gave assurances that secure
accommodation in other local authorities would be used when needed and that disruptive children would
not be deprived of education; (emphasis added).
(b) that the term juvenile justice be discontinued and be replaced by the term 'services for young
people';
(c) that 100 Chell Heath Road, Stoke-on-Trent, cease to be a 12 place community unit in the juvenile
justice system and revert to being a 15 place family centre;
(d) that Heron Cross House, Stoke-on-Trent, cease to be a 15 place family centre and become a 15
place County Young People’s Centre from 1 April 1990;
(e) that the staff of 245 Hartshill Road and Heron Cross House be redeployed at the new Heron Cross
House establishment;
(f) that arrangements be made with the district health authority for psychiatric and psychological input
and the Chief Educational Officer for educational services including teachers for Heron Cross House;
and
(g) that 245 Hartshill Road cease to operate as a 10 place community unit and become the base for the
North Staffordshire Child Protection Unit and Family Placement Unit.

10.80 The report contained two other matters affecting organisation of services. One was a major
review of boarding out allowances and payments for placements of 'particularly disturbed adolescents'.
The other was the official end of Pindown. It was minuted as follows: ‘245 Hartshill Road, Stoke-on-Trent
– Care and Control: criticisms were recently made in the course of legal proceedings about the form of
care received by two young people resident at 245 Hartshill Road, Stoke-on-Trent. The system which has
operated since 1983 but has now been discontinued was introduced as a method of making an impression and
getting a positive response from young people who are normally hard to reach and influence’ (emphasis
added).

10.81 Related to the decisions above was a report to the committee entitled 'Review of residential
services for children and young people'. This examined the county provision in considerable detail.
Important points for the future of child care residential work were:
(a) family centres would continue but would mainly accommodate children up to the age of thirteen
years;
(b) long stay homes would be kept to a minimum;
(c) the new unit at Heron Cross House would be the main resource for young people requiring
specialised care;
(d) it would also be expected to provide an advisory and support service to units elsewhere in the county.

(e) The Career of Tony Latham

10.82 During 1989 Tony Latham was asked by Peter Crockett, deputy director of social services, to
intervene in three residential establishments which were experiencing problems in controlling young
people in care. These were: The Alders at Tamworth, 100 Chell Heath Road and Heron Cross House at
Stoke-on-Trent. In each instance Tony Latham was assisted by Philip Price and Glynnis Mellors. A
Pindown unit was established in The Alders and Heron Cross House but not at 100 Chell Heath Road.

10.83 From the late autumn of 1989 Tony Latham was on extended sick leave from his employment with
Staffordshire County Council.
PART 3: The Pindown Experience

Chapter 11

Pindown Profiles

11.1 The following seven individual accounts cover children, both boys and girls, of differing ages, who came into care for varying reasons, but who all experienced the rigours of Pindown. They have each been given a pseudonym. Though the details are not exhaustive, the essential features of their Pindown experience are identified.

11.2 Jane was born in 1972. She is the youngest of a family of four children, having an older brother and two sisters. Each of her parents suffered from a psychiatric illness. When Jane was almost three years old, all four children went into the care of Staffordshire County Council because the parents were unable to look after them. All were subsequently made the subject of care orders granted by a juvenile court and remained in care until the age of 18.

11.3 Initially Jane was placed with one of her sisters at a nursery. The other two children were placed in a children’s home. Eventually the four children were re-united and remained in the same foster home between 1976 and 1983.

11.4 In 1983 as a result of serious difficulties in the relationship between the foster parents and Jane’s brother, he was moved elsewhere. Ultimately an adoption application by the foster parents in respect of the three girls was not pursued and the children were moved to a new foster placement when Jane was 11. She told the Inquiry that she was given no warning or explanation of the move. She was deeply affected by it.

11.5 About 18 months later in 1985 Jane’s eldest sister, who was then 15 years old, was moved after disagreements with the foster mother. Jane was very unhappy in the foster home and in particular missed her sister. She told the Inquiry that she ran away from the foster home one night wearing only her nightdress. She attempted to cut her wrists. The police returned her to the foster home. A doctor was called and she received sedation.

11.6 The following day she was moved to 245 Hartshill Road and put straight into Pindown. She was then aged 13. She was given a nightdress to wear and her clothes and shoes were taken away in a black plastic bag. She was placed in the back Pindown room which had in it a bed, a table and a wardrobe. She was told not to go out of the room and if she wanted anything she had to knock on the door. This included wanting to go to the toilet. The room overlooked a first floor flat next door.

11.7 The morning after her admission to Pindown she was taken out of the room to a meeting with three residential workers. In her own words: ‘I was informed that I had done wrong by running away from my foster parents and that I had lost all my privileges. To regain these privileges I had to prove that I could be good by doing what the staff told me. I had to sign a “contract” that I would keep it, if I disobeyed anyone on this contract a privilege would be taken away’. She was then placed back in the Pindown room.

11.8 On admission to the unit the programme written for Jane in the ‘Intensive Training Unit’ programme book included the following: ‘foster breakdown – very loose programme’. She was to attend school and ‘allowed visitors/phone calls/letters’. She was to rise at 7-15 a.m. and have a bath. Her bedtime after a bath was 9 p.m.

11.9 A month later the programme recorded: ‘to reside in back room crash pad’. She was to be up at 7 a.m. and have a bath. Her bedtime was altered to 7.30 p.m., after a bath. There was to be ‘no contact . . .
Pindown scheme but not to be nasty to her – sympathetic pindown’. There was added ‘close supervision against self abuse – schooling in room for one week’.

11.10 Five days later the programme stated: ‘Remains on pindown . . . no clothes . . . work programme in Unit over weekend.’

11.11 Four days later the entry in the ‘Intensive Training Unit’ book included: ‘– Allowed school. Bedtime 8 p.m., allowed visitors – family only. No nights out. Chores as usual. Weekend work programme’.

11.12 Because records were inadequately kept or missing it is not possible to follow through what precisely happened to Jane. In addition her social work file is incomplete and in disarray. She thought that she was actually in the Pindown room for about 4 weeks. The programme clearly varied over a period of 3 months and for a part of her time her isolation was broken by being ‘allowed’ attendance at school, being permitted to go out of 245 Hartshill Road, and by receiving visitors. She also ran away on occasions. Her view of what happened to her is that ‘it was a degrading experience . . . I ran away a lot because I got so frustrated at not being allowed to see anyone and not being allowed to talk to anyone, my only friend in (there) was a woman who lived in the flats by the side of 245, I could look into her kitchen from the back Pindown unit. After either going back to 245 or being taken back by the police you were put back into the Pindown room and told to write what you’d done . . . I remember being really upset one night and going out of the Pindown room because I needed to talk and I got dragged back in.’

11.13 During some of the times that Jane was allowed out of the Pindown room she would be given her clothes back and have a meal with the other children. After the meal she was returned to the Pindown room and her clothes were taken away from her and put back in a black plastic bag. She was given back her nightdress.

11.14 Jane said that ‘After I’d worked my way out of the Pindown room, I was so depressed, and frustrated that I took an overdose. I was taken to hospital semi-conscious . . . I mean that’s the only way I got out of 245, if I hadn’t of done that I’d of probably still be in there.’ Jane was detained in hospital overnight. Staff also recorded removing a razor blade from her possessions. It was noted that ‘she keeps a razor . . . in case of emergencies . . . because she hates it here.’ Jane told the Inquiry that the Pindown system had a very destructive and negative effect on her life: ‘when I was in Pindown I was really messed up, after being in (there), I was in trouble with the cops and had tried to kill myself, I meant it did more harm than good.’

11.15 Jane added that she had felt frightened when she was in Pindown. She had had no exercise and the only conversation she had with anyone was when her meal was brought. She had no books or magazines, and no television or radio. The door was not locked. Outside the door a chair was put next to it or pots and pans hung on the door handle: ‘It made you feel everyone was against you, you were always in the wrong, no-one would listen, it made me very depressed. It makes you hard, a loner, I don’t trust people anymore, it makes you distrust all sorts of authority.’

11.16 Jane moved from 245 Hartshill Road to another children’s home and eventually moved into independent accommodation when she was 17.

(2) Susan

11.17 Susan, who was born in 1976, was put into Pindown when she was 9 years old.

11.18 At the beginning of 1986 Susan, her half-sister aged 13, and her mother were living with the maternal grandfather. Her half-sister is the child of her mother’s former marriage. Susan’s father was one of her mother’s subsequent boyfriends.

11.19 Over a period of about a month, in early 1986, the mother contacted Staffordshire social services on a number of occasions requesting help with coping with Susan’s behaviour. Susan was said to be mixing
with older girls and smoking, stealing and upsetting her grandfather who did not want her to remain in his home.

11.20 Susan was then received into care and placed at 245 Hartshill Road.

11.21 She went straight into Pindown. The first entry in the log book was as follows: ‘(Susan) admitted—very basic programme be very nasty to her’ (emphasis added).

11.22 Susan was required to wear pyjamas and kept in a sparsely furnished room. She was not allowed contact with other children or non-Pindown staff and was not permitted to attend school. She was required to knock on the door before going to the toilet. She remained in Pindown for a week and then returned home. Subsequently five ‘family reviews’ were held at The Birches at about weekly intervals before social services contact with the family ceased and the case was closed.

11.23 Immediately after Susan’s admission to Pindown an entry in the log book at 245 Hartshill Road recorded a residential worker’s conversation with her headmaster: he was concerned that she was in care because she was no trouble at all in school being a good attender, well-behaved, and a hard worker. She was also in his view very bright.

11.24 Further entries in the log book during her week in Pindown included:

—‘wants to go to the toilet a lot, soon put a stop to that. Had harsh words twice. Once for calling through the bedroom wall (to another child in Pindown).’

—‘will try anything to get out of her room, after several tellings offs (sic) she stopped trying.’

—‘she thinks I’m room service, hasn’t anyone told her its not an hotel.’

—‘the little knocker has not knocked so much tonight, when I go in I usually look for a tip as I feel like a waiter.’

11.25 On the evening of Susan’s third day in Pindown a ‘review’ was held. Neither the log book nor the social services file on Susan records who was present. ‘Susan’s problems’ were ‘highlighted’. It was noted that the grandfather would not allow her back and her mother was prepared to move out of his home. It was ‘agreed that (Susan) remain in care’. It was recorded in the log book that ‘mother saw her 2 mins. Cried a little. Then later cried wanting to go home. Was her mother still here. Explained review system. Spoke to her about contract and may well come back if she breaks rules. Bath, bed. Toilet a lot still. First sign of hope for her, maybe!!!’

11.26 Susan is twice recorded in the log book as ‘working hard’. What she was doing in the Pindown room is not specified.

11.27 A further ‘review’ was held after Susan had been in Pindown for 7 days. It was agreed that she should ‘return home’ on various conditions, one of which was that she should write a letter of apology to her grandfather.

11.28 Susan returned to the home of her grandfather. Soon afterwards she and her mother and half-sister were re-housed.

11.29 Just over a year later, the mother again brought Susan, then aged 10, to the social services office. She said that she had been having problems with Susan’s behaviour for some considerable time. She would not do what she was told, called her mother unpleasant names and embarrassed her in public. The mother said that she had eventually lost her temper and attempted ‘to strangle’ Susan. She could not look at Susan without wanting to attack her and Susan was unrepentant about her behaviour. There were also problems with the mother’s boyfriend who was living in their home and about whom Susan complained.
11.30 Susan was again received into care and placed into Pindown. The entry in the log book at 245 Hartshill Road records that ‘(Susan) admitted to Pindown after family meeting. . . she is an extremely naughty and manipulative little girl: so much so that she has driven her mother to the point of violence. Basic Pindown — plenty of schoolwork.’ Later on the day of admission to Pindown it is recorded that ‘if she knocked on the door once, she knocked ten thousand times. Other than that no problems, she did not eat much tea, had a bath at 6-30 tucked up in bed 7 p.m.’

11.31 Three days later the following entry was made in the log book: ‘(Susan) reviewed this afternoon. She fully expected to go home. When she realised that this wasn’t going to happen she became very upset. Cried off and on until 8-30 — at times becoming hysterical. She will go to school on Monday; she understands that this is a privilege and is the only one she will be given for some time to come.’

11.32 After ten days of Pindown it was noted by the child’s social worker in the social services file that ‘there are no complaints about (Susan’s) behaviour at Hartshill Road but she is in no position to misbehave as she is restricted’.

11.33 Subsequently the mother recognised that ‘problems can only be resolved at home’ and Susan spent some of her time at home and some in Pindown at 245 Hartshill Road. It would seem that she actually spent some 20 days in Pindown before being transferred to The Birches. After spending about 3 months at The Birches during which time she spent regular weekends at home, Susan was moved to another children’s home. She eventually went home at the beginning of 1988, some six months after being received into care for the second time. More recently further problems occurred and Susan was placed in a foster home.

11.35 Susan at 9 years of age was one of the youngest children placed in Pindown. During her two spells in care in 1986 and 1987 she spent at least 27 days in the unit.

(3) Michael

11.36 Michael first went into Pindown in 1984 when he was 11 years old. He then had further spells in the unit on at least two occasions in each of the next four years. In total he was in Pindown on not less than twelve occasions and for about ten weeks in all.

11.37 He was born in 1972. His mother had herself been brought up in residential care from the age of 8. In 1975 she gave birth to twin boys. In the following year social services were notified that Michael’s behaviour was uncontrollable. At the time his mother was suffering from post natal depression and his father working away from home. Michael’s behaviour subsequently improved for a time but there were further referrals to social services in the next four years.

11.38 There were reports of violence between Michael’s parents which were witnessed by him. In one incident his nose was broken. A psychiatric report on Michael at the age of 9 suggested a placement at a school for maladjusted children. This appears not to have been followed up. His parents separated and both remarried. Michael and his twin brothers remained with their mother. A half-brother was born in 1981. Michael’s relationship with his mother and step-father deteriorated and eventually in 1983, when he was 10 years old, he was received into care by Staffordshire County Council and placed at The Birches. The previous day he had run away from home and his mother had refused to have him back.

11.39 Within hours of coming into care he absconded and went to his father. The following day he was returned to The Birches. At the beginning of 1984 there were problems with Michael’s behaviour at school. He was taken from school in February 1984 by a residential worker from 245 Hartshill Road and shown over the Pindown unit. He was threatened with admission to Pindown if his behaviour did not improve.

11.40 He subsequently lived with his father and step-mother for a short time but then ran away to his mother who kept him overnight but was not prepared to offer him a home. As a consequence he was
admitted to 245 Hartshill Road and to the Intensive Training Unit. The reason recorded for his entry into Pindown was that it was ‘an attempt to work through a few of his feelings and his understanding of the current situation.’

11.41 Michael told the Inquiry that he was taken up to the back Pindown room and told to remove his clothes. He refused to do so. He was then held down on a bed in the room and stripped. He was made to have a bath and given a pair of pyjamas to wear. In addition to the bed the room contained a table and a chair. There were no reading or writing materials. He was not allowed to communicate with any other children. The worst aspect of Pindown, in his view, was the boredom and the isolation: ‘it was doing my head in.’ Michael spent ten days in the unit before being returned home to his father and step-mother with an arrangement for weekly review meetings at 245 Hartshill Road.

11.42 Later in 1984 he moved to live with his mother and step-father. He was subject to a matrimonial supervision order to Staffordshire County Council. His behaviour varied over the next year. Regular ‘reviews’ were held at 245 Hartshill Road. One review in mid-1985 decided that there had been no improvement after a spell of bad behaviour. Michael’s parents were asked to leave the review and Michael under protest was made ‘to write down all the misdemeanours he was involved in over the past weeks.’ This process apparently over three hours.

11.43 A refusal to co-operate with an ‘evening care programme’ at 245 Hartshill Road led to Michael being taken from his mother’s home and being admitted to care in August 1985 at 245 Hartshill Road, where he remained in Pindown for three weeks. He was then re-admitted in September for about nine days. He was permitted to attend school, but otherwise confined to his room. He went to bed at 7-30 p.m.

11.44 In October 1985 he was again re-admitted to Pindown because he was beyond his mother’s control. It was said by staff that ‘he needed a spell at 245’. He absconded and went to his father’s home. He was subsequently returned to 245 Hartshill Road by the police. He was then put on what was recorded as a basic Pindown Programme for some six days. He was required to work at Duke’s Lodge, the home of Tony Latham, during the programme. He again absconded, got into trouble with the police and was rejected by his parents. He was returned and put into Pindown: ‘reside in front bedroom crash pad. Full PIN-DOWN; 7 a.m. up bath; 7 p.m. bath, 7-30 p.m. bed; no communication, no family contact; To go to D/L (Duke’s Lodge) or schooling in room. No clothes (sic) allowed.’ Five days later the programme was amended to ‘Remains on Pin-Down; allowed clothes; allowed work based program (sic) over the Top Landing (when other kds are out); During Wk/End to remain in room; school program; allowed to speak to family on the phone; no phone calls out; T.V., radio etc; family may visit; Bed 7 p.m. – Rise 7 a.m.; Bath morning and evening.’ A few days later he was found in a state of collapse on the floor of his room. He was taken to hospital where no obvious cause for his condition was found. It was suggested that what had happened to him may have been stress related.

11.45 In December 1985 Michael returned to live with his mother at her request although apparently against the advice of the residential staff. He was back in residential care in April 1986. He was suspended from school on a number of occasions before being permanently excluded. He committed a number of criminal offences and spent a period in a Detention Centre. He continued in residential care until 1989. After April 1986 he went into Pindown on at least seven further occasions for a total period of about four weeks. He absconded from care between 1986 and 1989 on not less than fourteen occasions. He was known to associate with experienced criminals. He was heavily involved in solvent abuse. Between 1983 and 1988 social work records disclose over fifty ‘reviews’ or ‘meetings’ concerning Michael. There are few actual records of these occasions or of any expert help sought or details of any decisions taken. He is now unemployed, has an extensive criminal record and moves between various addresses. As the unfortunate victim originally of a broken family, he told the Inquiry that the care system ‘has messed my life up.’

(4) Simon

11.46 Simon at 9 years of age was one of the youngest boys put into Pindown. He went into the unit on two separate occasions in 1986 for a total period of not less than eight days and probably much longer.
11.47 He was born in 1976 the third of four illegitimate children. His mother had become pregnant for the first time at the age of 17 whilst in care herself. By the age of 5 Simon had been received into care on a number of occasions at the request of his mother who experienced continual difficulties in coping with the children.

11.48 At the beginning of 1982 Simon was again received into care and eventually placed at The Birches. He was described as a difficult child to control being extremely active, mischievous and accident prone. He also displayed very aggressive behaviour towards other children.

11.49 Simon returned home at the end of 1983. Despite frequent co-operation between his school and social services his behaviour deteriorated further. He was excluded from school on a number of occasions. Special teaching was provided for him. He failed, however, to respond to special teaching programmes provided by an educational psychologist. He regularly bullied other children and was accused of assaults of a sexual nature against both boys and girls. He also indecently exposed himself on a number of occasions.

11.50 In 1985 a programme was organised at 245 Hartshill Road to provide evening and weekend care. It had only limited success. It involved Simon being picked up daily from school by a member of staff of 245 Hartshill Road and being put in a form of Pindown until 8-30 p.m. when he was returned home having had a bath and worn pyjamas in the residential home. At weekends he would remain at 245 Hartshill Road between 10 a.m. and 8.30 p.m. each day.

11.51 The programme for Simon outlined in the log book at 245 Hartshill Road provided for 'a totally negative approach to be adopted . . . plenty of stern looks and tellings off to make him glad to go home . . . He will be based in the back pindown room and will eat in there . . . under no circumstances is he to communicate with other children . . . he is to perform tasks . . . of a negative kind . . . if it appears that he is enjoying a task stop him and make him do something else.'

11.52 In February 1986 Simon was sent to The Birches from school after being involved in fighting and swearing at the teachers. At The Birches, in the late afternoon, he was told to put his pyjamas on. He was then taken outside and put in a van. He was wearing underpants, pyjamas and slippers. He was not told what was happening or where he was going. His clothes were put in a black bag in the front of the van. He was driven to 245 Hartshill Road. On arrival he was put in a room, which he thought was then locked, and his slippers and pyjama trousers were taken away. The room contained a chair, a desk and a bed with a mattress, a sheet and a blanket. There were no books or writing materials in the room. He was told that he had to stay in the room because he had been 'pratting around' at school. After knocking on the door he was allowed out only to go to the toilet and to have a bath. During his stay in Pindown meals were brought to his room and he was not allowed contact with other children.

11.53 Soon after being put in the Pindown room he was allowed to go to the toilet and he opened a window in the bathroom, climbed out on to the roof and down a drain pipe and ran off in his underpants and a pyjama jacket. He was not wearing any footwear.

11.54 After being returned to Pindown the regime appears to have been gradually relaxed and he was given some schoolwork of a basic kind and eventually allowed to watch television. He was then returned to The Birches. Whilst in the Pindown unit he had been very frightened after seeing another boy from an adjoining room who had just slashed his wrists.

11.55 It would seem from the records that Simon spent a further short spell in Pindown towards the end of 1986. Social work records contain comments that the use of Pindown produced no positive results and that, if anything, his behaviour became worse. Ultimately, he was transferred to a special school.

(5) Sophie

11.56 Sophie, who was born in 1971, is one of six children. Her father is a Nigerian who returned to
Africa some years ago. Her mother is English. From the age of 8 Sophie lived with her maternal grandmother and two of her half-sisters and a half-brother. Sophie had behavioural problems from an early age. By the age of 11 she was said to have been stealing from neighbours and to have made a false allegation that she had been raped and had become pregnant. At the request of her grandmother she was received into care in 1982.

11.57 Sophie was placed in a children’s home. About six months later she absconded and went to her grandmother who, against social work advice, discharged her from care.

11.58 Towards the end of 1983 the grandmother had a stroke and was hospitalised. Sophie’s behaviour deteriorated rapidly and she had to be admitted to an adolescent psychiatric unit. Opinions varied: she was described as having an identity crisis based on a traumatic childhood and was said to be obsessed with babies. Another view was that she was a gross hysterical having little appreciation of the boundaries of fantasy and reality. On discharge from the unit Sophie, aged 12, came into care and was admitted to The Birches. She absconded on several occasions from The Birches and was excluded from school. She was again recorded as claiming to be pregnant.

11.59 Whilst away from The Birches Sophie located her mother and they both expressed the wish that Sophie should be discharged from care and live with her. The view was taken that the mother had major problems which precluded the possibility of rehabilitation. Around the middle of 1984, Sophie was admitted to the Intensive Training Unit at 245 Hartshill Road after having again absconded. She was recorded in the log book as having been admitted and ‘off all privileges (sic)’. Her clothes were taken away and she was given a nightdress.

11.60 The following morning she tried to abscond. A residential worker recorded that ‘somehow she had obtained some of her clothes . . . I went straight away to (Sophie) and asked her to take her clothes off and get back into her nightdress. She refused to do this so I started to undress her.’ Sophie then took off her clothes but locked herself in the bathroom. The door was forced and she was told to get into bed. Her mother was then allowed to visit her. Later in the day ‘a review’ was held and it was decided that in respect of Sophie it was ‘no change pindown situation’. Four days later she is again recorded as being ‘in pindown situation’. She then absconded. The police were informed and they returned her the following day. She told the police that she had been having intercourse and was pregnant. This was later confirmed by a doctor.

11.61 After 10 days in Pindown Sophie was transferred to The Birches. She was, however, re-admitted to the Intensive Training Unit a fortnight later. Within two hours she had absconded and gone to stay with her mother. The following day the police brought her back to 245 Hartshill Road. Five days later she absconded again.

11.62 In the period of three months after she was first put into Pindown Sophie absconded on about nine occasions. Confusing and often contradictory records preclude a wholly accurate picture from emerging. Entries in the relevant records, however, point to her having spent a total of 58 days in Pindown in four separate spells during the three months. At the end of the period she had just turned 13.

11.63 Sophie was eventually transferred to another establishment from which she absconded on a number of occasions. She was also found guilty by a juvenile court of a number of offences of dishonesty. Ultimately she was placed in an (authorised) secure unit outside Staffordshire. Her pregnancy had ended in a miscarriage. After being in the secure unit she was transferred to an open unit from which she absconded. For most of 1986 her whereabouts were unknown. She was eventually found living with her mother and again pregnant. After a further miscarriage she again went missing.

11.64 In 1987 Sophie aged 15 was arrested for shoplifting and remanded into the care of Staffordshire County Council. She was again placed at 245 Hartshill Road but not put into Pindown. Subsequently she was sentenced to a period of youth custody.
11.65 Sophie told the Inquiry that she was put into Pindown originally because she kept running away. When she arrived at the unit her clothes were taken away and she had to wear a vest and pants. She made no mention of a nightdress. She was in the back Pindown room. She had to knock on the door if she wanted to go to the toilet. It often ‘took ages’ before someone came along. The room only contained a bed, a table and a chair. She had to do schoolwork every day. She was not allowed out of the room except to go to the toilet and also to have a bath. She thought that she was initially in Pindown for about 4 weeks and a review was held each week. She was not allowed to attend but was told what had been decided. On the second occasion and subsequently when she went into Pindown she was allowed to wear a dressing gown as well as her vest and pants. She thought that she had been locked into the Pindown room because she had to knock on the door.

11.66 Sophie told the Inquiry that she has ‘always thought that Pindown should never have been allowed’. She added that ‘the only person I was hurting by running away was myself because I could easily have been murdered for anything, running through country lanes. I never thought of that because wherever I am running to is better than what I am running from.’ She now lives in a flat with her baby daughter.

(6) Peter

11.67 Peter was one of the first three boys to be put into Pindown in 1983.

11.68 He was born in 1967. Together with his older brother and younger sister he was taken into care by Staffordshire County Council in 1971 when his mother, who was separated from his father, said that she was unable to cope with the children. Subsequently a juvenile court granted care orders despite the mother’s objection at that time. In the following months the mother twice unsuccessfully tried to revoke the orders.

11.69 After ten months in care the three children were returned to the mother. Two months later the family became homeless and Peter was placed in a foster home with his sister. The placement quickly broke down and Peter lived in a succession of children’s homes. He remained in contact with his mother and grandmother. At the age of 11 he became involved together with his brother in a number of episodes of petty theft. In the following two years Peter had contact with various relatives but none of them were able to provide a suitable home for him.

11.70 Peter was moved to The Birches when he was 15. He was already glue sniffing, truanting from school and involved again in stealing. He told the Inquiry that ‘I was skiving school and usually that turned into us running away. I didn’t run away much and we ran away this one time and they caught us, the Old Bill caught us and they took us back to The Birches and we went into the front room and then we were undressed’. This occurred at the beginning of November 1983.

11.71 Peter told the Inquiry what happened next. Together with two other boys both aged 14 he was taken to 245 Hartshill Road. Each was wearing only his underpants and no footwear. Peter was terrified: he did not know where he was going or what was happening.

11.72 When the boys arrived at 245 Hartshill Road they were told to try and break through a locked door into the part of the house where they were to stay. A key to the door was then found and the boys were all put into a room together. They moved a table and chairs into the room and then had to take a cold shower and do some ‘keep fit’ exercises. Later they were moved into another room and slept on mattresses on the floor with no other bedding. A residential worker was also sleeping in the room. The log book recorded that they were to have ‘no privileges’.

11.73 The following morning the boys were required to do ‘bunny hops’ around a concrete square outside the building in their underwear for about twenty minutes. Peter described what happened: ‘we were bunny hopping round and (a residential worker) had a stick and he was standing there in the middle and we had nothing on, just our underpants still, nothing on our feet, and we were bunny hopping around and he was saying move over and he was whipping us, he is mad, but I was laughing, so I was getting it and
he was taking it worse because I was laughing'. He added that some 'Fundwell workers' were watching what was happening and 'they thought it was hilarious.' The residential worker has denied hitting him.

11.74 On the third day Peter was returned to The Birches 'to see how he performs', according to the log book. During his stay in the 'Special Unit' at 245 Hartshill Road he had been kept isolated from everyone else except the other two boys. They were, however, stopped from speaking to each other after 6 p.m. For part of the time they were occupied doing schoolwork, moving furniture and being made to do physical exercises.

11.75 Peter was returned to the unit three weeks later after having been excluded from school. He remained at 245 Hartshill Road for a further eleven days in all.

11.76 Peter remained in care until he was a few months short of his eighteenth birthday. A report in his social work file observes that his 'spell in the intensive unit was a clear failure'. He now has a serious drink problem and has served a term of imprisonment. He is married and in contact with his family.

(7) Sheraz

11.77 When Sheraz went into Pindown in March 1989 at The Alders in Tamworth she was aged 15, having been born in October 1973.

11.78 Her father is of Bangladeshi origin and her mother English. She is the only girl in a family of four children. Her father left the matrimonial home some years ago and then had no contact with the children. One child was adopted and Sheraz' mother remarried in 1983.

11.79 The family has been well-known to social services for many years. In June 1988, when she was 14, Sheraz was committed into the care of Staffordshire County Council in care proceedings. The Juvenile Court found that she was beyond the control of her parents. She had run away from home on two occasions. She was placed at The Alders family centre. Initially she is reported to have settled down, with no wish to return home.

11.80 After a few months her behaviour began to deteriorate. She is noted as having been abusive to staff, truanting, and absconding for short periods. She was then suspended from school.

11.81 General control problems developed at The Alders and events eventually came to a head with a serious disturbance in which Sheraz was alleged to have taken part and threatened a member of staff with a weapon. As a consequence she was transferred to another children's home for about a month, returning to The Alders just after Christmas 1988.

11.82 During the next three months some of the residents continued to cause trouble and the staff had considerable difficulty in managing the situation. In March 1989 Tony Latham, Philip Price and Glynis Mellors arrived at The Alders in order to attempt to restore order. They introduced a Pindown unit to achieve their aim. They were known at this time as 'The Hit Squad' or 'The A Team'.

11.83 Sheraz was put into the newly established Pindown unit: a room at the top of the house approached by a winding staircase. Apart from absconding on two occasions for brief periods, she remained in the unit for about three weeks.

11.84 Sheraz told the Inquiry about her introduction into the unit. She had absconded from the home and then telephoned in order to talk to the staff. Sheraz was then picked up in a car which contained her mother and brother and a residential worker. When they returned to The Alders she was taken into a meeting. At about 4-15 p.m. she was told that, apparently with the agreement of her mother and brother, she was going to be put into Pindown. The log book records what happened next: 'very reluctant to stay at F/C (Family Centre). Physically and verbally abusive to staff - had to be escorted by several staff to bathroom, where she was stripped of clothing and placed into the bath - kicking, screaming and lashing
out at staff... Eventually got into pyjamas and escorted to top floor pin down. Refused tea initially but decided to eat later - had nothing to eat during the day. A little stroppy at times but no untoward behaviour at this point. Gave her a pen and paper to write down what she sees in her future and what she needs to achieve to "get out of here".

11.85 Sheraz was placed in the Pindown room which contained a bed, a table, a chair and a small electric wall heater. There was a portaloo in a cupboard. She was later allowed to go to the toilet after knocking on the door. The two windows had been boarded up. At 9 p.m her mother was allowed to visit her for a short time. A residential worker recorded that 'Sheraz initially resentful to Mum but later changed to pleading with her to take her home for the night and to bring her back tomorrow. Mother did not relent. Sheraz threatening to kill herself and/or jump through the window... started to shout... attempted to take wood from window.'

11.86 The following morning the log book record is as follows: '(Sheraz) refused to get up when called at 7 a.m. Woke up stroppy got stroppy attitude back - tipped out of bed and bed covers removed. Said 'I want some clothes I'm freezing. I'm not staying in here all day waiting for those bastards to come.' (Sheraz) asked if she wanted breakfast - she said she didn't so she didn't get anything. No food to be given until lunch time at 12-30. Because of (S's) stroppy attitude heavier tactics needed - i.e. please/thank you/may I's etc. otherwise nothing to be given... upstairs rooms and landing is cold. Fuse has been taken out of fire in (S's) bedroom. Perhaps consideration for this to be returned after this afternoons meeting.'

11.87 Two days later Sheraz was again tipped out of bed and the bed covers removed. The residential worker recorded that she 'became very angry and she thumped me by left eye (upper). So was restrained... mattress removed.' Fifteen minutes later Sheraz pulled the boarding off the window went out on to the roof across the roof and down the fire exit and ran off. Collected by police... returned to unit. Kicking and shouting put into the opposite room until window can be board(ed) up again.' Later it is recorded that she was 'in her old room window closed. One staff sat in room with her another in hallway.' Then 'work' was set for her.

11.88 On the fourth day in Pindown in respect of a visit by Sheraz' mother, it was noted in the log book that 'Mum totally abided by rules of pindown and has said that she has welcomed this intervention. (Sheraz) also feels that though the initial response was aggression she is beginning to see and understand the reasons for this exercise.'

11.89 On the ninth day in Pindown Sheraz, suffering from an ear infection, was taken to see a local GP. A residential worker recorded that she was 'very well behaved I think she thought it strange seeing daylight, maybe she realises the freedom she was having and hopes to have again soon (sic).'

11.90 After fourteen days Sheraz absconded with another girl. Two days later they were picked up by the police and returned to the home at 8 p.m. Sheraz 'went quietly to Pin Down Unit, and straight to bed and lights out'.

11.91 During Sheraz' third week in Pindown, a residential worker assessed the 'written work' Sheraz had been given: 'Having read through all the "guff" (Sheraz) has produced what do we know that we did not know before? C.K. she's got nice handwriting, is articulate and can use the written word as a useful form of communication. However what are we trying to achieve? Sure it occupies her time and keeps her quiet, she is not a management problem - so what?'

11.92 After three weeks Sheraz was allowed into the main part of the house and to see and talk to other children. She told the Inquiry that she hated Pindown because she had no-one to talk to unless her mother visited. She thought that Pindown was simply a punishment. She regarded being forced to write about herself as upsetting and futile. She thought that her experience of Pindown had probably made her worse. Soon after leaving Pindown her social worker found her a foster placement.
PART 4: Analysis

Chapter 12

Pindown

12.1 We have traced in earlier chapters the pre-November 1983 influences and events which, in our view, contributed to some extent to the general conditions that permitted the appearance of Pindown. In addition we have set out in some detail the history of its practice before it was summarily terminated at the beginning of October 1989. In the last chapter the seven profiles of children who underwent the ‘Pindown Experience’ are an attempt to encapsulate its reality in human terms. We consider now the specific matters that we have to deal with in the light of the Terms of Reference \(^{23}\) and in particular paragraphs 1, 4 and 8.

The Nature of Pindown

12.2 When considering events in the past the bonus of having a wealth of contemporary documents is considerable. In the case of the practice of Pindown there is available, amongst other documentation, almost a complete set of log books and measures of control books together with Pindown unit books (under various titles) and books of so-called programmes. In addition the main practitioners of Pindown, Tony Latham and Philip Price, together with Glynis Mellors who played a significant part, have set out at various times between 1983 and 1989 their accounts of the ‘philosophy’ and practice of Pindown. \(^{24}\) There are also contributions by others which, for example, refer in detail to the ‘rules’ of Pindown. In respect of the various books of records kept in the residential units there is, as will have been noted from the numerous quotations in earlier chapters which speak for themselves, an extraordinary frankness and clarity in the vast majority of the entries relating to Pindown and the children who were put into the various units.

12.3 We also have had the advantage of hearing evidence from very many witnesses who could throw considerable light on the true nature of what took place over a period of almost six years. These included: children, adults who as children were in Pindown, parents, social workers, residential workers, managers, politicians, members of the public who lived near to residential units, and a number of distinguished experts. We also had the benefit of written evidence put in by many people. Our views based on the extensive evidence we received are set out below.

Documentation

12.4 The true nature of Pindown, in our view, emerges clearly from the writings of its practitioners. Prior to August 1984, Tony Latham and Philip Price produced ‘Routine of the Intensive Training Unit’. This is set out in appendix F as document 2 and has been considered in detail earlier in Chapter 5, paragraphs 5.49 to 5.55. The message, in our view, is crystallised in the words ‘DO AS IS TOLD’ and in the observation on page 2 of the document, ‘the philosophy behind (sic) the Intensive Training Unit is undermined if the “Rules of the Establishment” are not strictly adhered to’. It is made clear that ‘privileges are to be earned through co-operation with staff and decided upon at specified review times. Failure to sustain co-operation will automatically lose the right for privileges and the basic programme will again be enforced.’ One notes that throughout the Pindown era such matters as communicating with other children and/or the staff, going to school, taking exercise, having reading and writing materials, wearing ordinary clothing as opposed to night wear, being allowed to have visits, and going out of a room to go to the toilet without knocking on the door first and being given permission, are categorised and treated as ‘privileges’ which have to be earned.

\(^{23}\) See appendix B.

\(^{24}\) See appendix F, documents 1-8
12.5 About two years later, some time after July 1986, Glynis Mellors (then Bonnici) produced 'Intermediate Treatment in Newcastle Staffordshire Evaluation Report'. Parts of the document appear in appendix F as document 4 and we describe the Report at length in Chapter 7, paragraphs 7.23 to 7.35. Tony Latham approved the document which we were told was sent to Elizabeth Brennan, the principal area officer, who could not herself recall seeing it. Under a heading 'Intermediate Treatment - Preventative and Rehabilitation Work' Glynis Mellors wrote that, 'a unit was set up detached from the main part of the residential building based at 245 Hartshill Road. In those days it was referred to as the 'special unit' (currently, known as the Intensive Training Unit). This section of the building soon became recognised as the place where problematical children were placed. Being totally isolated and self-contained it enabled its residents to be observed, assessed, appraised and programmes developed. Above all, it enabled at times hard line punishment and reward tactics to be adopted without influence, prejudice or inconsistency' (emphasis added). Glynis Mellors referred to the unit as having this 'so called "radical" practice of preventative and rehabilitation work'. Some attempts were made at the Inquiry to persuade us that the words quoted did not reflect the reality of the practice. We have, however, no doubt after considering the totality of the evidence that in the vast majority of cases the children perceived Pindown with its supposed panopoly of meetings, reviews, contracts and attempts to establish a structure of understanding and trust, as a narrow, punitive and harshly restrictive experience. We think that their perceptions were correct.

12.6 On page 6 of her document Glynis Mellors wrote that 'care is presented as a totally negative experience'. What she referred to as 'negative I.T.' (Intermediate Treatment) was 'ensuring the participant clearly identifies, comes to terms with and works through his problems and is not allowed to take the easy way out'. On page 8 of the document, Glynis Mellors referred to a girl whose 'programme was structured on what was called a "heavy pin down", her only privilege being that of being allowed to attend school'. It should be noted that, as far as we are aware from the evidence, no contact was ever made with the relevant education department in respect of the use as a sanction of preventing children in care from attending school.

12.7 At the beginning of 1988, nearly two years after Glynis Mellors' Report, a set of 'rules' of Pindown was written down on the front cover of the 'Pindown - Other House' log book at The Birches (see appendix F, document 5 and Chapter 9, paragraph 9.15). The 'rules' are in the handwriting of Louise Doherty, a residential worker, who was acting on the instructions of Peter Nicol-Harper, who was in charge of The Birches. Four years after it commenced Pindown in its traditional form is documented again: removal of clothes and personal possessions on admission; baths; wearing of nightwear, underwear and dressing gown and 'no footwear of any description'; meals in the room; knocking on the door for permission to 'impair information' or go to the bathroom; no communication with other residents; no television, music, magazines, cigarettes or telephone calls; visits from social workers or parents are permitted 'by arrangement with team leader'; during the day any school work set should be completed and 'all books and writing materials should be removed after 4 o'clock; and rising at 7 a.m., bed 7 p.m. after having a bath'. The 'rules' are headed by the instruction 'it is essential that each child is made aware of these rules at the time of their admission'.

12.8 In the middle of 1988, after returning from a training course, Philip Price renewed the Pindown documentation (see appendix F, document 6, and Chapter 9, paragraph 9.33). Some awareness of the legal implications and the basic nature of Pindown is apparent from the opening words 'while I recognise that most people working in the arena of Social Work may have difficulty in coming to terms with the working practices of a pin down unit i.e. possible infringements of rights, civil liberties etc. it has become necessary to devise such a unit within the structure of the 245 Community unit'.

12.9 Tony Latham after leaving The Alders, Tamworth, in August 1989 produced a report on the establishment (see appendix F, document 7 and Chapter 10, paragraph 10.56). It eventually came into the hands of senior management. It was dated 12 September 1989 and dealt with the use of Pindown. On pages 12 and 13 of the document, Tony Latham wrote as follows: 'following the successful introduction some years ago of a specialised unit at 245 Hartshill Road, the profound problems being created by certain youngsters at Tamworth promoted an introduction of this case in Tamworth. Special unit with all
its mystiques basically challenges the concept of positive care ideals and consequently is often misinterpreted and has been quoted as a lock up job!"

Basic Philosophies

12.10 Tony Latham then described the ‘basic philosophies’ of the special unit: ‘The isolation of a young person to a room away from the main care of the building, where loss of privileges are asserted. The young person is supervised 24 hours a day under a contract basis whereby issues, problems and relationships can be confronted. Care is presented as a totally negative experience initially ensuring that the participant can clearly identify their problems, come to terms with them through counselling and time out sessions with appointed staff, and is encouraged to work through the problems by not being allowed to take the easy way out. To ensure that work with the children on these lines is planned and clearly structured, it needs to include family contact, participation and agreement to the sanctions employed (where applicable) and the opportunity for the child to learn how privileges are earned and how co-operation brings rewards."

12.11 In respect of the unit’s use, Tony Latham wrote that the ‘special unit should seldom be used. It should be a last resort and not be used liberally to exert heavy handed discipline or sanctions to children. Family Centre staff have worked with its philosophies and have seen what rewards and changes it brings in children when all else fails. Area Office Social Workers generally do not agree with its operation but are unable to offer alternatives, save secure units’ (emphasis added).

12.12 The actual use of Pindown, in our view, wandered far from its so-called ‘philosophy’. Whilst a very few children who were in Pindown for a very short time were said to have benefitted from it, almost all who were in Pindown over the years suffered in varying degrees the despair and the potentially damaging effects of isolation, the humiliation of having to wear night clothes, knock on the door in order to ‘impart information’ as it was termed, and of having all their personal possessions removed; and the intense frustration and boredom from the lack of communication, companionship with others and recreation. To many Pindown must undoubtedly have appeared as ‘heavy handed discipline’. It is not insignificant, in our view, that at the beginning of November 1983 when one of the first children was transferred from The Birches to 245 Hartshill Road to go into Pindown, the entry in the log book stated: ‘R is at the secure unit at Hartshill’. Later on the 9 November 1983 John Aston recorded in the Hartshill log book: ‘Tony please note . . . to keep the impression of a special (sic) /secure unit going means no allowance of privileges (sic) as it would defeat our “face” to other members of The Birches’. When Peter Nicol-Harper, who was an experienced practitioner of Pindown and who had tried to introduce a ‘positive’ form of it in early 1988 at The Birches, gave evidence he expressed the view that the Pindown unit had been used, at least on some occasions, as secure accommodation.

12.13 There are many references in the records to children being ‘detained in the special unit’ and to ‘solitary confinement’. One particular example, noted in an earlier chapter, is not, in our view, unrepresentative. A boy, just fifteen years old, had ‘absconded’ from school and was put in the unit in early 1985 in 245 Hartshill Road. A log book entry states: ‘another week of solitary confinement’ for (P.E.) has had some rather peculiar effects. He is talking to himself a great deal and we had tears several times during the course of the week. Sleeping in staff also report incidents of (P.E.) talking in his sleep’ (emphasis added).

Definition


12.15 With some exceptions, the names in the main give a clue as to the approach used in the practice of Pindown. What, however, are the minimum criteria which qualify the practice as Pindown? It is almost
impossible to be absolutely precise but we decided that four features were usually present: firstly, isolation for part of the time in a part of a children’s home cordoned off as a ‘special’ or Pindown unit; secondly, removal of ordinary clothing for part of the time and the enforced wearing of shorts or night clothes; thirdly, being told of having to earn ‘privileges’; and fourthly being allowed to attend school or a ‘school room’ in the unit, and changing back into shorts or night clothes after returning from school.

12.16 ‘Full’ or ‘Total’ Pindown, in our view, must have the following features: firstly, persistent isolation in a part of a children’s home cordoned off as a special or Pindown unit; secondly removal of ordinary clothing for lengthy periods and the enforced wearing of shorts or night clothes; thirdly, persistent loss of all ‘privileges’; fourthly, having to knock on the door to ‘impert information’, for example, a wish to visit the bathroom; and fifthly, non-attendance at school, no writing or reading materials, no television, radio, cigarettes or visits.

12.17 The place in which Pindown was practised was variously called, ‘the special unit’, ‘the Intensive Training Unit’; ‘the structured unit’; the ‘sculptured unit’, the ‘secure unit’; the ‘time out area’; or ‘the crash pad’.

12.18 As noted in chapter 1, the origin of the word ‘Pindown’ was said to be the use by Tony Latham of the words, ‘we must pin down the problem’ whilst he gestured with his forefinger pointing towards the floor. The children began to speak of ‘being in Pindown’.

The Regime

12.19 Tony Latham informed the Inquiry that ‘the regime of Pindown which developed was based on the principle that we were re-establishing control of the young person. By taking away all privileges from that person for a short period we felt that we would firstly force the young person to face up to his or her difficulties, and secondly provide the mechanism for negotiation with that person since by taking responsibility for their actions they could earn the privileges previously denied to them, and by active participation in family meetings could have a say in their future’. He added that ‘the Pindown unit was designed to concentrate on the specific issues to be addressed. The time spent in the unit, however, was seen as a very small part of a much wider process of formulating and developing care plans or contracts with each young person’. He pointed out that ‘when the regime was first used it was a form of crisis intervention to deal with three particularly difficult youngsters at The Birches. However in order to avoid the intake of children coming into care inappropriately the model increasingly evolved into a preventative mode... This model of intervention was never envisaged as a punishment to young people but merely a method of containment for disruptive youngsters.’ Tony Latham further indicated that ‘the model was never a deliberate attempt to damage the children in any way or to restrict their liberty. No doors (were) ever locked, and the young people were always free to walk out of the building if that is what they chose to do albeit we would have tried to dissuade them from doing so.’

12.20 We were informed by Tony Latham that the review meeting ‘was undoubtedly the most crucial element in the programme and they were often heated and charged with emotion by the young person and his or her family’. He encouraged accountability for everybody who attended the meeting. He acknowledged that ‘by forcing people in a confrontational way to keep their part of any contract, I was not terribly popular amongst some of the area social workers’. Tony Latham chaired the meetings until September 1987. He also ‘encouraged positive and negative role play with the idea that by creating conflict, people start saying what they think’.

12.21 A number of witnesses at the Inquiry told us that in their view the family meetings were an ordeal not only for parents and children but also for the social workers. They were centred on ‘a powerful personality chairman’ and one social worker, as noted in Chapter 10, told us that she ‘used to go in with butterflies in my stomach and feeling really worried and I really don’t know what the child felt’. Others were offended by the bad language deliberately used. A child, for example, was told ‘you are fucking useless’. Overall we formed a critical view of what we heard of the meetings. No proper documentation was apparently produced for the meeting and in the main no proper or any record kept of it. A great deal
of play-acting by the Pindown practitioners appeared to be the order of the day. Additionally we heard that children often attended in their night clothes and girls who were wearing short night dresses felt very embarrassed and humiliated. Regarding 'contracts' and 'programmes', those produced to the Inquiry appeared to be extremely basic. Meetings in the early days of Pindown took place apparently once a week. Later at 245 Hartshill Road it would seem that they were not as frequent or as regular. At Heron Cross House and The Alders, however, during the short existence of Pindown in those establishments, there were frequent meetings.

12.22 Staff Contact and Nature of Engagement

Lack of sufficient staff and lack of qualified and experienced people dictated the kind and quality of the contact with children in Pindown. The laudable aim of saturating the child with attention was in effect a pipe-dream. We formed the view that in the main staff in fact spent very little time with the Pindown residents. Complaints about the excruciating boredom of being alone without any means of recreation were legion. Other complaints related to being given such tasks as writing out a telephone directory or answering in writing very personal and difficult questions. Many examples are recorded in the log books of the occasions and the manner in which staff rebuffed attempts by the children to communicate with them. The instruction to staff in very many cases was 'strictly isolated no contact at all'. There were examples, however, of staff who literally took pity on the isolated child and broke the rules to speak to him or her. Our impression was that this was very much the exception rather than the rule. For those permitted some contact, some members of the staff seem to have made efforts to build up a kind of relationship with the child. The log books, however, are littered with examples of disparaging remarks by staff about individual children. One example catches the flavour of many: 'this little runt' wrote one residential worker.

Variation in the practice of Pindown

12.23 Pindown was in existence at 245 Hartshill Road, Stoke-on-Trent between November 1983 and October 1989; at The Birches in 1988; and at The Alders, Tamworth and Heron Cross House, Stoke-on-Trent in 1989. We set out the precise dates below. We are of the view that over the period of almost six years there was no real variation in Pindown. In May 1988 an attempt was made to introduce, in the words of Peter Nicol-Harper, 'a positive version of the negative Pindown, in other words all the extra resources, without the taking away of children's rights'. It was called 'Maisie' which was short for maisonette 'because there's a maisonette opposite part of 245, basically a flat, in which we theoretically wanted to set up a ... therapeutic community for the children using positive re-inforcement'. Peter Nicol-Harper, as noted already in Chapter 9, paragraph 9.24, pointed out that 'the problems were that whereas Pindown can be operated by one member of staff, "Maisie" needed three members of staff on shift'. 'Maisie' could not be pursued.

12.24 Philip Price, an enthusiastic supporter of Pindown, returned from a training course in July 1988 to 245 Hartshill Road. He told the Inquiry that he was uneasy about what Pindown had become and the way it was used as a matter of course 'contrary to how it had originally been envisaged'. He also thought it was different from when he left it in September 1986 because it was not being used solely as 'a single element in a planned programme' and 'it did not invariably follow family meetings and involvement. It had become a practice for youngsters to be admitted to the unit either from police custody, remand or another family centre'. Having had the benefit of carefully sifting the evidence concerning Pindown over the period of almost six years we differ from his views. The application of Pindown, in our view, had already become almost a matter of administrative routine before 1986 and was not dependent in many cases upon being part of a wider programme or being used after a family meeting or involvement.

Places and Periods over which Pindown used

Places

12.25 As we have indicated above, we are quite satisfied that Pindown was used at four Staffordshire residential establishments: 245 Hartshill Road, Stoke-on-Trent; The Birches, Newcastle-under-Lyme;
The Alders, Tamworth and Heron Cross House, Stoke-on-Trent. (Photographs appear in appendix J)

12.26 The evidence for the above view is overwhelming. Amongst other matters there are contemporary documents recording the practice of Pindown and oral and written evidence about Pindown from numerous witnesses who carried out the practice or witnessed it in action.

12.27 We considered also the following establishments: Pembridge Road, Wood Street, and 100 Chell Heath Road, all in Stoke-on-Trent; Moorview, Leek; Riverside which closed at the beginning of 1989; and Lymewood, scene of some YTS activities. We received evidence in respect of each of these establishments. Pindown, in our view, was never in existence at any of them. We were initially concerned about the position at 100 Chell Heath Road because Tony Latham and Glynis Mellors had gone there in August 1989 immediately after using Pindown at The Alders. Later, in early September, they went on to Heron Cross House where they also used Pindown. After hearing witnesses, including some from 100 Chell Heath Road, considering the documentation and visiting the unit, we reached the conclusion that Pindown was not introduced there in any of its manifestations. One boy for whom Pindown was prescribed by the Latham team was sent to the unit at 245 Hartshill Road.

12.28 The precise locations in the establishments were as follows:

- **245 Hartshill Road**
  It would appear that Pindown began in a former staff flat on the second floor of the establishment. It contained two rooms, and a bathroom and toilet. The two rooms were used for Pindown. What eventually became known as 'Back Pindown' was a room overlooking an adjacent block of flats. 'Front Pindown' was a room overlooking the main road. The back room measured approximately 11 feet by 9 feet and the front room 11 feet by 11 feet. Within a year the practice of Pindown in the 'special unit' had been transferred to what was described as 'the integral ex-staff maisonette' on the other side of the building. It was partly on the first floor and partly on the second floor. It consisted of two bedrooms, a kitchen, a sitting/dining room, and a bathroom/toilet. The bedrooms on the second floor were used for Pindown. They measured 8 feet by 11 feet and 10 feet by 12 respectively. Eventually Pindown was transferred back to the original site of the former staff flat.

- **The Birches**
  Pindown was used in a house in the grounds of The Birches called 'The Laurels', but known also as the 'other house' or the 'little house'. Two bedrooms, as we understand it, were used for Pindown.

- **The Alders**
  The Pindown room was on the top floor of the establishment in a former storeroom approached by a winding staircase. The room measured approximately 14 feet by 16 feet but wide shelves reduced the size of it. It had a small window.

- **Heron Cross House**
  The Pindown unit was set up in a wing of the hexagonal building which contained two bedrooms, a bathroom and a toilet.

12.29 **Periods of Time over which Pindown used**

- **245 Hartshill Road**: Pindown commenced on 3 November 1983 and ceased on 2 October 1989. The use of Pindown was not continuous and an indication as to the gaps in its use can be gleaned from the earlier chapters tracing the history in some detail. There was, for example, no use of Pindown between 9 November 1985 and 14 January 1986, and between 26 February 1987 and 21 April 1987.

- **The Birches**: Pindown was used at The Birches only in 1988 in the following periods: 1 February to 28 March; 29 May to 7 June; and 8 November to 28 November.

- **The Alders**: Pindown was used at The Alders for one period only between 20 March 1989 and 2 October 1989.
– Heron Cross House: Pindown was used at Heron Cross House for one period only between 26 September 1989 and 2 October 1989.

12.30 Advice concerning the practice of Pindown

No psychiatric, psychological or educational advice of any kind was obtained before or after Pindown was brought into existence. In addition no formal legal advice was sought at any time regarding Pindown. We consider the legal context below.

12.31 Written Procedures

No consistent written procedures were specifically applicable to Pindown as such. Log books and measures of control books were completed in the normal way and some ‘programmes’ relating to Pindown were recorded in a separate book. A separate Pindown log book came into existence spasmodically alongside the normal log book. Specific documents relating to the ‘philosophies’ and practice of Pindown which have been referred to above and in earlier chapters, are set out in appendix F as documents 1 to 8. These include references to the ‘rules’ of Pindown to be followed; see, for example, document 5.

12.32 Children subject to Pindown

Using all the sources of evidence available to us, we are of the view that not less than 132 children went into Pindown between 3 November 1983 and 2 October 1989. This is probably a conservative figure. The records available leave a great deal to be desired in many cases and we have erred, if at all, on the cautious side. Figures concerning the children are set out on a yearly basis at the end of each chapter from chapters 4 to 10 inclusive. The following summarises the position:

- Total children: 132
- Boys: 81
- Girls: 51
- Longest continuous period: 84 days
- Longest overall period: 129 days (4 episodes)
- Most times in Pindown: 12 (a girl between the ages of 11 and 14)
- Youngest boy: 9 years
- Youngest girl: 9 years
- Oldest boy: 17 years
- Oldest girl: 17 years
- It should be noted that some children experienced Pindown in more than one establishment and were in Pindown in more than one individual year. Therefore the yearly totals at the end of each chapter (chapters 4 to 10) will add up to more than 132.

Impact of Pindown

12.33 There is no doubt that Pindown was intended to have an impact on the children subjected to its regime. In Tony Latham’s words, as noted above in paragraph 12.19 ‘(Pindown) was based on the principle that we were re-establishing control’. The whole approach, including the meetings, was confrontational and intended to cause conflict because then ‘people start saying what they think’. As we have indicated above, no professional advice was taken either before or after the introduction of Pindown. The following list of the apparent reactions of children in Pindown is taken from numerous entries in the log books of the establishments: ‘anger’, ‘depression’, ‘weeping’, ‘sobbing’, ‘anxiety’, ‘talking in sleep’, ‘talking to self’, ‘staring into space’, ‘lost confidence in people’, ‘frustrated’, ‘bored’, ‘banging on wall’, ‘lonesomeness’, ‘desperation’, ‘despair’, ‘could not eat’, ‘frantic attempts to get out’, ‘temper tantrums’, and ‘abscinding’. In addition there were incidents of wrist-slashings and the taking of overdoses.

12.34 The extent, if any, to which the reactions listed above, and indeed any long term effects, were triggered wholly or partly by Pindown may well be the subject of debate in each particular case. A commonsense approach, however, in our view, can only point to the likely negative effects of the use of a
regime intrinsically dependent on elements of isolation, humiliation and confrontation. The absence of professional advice in dealing with many children who were disturbed, depressed and in despair can only be described as inexplicable. More than one consultant psychiatrist later told us of the risks of some children suffering from post traumatic stress disorder.

Opinions on Pindown

12.35 We were greatly assisted by a number of recognised experts in various fields who assessed the practice of Pindown. We also received most helpful evidence from a number of organisations and individuals. We were particularly helped by submissions from the Official Solicitor to the Supreme Court. It has to be said that the evidence was all one way: it amounted to varying degrees of criticism. Some extracts are set out below.

12.36 Professor Norman Tutt has a formidable range of experience to draw on from having been variously a psychologist, a civil servant, a professor of applied social studies, and being presently a director of social services. We asked for his views on a range of topics concerning Pindown. He was surprised that as Pindown developed 'there did not seem to be any differentiation between the children, in terms of the reasons they came into care. Everybody got treated the same, even though some of the children had obviously come in for non-criminal behaviour, or, indeed behaviour that was not of their making but their family and their parents making . . . it seemed to apply a blanket regime to the children, without any regard to their reasons for admission to care, their legal status, even age and understanding.

Having said that, my next impression was that there are two explanations. One was that this was a rather malevolently intended regime and I dismissed that, and assumed that it was more likely to be a very naive implementation of an ill-digested understanding of behavioural psychology . . . I could not discern any very clear theoretical basis for this. It seemed to me that somebody had understood that you needed control, and then implemented it in a very rigid, inflexible, unthought-through way, with some elements of behavioural psychology in the language, but none of the conceptual understanding behind it'.

12.37 With regard to the Pindown 'rules', Professor Tutt was 'appalled that there were children coming into residential care and being given a bath immediately. The implications of that are actually quite serious. Stripping the child of their identity. The implication that they are bringing in filth from their own home.'

12.38 Professor Tutt considered that Pindown was in effect a case of 'hidden custody'. It 'had all the makings of a secure unit, without the physical design for a secure unit and the oversight by the proper bodies'.

12.39 Dr David Foreman, a consultant and Senior Research Fellow in child and adolescent psychiatry, was unable to recognise any clear theoretical framework for Pindown. He told us that 'it appears to include elements of the “time out” system of stimulus reduction in behaviour therapy, the “seclusion” of difficult patients in hospital, and the “anamnestic” approach to offenders used in secure therapeutic communities, where offenders are encouraged to describe in detail their offences. However Pindown differed from “time-out” in that it was used to forestall rather than respond to behaviour, and in its extremely long duration. It differed from hospital based “seclusion” in that the criteria of “dangerous” (to staff, self or others) did not appear to be included in the assessment criteria, and that the decision to remove a child to Pindown did not appear to be the subject of continued frequent review while in Pindown. It differed from “anamnestic” therapy in that, though the child was required to write down the reasons that brought (him or her) into the home, these were not discussed with the child until after the end of Pindown.'

12.40 Dr Foreman thought the possible harmful effects of Pindown were that: firstly the child might become fearful of admission to a children’s home; secondly, the child might develop an adversarial relationship to some or all members of social services; and thirdly, the child might develop a post traumatic stress disorder showing itself either as a deterioration in already existing difficulties, or the appearance of new problems. He thought that aside from Pindown being potentially harmful, ‘the manner of its implementation and supervision, if employed in a medical setting, would be regarded both
as bad professional practice and as unethical'. Dr Foreman told us that Pindown 'managed to combine the dangerous aspects of almost all the groups of therapies they have drawn on without including any of the safeguards in any of them'.

12.41 Dr Edna Irwin, a distinguished and highly qualified retired NHS consultant psychiatrist told us that a child who had been in Pindown might develop anxiety symptoms which could best be described as an irrational fear of being alone in a sparsely furnished room. In addition a child's trust in social workers might be denting or further denting. To what extent the presence of anxiety symptoms would handicap a child in the future would depend to a large degree on the nature of the stresses encountered over the following few years.

12.42 The British Association of Social Workers (‘BASW’) put in written evidence and Gail Tucker, its Advice and Representation Officer, and Christopher Andrews, a member of its Children and Families panel and a former General Secretary of the Association, gave oral evidence. It was pointed out to us that in recent years ‘there had been a massive run-down of residential care facilities for young people. More and more of them are either placed with families or are kept out of care altogether. The residue left in residential care tend to be the most difficult and disruptive, and even in small numbers they are extremely difficult to control . . . Staff in children’s homes therefore face a daunting task. Violence in some establishments is endemic, staff can feel terrorised, and the balance of power between residents and staff can quite easily be tipped in favour of the residents. And yet residential care staff tend to be unqualified and under-trained, to lack support and professional supervision, and to be thin on the ground’.

12.43 Nevertheless BASW noted that ‘those who embarked on developing Pindown as a front line strategy for dealing with young people displaying extreme difficulties must have been aware of the power they were exercising and of the potential for abuse’. It was regrettable in the view of BASW that ‘they did not construct a system of independent review, both for individual young people and for the operation of the system as a whole’.

12.44 BASW added that ‘the system might be said to be based upon a behaviourist philosophy, but “conditioning” which is grounded upon such a negative and punitive approach can never be called therapeutic. The worst elements of institutionalism (baths, special clothing, strict routine, segregation, humiliation and depersonalising practices, bed-times appropriate to a much younger age-group etc.) seem to have been introduced, apparently in direct contravention of the stated objectives of individualised programming and of developing life and social skills’.

12.45 Michael Hurley, a national development worker with the National Association of Young People in Care (NAYPIC) put in a written submission to the Inquiry and gave oral evidence. He wrote that ‘I look at “Pindown” in one way. It is a repressive regime of control’.

12.46 The National Association for the Care and Resettlement of Offenders (NACRO) put in a written submission to the Inquiry. NACRO’s view was that Pindown ‘appears to be based loosely upon a form of behaviour modification but the main focus is on control. The formal process outlined in the (Pindown) Documents) suggests a deliberate effort to “depersonalize individuals”. Admission procedures, compulsory bathing, the changing of clothes, lack of communication with others, and the earning of privileges are all examples of institutional control. There is little evidence that these approaches are effective and they run counter to generally accepted child care practice’.

12.47 The Official Solicitor to the Supreme Court represents a small number of children who have been made wards of court as a result of having been in Pindown. He put before us full written submissions and Michael Nicholls, a solicitor in his department, attended the Inquiry to assist us with legal and other aspects. He helpfully drew our attention, in particular, to The Naval Detention Quarters rules 1973 (S.I. 1973, No. 270) and The Imprisonment and Detention (Army) Rules 1979 (S.I. 1979, No. 1456). Aspects of Pindown: the lack of medical supervision, the wearing of night clothes, the control on communication with staff and other children and the placing of children in the equivalent of ‘close confinement’ compare
unfavourably with military measures. We consider further the submissions of the Official Solicitor under the heading 'The Legal Context' below. Overall the Official Solicitor considered the general nature of the regime of Pindown to be 'harsh and oppressive'. It could not in his view 'have benefitted the children who were subjected to it'.

The Legal Context

12.48 During the period Pindown was in existence, 3 November 1983 to 2 October 1989, the care of children in community homes was governed by the Community Homes Regulations 1972 (S.I. 1972 No. 319). Regulation 10 was concerned with measures of control. Regulation 10(1) specified that control in a community home 'must be maintained on the basis of good personal and professional relationships' between the staff and the resident children. Regulation 10(2) provided that additional measures of control could be used only if approved by the local authority on the basis that it considered them necessary for the maintenance of control in the home. The conditions under which the measures could be used had also to be approved by the local authority. Regulation 10(3) specified that any approval had to be given in writing and regulation 10(4) provided that full particulars of any measures used and the circumstances in which they were used had to be recorded in a permanent form by the person in charge of the home and the record kept at the home.

12.49 Regulation 10 was revoked by regulation 3(3) of the Children's Homes (Control and Discipline) Regulations 1990 which came into force some four months after Pindown ceased. Regulation 2 ("Control and discipline") replaced regulation 10 of the 1972 Regulations. It is interesting to note that it is expressed in different language: 'The responsible body shall ensure that control of the home is maintained in accordance with sound management, good professional practice and on the basis of good personal relationships with the children in the home': (regn 2(1)). Regulation 2(2) provides a list of prohibited sanctions. Included in the list is 'any restriction or refusal of any facility for a child to receive visits and communications from and to communicate by telephone or post with': (amongst others) his parents, his relatives, a statutory visitor, his or her social worker, or any solicitor acting for the child or whom the child wishes to instruct. A further prohibited sanction is 'requiring a child to wear distinctive or inappropriate clothes'. In respect of the recording of sanctions, the particulars must now include 'the individual circumstances in which a sanction is used': regulation 9A of the 1972 Regulations inserted by regulation 3(2) of the 1990 Regulations.

12.50 The advent of the Children Act 1989 means that a further set of regulations will be made: see paragraph 4 of Schedule 4 to the 1989 Act. It is understood that these will be published shortly.

12.51 As indicated above, the 1972 Regulations applied during the whole of the period covered by the Inquiry. DHSS Circular No. 78/1972 provided guidance when the Regulations first appeared. Under 'Control' it was indicated that regulation 10 was concerned with 'the maintenance of control in the community home, and not with punishment as such'. Regarding the actual wording of regulation 10 the Circular stated that 'in the nature of things, good personal relationships in the home will come from respect for the individuality of the children in it; while good professional relationships will involve the application of those special skills which enable the staff to cope with the problems associated with the child's removal from home, whether by recognising and dealing sympathetically with behaviour attributable directly to the child's separation from his family, or by supplying a degree of support and encouragement, and where necessary control, which is in the best interests of the child and the community' (emphasis added). It was hoped that 'in the great majority of community homes the need to have recourse to additional measures will rarely arise'.

12.52 Commentators criticised some of the wording of regulation 10 as being vague and the boundary between what constituted good personal and professional relationships and what was an additional measure of control was uncertain (see the reports of Committees of Inquiry into Besford House, Salop 1976 and Moorfield, Salford 1977; and paragraphs 37 and 129 of 'Control and Discipline in Community

25 See appendix L
Homes', DHSS 1981). Underpinning regulation 10, in our view, was the application of good child care practice which may, of course, be a matter for reasonable disagreement in some areas.

12.53 Staffordshire was not approved by the Secretary of State to use secure accommodation. Under regulation 2 of the Secure Accommodation (No. 2) Regulations 1983 secure accommodation is defined as 'accommodation provided for the purpose of restricting the liberty of children'. DHSS Circular LAC (83) 18 relating to the 1983 Regulations provides guidance (in paragraph 4 of Annex B) as to the definition of restriction of liberty of children in care. It states that 'control imposed or implied by staff or other responsible adults will not be considered to constitute the restriction of liberty, though control should always be imposed or implied in a manner consistent with good child care practice.'

12.54 Staffordshire social services committee reviewed its measures of control in 1982 and 1986. Following both reviews it was pointed out to staff by way of circulars that 'penalties can be applied, with the prior agreement of the Officer-in-Charge, in the form of the temporary denial of privileges or the imposition of an unwelcome chore.'

Conclusions regarding the Legal Context

12.55 Pindown, in our view, whether 'Total Pindown' or 'Sympathetic Pindown' involved elements of isolation, humiliation and confrontation to varying degrees. There was no satisfactory evidence before the Inquiry that doors were actually locked when children were in a Pindown room, although we accept that on at least one occasion at 245 Hartshill Road a door handle was probably removed and placed in an office drawer over night. We are quite satisfied, however, that saucepans and other objects were put on door handles as a warning signal; that staff remained and slept outside rooms in order to deter children from coming out; and very many children simply accepted that their liberty was restricted in that they had to knock on the door and make a request to leave the room. Some clearly demonstrated their understanding of the restraint by jumping out of the window of a Pindown room or attempting to do so. We have no doubt that children were humiliated in many ways, by, for example, being made to wear night clothes all the time, having their personal possessions removed and being denied any normal recreation. In addition during confrontational 'meetings' numerous children were harangued and referred to in grossly abusive terms.

12.56 Whilst one must, of course, be cautious about applying the same standard to all of the 132 children who experienced Pindown because of their varying experiences, we nevertheless are firmly of the view that Pindown in all its many manifestations was intrinsically unethical, unprofessional and unacceptable. It falls, in our opinion, decisively outside anything that could be considered good child care practice. Accordingly we consider that it was used in breach of regulation 10 of the 1972 Regulations. It is implicit in our view, of course, that it could not lawfully have amounted to an additional measure of control.

12.57 Rachel Hodgkin, on behalf of the Children's Legal Centre, submitted to us that if a child was prevented from leaving a room, not by locks or bolts, but by, for example, a staff presence outside the room, that could amount to a restriction of liberty. Accordingly if a child was confined for hours or days against their will, as opposed to a purely temporary restraint, this would bring the accommodation used within the provisions relating to secure accommodation. The situation, in her view, would not be within the definition given by way of guidance in Annex B to Circular LAC (83) 18 (see paragraph 12.53 above): 'control imposed or implied by staff ... will not be considered to constitute the restriction of liberty, though control should always be imposed or implied in a manner consistent with good child care practice.'

12.58 The Official Solicitor supported this view. He pointed out that the test is not whether the door is locked, but whether liberty is restricted. Pindown, in his submission, constituted placing children in accommodation provided for the restriction of their liberty and could only be regarded as a method of 'control' subject to the secure accommodation provisions (see section 21A of the Child Care Act 1980).

12.59 It was argued, in particular, on behalf of Tony Latham, Philip Price and Glynis Mellors that the definition in Annex B to Circular LAC (83) 18 should be 'interpreted narrowly'. It was said that it was
provided to make clear that only the worst abuses should be caught and 'it was not intended to apply to marginal cases'. We have considered carefully the full written and oral submissions made to us.

12.60 We agree with the submissions of the Children's Legal Centre and the Official Solicitor. Pindown involved the cordonning off of parts of children's homes and the imposition of a regime within a particular unit designed to confine and control a child for significant periods. It did not involve merely momentary or purely temporary restraint. It could not, as we have indicated earlier in this chapter, amount in our view, to good child care practice. Consequently the secure accommodation provisions applied. Staffordshire did not have the necessary approval of the Secretary of State to provide such accommodation.

12.61 It seems to us that the law regarding 'control' of children in residential homes needs some further clarification. It is not satisfactory, in our view, that crucial decisions upon whether or not a child's liberty has been restricted should have to rest on a definition in a circular giving guidance rather than being spelt out in clear language in a statute or in accompanying regulations.

12.62 Police Investigations

Staffordshire police, as we understand it, conducted a full investigation into allegations concerning various residential homes. Ultimately, on the 25 February 1991, it was announced that 'it is the opinion of the Director of Public Prosecutions . . . that there is no evidence to warrant proceedings against anyone.'

12.63 Civil Claims

Regarding possible claims that may arise out of events relating to Pindown, we were informed that at least one writ had been issued. It is anticipated apparently that more writs will be issued in due course. In the circumstances we consider it inappropriate to survey the wider legal position. It is, in our view, a matter properly left to the respective civil court if and when the claim or claims proceed.

12.64 We should add that we heard in evidence some allegations of assault made against a few members of the staff of residential homes. The allegations were strongly denied and were, as we understand the position, looked into during the police investigation. Having carefully considered the likelihood of possible claims it would, in our view, be unwise to offer any comments.

The Professional and Managerial Oversight of Pindown

12.65 As we indicated above no psychiatric, psychological or educational advice was obtained either before Pindown was first used or during its active life. In addition no legal advice of any kind was sought at any time.

12.66 During 1984 and part of 1985 the social services department at the instigation of Fred Hill, a senior assistant, actually focussed on the running of the 'special unit' or 'Intensive Training Unit' at 245 Harthill Road (see Chapter 5, paragraphs 5.22 to 5.25, and paragraphs 5.70 to 5.80) Fred Hill expressed the view that certain practices were apparently in contravention of the Community Homes Regulations 1972 on control. Some months later he thought that the department was 'obviously sailing close to the wind'. Even allowing for the benefit of hindsight, we can only register our surprise that the very senior members of the department who were appraised of the situation never sought any legal advice then or thereafter.

12.67 Pindown received no professional oversight.

12.68 Managerial oversight has to be considered at three levels. Firstly those in charge of the day-to-day running of Pindown; secondly middle management; and thirdly, senior management.

12.69 Those who ran Pindown in the main gave it their uncritical attention and enthusiasm. Peter Nicol-Harper, with the assistance of Jane Taylor, in May 1988 attempted unsuccessfully to introduce a
'positive' form of Pindown (see Chapter 9, paragraph 9.24) because of a concern with the normal 'negative' Pindown. Others provided no oversight or evaluation whatsoever of Pindown. When the Latham team went into The Alders and Heron Cross House in 1989 they, in our view, unceremoniously pushed aside the regular staff.

12.70 Tony Latham as area officer from 1983 until September 1987 was the architect and prime practitioner of Pindown. He was wholly and uncritically, in our view, involved in it. Jane Taylor succeeded him and, whilst having reservations and attempting to introduce 'positive' Pindown, permitted the regime to continue. Elizabeth Brennan, as principal area officer during the major periods of Pindown exercised, in our view, no critical faculty and accepted in evidence that she should have visited the unit more often.

12.71 Senior management was informed about the special unit, as noted above, in 1984 and exercised some oversight. However it is clear from the documentation available that the early interest shown petered out and major potential issues were unresolved. Both deputy directors, Peter Crockett and John Spurr, approved the sending of the Latham team into The Alders and Heron Cross House in 1989. If they were in fact unaware of the nature of Pindown, as they claim, then it seems to us that that fact itself is a serious indictment of senior management. Indeed John Spurr accepted in evidence that ignorance of Pindown over six years could only reflect a serious flaw in managerial oversight.

Statutory Visits

12.72 Regulation 3(2) of the Community Homes Regulations 1972 provides for statutory visits of inspection to residential child care establishments. A group of senior managers visited in rotation 245 Hartshill Road, The Birches, The Alders, and Heron Cross House. Even though oddities about the measures of control books were noted and occasional questions raised about the care and treatment of children, the system, in our view, wholly failed to bring to light the practice of Pindown and the very serious failings associated with it. We noted that on occasions critical comments made by a statutory visitor on the forms used would be missing from or couched in more anodyne language in the report which was later sent to the district advisory sub-committees.

12.73 The forms used by the statutory visitor appear in appendix K. We consider that they should be amended to highlight the question of 'control' and to allow for specific and detailed comments in respect of the subject.

Social Services Inspectorate Visit

12.74 It was put to us in evidence by Tony Latham and others that when the Social Services Inspectorate visited Staffordshire in December 1987 they in effect gave the 'green light' to Pindown (see Chapter 8, paragraphs 8.39 to 8.45). This, it was said, followed because the Inspectors visited 245 Hartshill Road and said nothing about Pindown in their eventual report. We heard from the Inspectors and from Jaime Rodriguez who showed them round the establishment. Jaime Rodriguez helpfully attended at the Inquiry on three occasions altogether so that all the points arising could be clarified.

12.75 We are quite satisfied that the Inspectors were not told about Pindown and its workings or shown a unit in action. Had they been told we cannot believe that they would not have investigated further and fully reported on the Pindown unit. With hindsight it is clear that there were a number of clues available, particularly in log books and measures of control books, to alert them to something out of the ordinary. The nature of their visit, however, as part of a general survey of family centres did not involve the level of detailed inspection normally carried out.

RECOMMENDATIONS

12.76 Arising out of the matters considered in this chapter we make the following recommendations.
12.77 We recommend that social services departments regularly scrutinise the measures of control used in residential child care establishments.

12.78 We recommend that those appointed in social services departments to monitor regularly the measures of control used in residential child care establishments should liaise closely with the legal department of the local authority.

12.79 We recommend that social services departments ensure that log books in residential child care establishments are completed in such a way (a) that they disclose who is on duty on the day on which entries are made; (b) that all entries are written in appropriate and clear language; (c) that all entries are signed with the name of the signatory clearly identified; and (d) that all entries are clearly dated.

12.80 We recommend that social services departments ensure that measures of control books in residential child care establishments are completed properly in compliance with the relevant Regulations and that entries are dated and signed with the name of the signatory clearly identified.

12.81 We recommend that the forms used by statutory visitors to residential child care establishments should highlight the question of ‘control’ and direct the visitor to make specific comments regarding measures of control used.

12.82 We recommend that prior to a visit to a child care establishment by a statutory visitor, there is made available to him or her the previous visitors’ completed forms over a period of at least six months.

12.83 We recommend that statutory visitors’ reports should go unaltered to the appropriate committee.

12.84 We recommend that statutory visits should be made without advance notice being given to the residential home.

12.85 We recommend that the law regarding the ‘control and discipline’ of children in residential establishments is amended so that definitions of the circumstances which amount to the restriction of a child’s liberty appear in legislative provisions and are not left to the language of guidance in circulars.
Chapter 13:
Fundwell

13.1 We were asked to consider five specific areas in relation to the participation of children in the activities of undertakings known as Fundwell. The five areas were:
(a) the nature and extent of the organisations;
(b) the nature and extent of the children’s participation;
(c) the number of children involved;
(d) the benefits or disadvantages of the children’s participation;
(e) the managerial and professional oversight of the children’s participation.

The Nature and Extent of the Organisations

13.2 From the mid-1970s until 1987 Tony Latham set up and developed a network of voluntary organisations and private companies which in some instances contracted their services directly back to the social services department and in other instances were concerned with intermediate treatment and other activities in which children and young people were involved in a variety of ways: see Chapter 3, paragraphs 3.47 to 3.56.

13.3 The network was constantly changing and developing and parts of it were significantly shaped by the availability of financial resources from the Manpower Services Commission through the Community Project and the Youth Training Schemes (YTS). Tony Latham continued to be the mainspring of the organisations after he became area officer in Newcastle-under-Lyme in 1983 and later area officer (children and families) in 1985. By 1986 it was becoming clear that the responsibilities of his Staffordshire County Council appointment and the organisations he had set up were too much for one person: see Chapter 7, paragraphs 7.68 to 7.76.

13.4 Barry O’Neill, who became director of social services in 1985 following the retirement of Paul Hudson, indicated in his written submission that he was ‘horrified by the range of things that had developed’ and recognised ‘there were potential conflicts in (Tony Latham’s) joint role’. He decided that the situation had to be changed. Subsequently Tony Latham was appointed as Voluntary Bodies Co-ordinator in September 1987. ‘Fundwell Ltd.’ was formed at approximately the same time to draw together and rationalise the many organisations and activities.

13.5 In his written submission to the Inquiry and in his evidence, Tony Latham gave information about the organisations and activities in which children and young people in care were involved and which had been known as Fundwell. In addition the Inquiry took evidence from a number of witnesses, including young people who had been in care, and examined log books and other documentation.

13.6 Precise records were not kept about much of what took place and it is not possible over such a long period of time and with the involvement of so many different adults and children to give an exact picture of the nature and extent of the activities of the Fundwell organisations. Philip Price told us in evidence that the YTS and intermediate treatment and young people in care ‘are all so inter-linked even I can’t actually break them apart’. Tony Latham himself told us ‘there is absolutely no way I could give any figure or indication or proportion’. His legal adviser added ‘we are not able to give you a clear . . . list that might have given you . . . a starting point’. It was said in evidence that it was ‘extremely difficult to untangle one group of children from another’. Tony Latham did, however, provide valuable material which has contributed to our findings.

13.7 The following is a list compiled within the limits explained above of organisations and activities which involved children in care, in some instances as recipients of a service, in some as people involved in providing a service and in others as people carrying out various kinds of work:
(a) North Staffs Resource Co. Ltd. – involved young children in activities and provided some intermediate treatment opportunities for older children and young people;
(b) Playbus – provided a service for children under 5, while young people in YTS, some of whom may have been in care, assisted as part of their training;
(c) North Staffs Activities Project – young people in care were occasionally involved in delivering equipment etc.;
(d) Voluntary Youth Project – was an approved unit for intermediate treatment;
(e) Com. unity Social Services YTS Ltd. – amongst the many young people involved were some who were in care;
(f) Forest Enterprises (including the animal project) – involved young people in YTS or intermediate treatment, or because of general interest. Some would have been in care;
(g) Vehicle repairs and maintenance – young people in YTS and intermediate treatment. Some were in care;
(h) Gardening and allotment – most young people in YTS, some in intermediate treatment. Some were in care;
(i) Woodwork (including construction and maintenance) – young people in YTS and some in intermediate treatment. Some would have been in care;
(j) Community Warehouse – mainly young people in YTS, some in intermediate treatment. Some were in care;
(k) Painting and decorating – mainly young people in YTS, some of whom were in care;
(l) Transport, which included a number of Land Rovers and minibuses – these were driven by Community Project adults, volunteers and staff but young people often participated in an activity and some were in care;
(m) Skip hire, which was for a time part of Transport and Fundwell – young people in YTS and intermediate treatment assisted with the Skip hire and some were in care;
(n) North Staffs Voluntary Projects Ltd. (including day centres for elderly people) – young people in YTS and in intermediate treatment, some of whom were in care;
(o) SHAP (Supportive Housing Accommodation Project) – young people in YTS and some who were in care were involved in decorating and preparing houses, as well as in some instances living in them;
(p) Cycle and motor cycle building – young people from various sources, some of whom were in care;
(q) Practical jobs at Duke’s Lodge – part time work and activities, often involving young people in care, sometimes for pocket money, sometimes for activity purposes only.

13.8 Some of the locations in which these activities and organisations operated included a number of day centres for elderly people, a former hospital building called Lynnewood, 245 Hartshill Road, Stoke-on-Trent, The Birches, Newcastle-under-Lyme, a garage at Pittsburgh House, Filverston Hall gardens, Olditch fishing club, an allotment, Duke’s Lodge and a number of houses which were within the SHAP scheme. This list is not exhaustive. Some activities, such as the collection and delivery of furniture and skips, took place on the move and on a supply and demand basis.

The Nature and Extent of the Children’s Participation

13.9 Some children and young people were involved as recipients of services in, for example, the Playbus for under fives and traditional intermediate treatment activities such as outings and play schemes for older children. YTS work, intermediate treatment and work or activities outside of YTS and intermediate treatment were difficult, if not impossible, to differentiate precisely as can be seen from the list outlined in paragraph 13.7 above. YTS schemes in which young people in care were involved contained various forms of work which were accompanied by some teaching and other educational opportunities. Intermediate treatment was intended to be preventive in relation particularly to juvenile offending, but official policy encouraged local authorities and others to interpret it widely and flexibly. In Staffordshire almost everything involved in the organisations and activities outlined above seemed to have been, at some time, deemed to be intermediate treatment. There was, however, also a range of
activities in which a number of children in care were involved when they were in Pindown. These were sometimes identified as intermediate treatment but were often part of the programmes designed for the children by the staff, particularly at 245 Hartshill Road. The log books indicated that these activities at Duke’s Lodge were also, at times, a way of circumventing staff shortages at 245 Hartshill Road.

13.10 The young people in YTS schemes, whether in care or not, were registered within those schemes as YTS trainees and received payments on a national scale. They also received the education which the schemes supplied. The schemes were subject to inspection and monitoring by officials of the Manpower Services Commission who visited the sponsors, such as Tony Latham, and also the sites and personnel where the young people were employed. The Inquiry took evidence from two of these officials.

13.11 A number of the young people in care had experienced more than one YTS scheme and in some cases, because of their personal difficulties and their school history, were not able to benefit from more conventional, achievement oriented YTS schemes. The scheme which Tony Latham sponsored, which later became part of Staffordshire social services, had been organised, and clearly identified by the MSC to cater for young people who found work and achievement more difficult than some of their contemporaries. The young people in it participated in the Fundwell organisations as well and the two concepts were, in practice, interlocked.

13.12 The kinds of activities in which young people, some of whom were of school age, were engaged included the following list, which is not exhaustive but is based on the records which were presented to the Inquiry and the evidence of both former young people in care and adults who were concerned with them:

(a) work on the allotment and cleaning yards;
(b) growing plants and selling them;
(c) selling fruit and vegetables;
(d) feeding chickens, collecting and washing eggs and selling them and doing cleaning jobs;
(e) feeding ducks and rabbits and exercising a goat;
(f) mowing lawns;
(g) cutting up, splitting and chopping logs (some from railway sleepers);
(h) bagging, distributing and selling logs;
(i) removals from house to house and collection of furniture, clothes and other gifts from the public;
(j) breaking up furniture;
(k) keeping the furnace at Duke’s Lodge going;
(l) fence repairing;
(m) ditch digging;
(n) woodwork;
(o) building work;
(p) helping with skip hire and collection;
(q) working in day centres for older people;
(r) serving at a snack bar at Duke’s Lodge;
(s) serving at a hot dog stall at Duke’s Lodge.

13.13 The young people in care who were living in SHAP houses were apparently licencees and not tenants. The financial aspects of the use of SHAP houses were amongst the matters which the District Auditor agreed to investigate. Young people in care at various times lived, usually with one or two other young people in care, in any one of nineteen different houses. These houses were situated in Staffordshire in Hanley, Cobridge, Longbridge Hayes, Etruria, Northwood, Tunstall, Fenton and Lichfield.

13.14 The great majority of children who participated in the organisations which were the subject of the Inquiry, did so either as recipients of a service, as employees, as trainees, or for the purpose of gaining work experience, or as licencees in SHAP houses. There were also a small number of children who, in our view, on the evidence, were required to carry out certain tasks, usually at Duke’s Lodge, associated with the overall programmes in Pindown. There is little doubt that some of the children considered that they were being punished.
13.15 Listing all the Children

It is quite impossible to compile a list of the children because there are no records on which such a list could reliably be based. In relation to the YTS scheme alone, as Tony Latham put it ‘we are talking about huge number of youngsters . . . not necessarily . . . all in care.’ He added, concerning the children as a whole, ‘we are scanning a very large period of time and it’s almost impossible for me to identify age or anything else’.

The Benefits or Disadvantages of the Children’s Participation.

13.16 The former manager of programmes for the Manpower Services Commission in the Staffordshire area gave evidence to the Inquiry. He made it clear that for some young people it was necessary for there to be a ‘considerable degree of rehabilitation before training was embarked on’ in a YTS scheme. The YTS scheme which was later associated with Fundwell was, as we understand it, well regarded by the MSC though it had a considerable element of manual labour and was seen more as an introduction to work than specific work training.

13.17 The scheme was under relatively close supervision by the MSC although selection of staff was the scheme’s own responsibility. We understand that if any complaints had been made to the MSC they would have investigated them. Because of subsequent re-organisations and changes, no records were available so as to be able to check whether complaints were made or not.

13.18 Some of the witnesses at the Inquiry were very critical of the arrangements made for training on the YTS scheme. Specific complaints included: inadequate attention to health and safety at work matters such as safety boots, non slip ladder feet, scaffolding, other protective clothing and safety of woodworking machinery; lack of shelter on open work sites such as the allotment and ditch digging; inadequately heated premises at Lymewood Centre for YTS; lack of educational materials and tools; no budget to buy teaching materials; lack of planning and precision in activities; unsafe and unsuitable locations for teaching such as garages and open sites. Minutes of staff meetings at Lymewood YTS centre showed clearly that working conditions were a cause for complaint.

13.19 Tony Latham in evidence said that advice and guidance was sought from the Health and Safety Executive inspectors and a copy of the Woodworking Machinery Regulations was available at Duke’s Lodge where the woodworking machinery was kept and used. We were told that protective clothing was purchased from time to time, that no young person was allowed to operate power driven woodworking machinery and that scaffolding was scarcely ever used and when it was, that it conformed to safety requirements. Concerning open sites, at times a caravan was available for shelter and at the allotment there was a hut from which we were told the young people had been banned because of bad behaviour. They then used a motor vehicle for shelter. The premises at Lymewood had been standing empty for a long time and young people helped in getting them ready for use by the YTS scheme. Tony Latham stated that there was some heating on these premises. Regarding educational materials and tools, for example, we understand that the budget was always limited and it was not unusual for workmen to have to use their own tools and for teachers to provide some of their own materials in schools.

13.20 A number of the arrangements made for the YTS scheme were, in our view, likely to have been very makeshift and lacking in the careful organisation, planning and provision which might have been desirable. On the other hand we also recognise that the young people for whom the scheme was provided presented, in some cases, difficult educational and disciplinary problems. The MSC staff felt that staff on the scheme needed and often had special understanding of the young people’s problems.

13.21 Our view that the scheme suffered a number of disadvantages was supported by the fact that when the terms of reference of the YTS schemes changed and schemes had to apply for accredited training status in about 1985, this presented difficulties to the scheme for which Tony Latham had been responsible. In depth monitoring found the scheme wanting. Although initially it obtained provisional
approval, it was later re-monitored and, after the social services department had stepped in in 1987/1988, it did not achieve accredited training status. Eventually as a result of this and changes in national funding for YTS schemes, the Staffordshire social services YTS scheme closed down.

13.22 It was put to us that the children benefitted from their involvement in Fundwell activities because they had an introduction to work and learned certain simple skills such as the planning of collections and deliveries, receiving money and giving change, and looking after animals. The wide variety of activities was also, it was said, an opportunity to try different types of occupational experience. It must be recognised, however, in our view, that a number of children were engaged in repetitive labour which sometimes had an element of risk and was often quite heavy and at times unpleasant work. Some children had to work during the evening and at weekends. This was on occasions for small sums of pocket money, £2 or £3, and sometimes for nothing.

13.23 Some of the children were still of school age and worked at Duke’s Lodge during school hours as well as working there at other times of the day. We were told in evidence by Bill Tomlinson who worked at Duke’s Lodge as works manager that ‘the youngsters that came there were probably in the last few months of school . . . probably kicked school into touch . . . rejected it’. Some had been excluded from school. The Inquiry was told by the Chief Education Officer of Staffordshire that the social services department had not asked for permission to occupy children excluded from school in this way, and that in fact it was not permissible save in exceptional circumstances. Occasionally a boy or girl who had been excluded from school in Staffordshire was allowed, for individual reasons, to enrol at a college of further education, but the employment of school age children was governed by Staffordshire County Council Education Committee Byelaws (see appendix N).

13.24 Glynis Mellors who was managerially responsible for the YTS at Lymewood and who also worked at Duke’s Lodge and in a number of other capacities in relation to children in care, said in evidence that some school age children worked at Duke’s Lodge. She referred to ‘one or two that were school refusers . . . some youngsters wanted to do part-time work who technically should have been at school and I actually got a copy of the byelaws’. She thought one or two might have been involved after discussion with an official from the education welfare department, but ‘obviously there were employment regulations for anyone at school . . . I was aware of this.’

13.25 Some of the children in care who worked in the organisations and activities listed in paragraph 13.7 may, of course, have benefitted from their involvement and enjoyed it. This seemed to be true of children, usually in YTS, who worked, for example, in day centres for older people. In 1988 when the director of social services was making proposals about the future of the YTS scheme, he was anxious that the committee should appreciate its value, and drew attention to the fact that at that time amongst the trainees were 17 on care orders, 2 in voluntary care, 7 on supervision or probation orders, 2 on remand and 2 on voluntary supervision. He also stated that the scheme provided support in a variety of ways for young people excluded from school and for whom day care in a family centre may not have been appropriate. The work of ‘Mr Latham and his team’ was warmly acknowledged in the director’s report.

13.26 A number of other children however, including some of school age and above school leaving age, either did not wish to be involved in work activities or actively resisted involvement. The evidence from log books, as well as personal evidence from children and other witnesses, clearly indicated that while some who did not wish to take part did not have to, there were others who were required to go. The level of pressure was such that in one or two instances the word coerced is not too strong.

13.27 Duke’s Lodge was being used a great deal, for example, in the autumn period of 1985. An entry in the log book at 245 Hartshill Road indicated that a boy, C. I., came back ‘very dirty and smelly after his day at Duke’s Lodge’. On 14 October 1985 another boy, P., did not want to go to Duke’s Lodge, partly because he had ‘backache’. He later had hospital treatment for this condition. The next day John Aston passed on a message which was recorded in the log book that ‘P. MUST ATTEND DUKE’S LODGE tonight . . . unless he is dying!’ A girl was also recorded as not wanting to go, but had to go. A boy who
was recorded as having refused to go to Duke’s Lodge, was then put in Pindown for the rest of the weekend. Another boy was recorded as having barricaded himself behind the boiler room door at 245 Hartshill Road in order to avoid going to Duke’s Lodge. The doors were broken through and he was taken to Duke’s Lodge. The log book recorded ‘No Choice’.

13.28 Much of the work, in our view, was not educational or generally beneficial in other respects. Some of the young people who were interviewed by the Inquiry resented being used as a ‘general dogsbody’ and working very hard for little or no reward and without any choice.

The Managerial and Professional Oversight of the Children’s Participation.

13.29 The organisations and activities which Tony Latham created and developed were widely known in the social services department to involve children.

13.30 The former director of social services, Barry O’Neill in his written submission to the Inquiry in relation to the ‘Latham enterprises’ said that ‘up until my appointment as director there was a clear policy decision to let him (Tony Latham) get on with it and not to interfere as long as he “produced the goods”’. There were many ways in which the interests of Tony Latham and people involved with him were known to be associated with what was later called Fundwell. These included printed letter heads, and accounts submitted to the county treasurer’s department from other parts of the social services department. It was clear, however, from the evidence presented that a number of staff and councillors were not fully aware of the status of the activities and the interests of Tony Latham and others in them. In our judgment that was less his fault than failure of communication at a variety of levels within the social services department and the county council as a whole.

13.31 Elizabeth Brennan, principal area officer for the Newcastle-under-Lyme area, was Tony Latham’s line manager from 1 April 1983 to September 1987 when he became Voluntary Bodies Co-ordinator at headquarters. During that time she wrote to Peter Crockett, deputy director, about the conflict between Tony Latham’s job as area officer and the demands of the many organisations he was running (see Chapter 7, paragraphs 7.68-7.72).

13.32 Elizabeth Brennan gave some additional impetus to the winding down of some of the organisations from 1987 onwards. Barry O’Neill in his written submission acknowledged some of the problems in managing Tony Latham. He said that ‘I have no doubt . . . that his responsibility for Fundwell, together with his unique commitment, energy and undoubted talent in working with young adults in an innovative way, made him a difficult and unusual member of staff to supervise’.

13.33 Tony Latham and Glynis Mellors, who worked alongside him in much of the work related to the organisations and activities known latterly as ‘Fundwell’, both worked extremely long hours and with enthusiastic commitment. Tony Latham also involved his own home in the activities going on at Duke’s Lodge in a way which was unusual. They were both involved in a wide range of activities. From the children’s point of view this sometimes meant that there was scarcely any aspect of their lives which was not under the control of Tony Latham and those working closely with him.

13.34 There was, in our view, no adequate supervision by senior management of what happened in relation to children and Fundwell as distinct from supervision of accounts and some other financial matters. Recruitment of staff appeared to be mainly left to Tony Latham and Glynis Mellors and although a number of the staff recruited for YTS were qualified teachers, for example, some other staff recruited first as volunteers or social aides or community project workers and then promoted to be unqualified social workers, seemed to us to be less happy choices. We were told in evidence that Tony Latham did not often make use of such limited training opportunities as there were to provide staff with the important development of knowledge and skills. Training was, we were told, regarded as unnecessary and irrelevant. The former director, Barry O’Neill, confirmed that training had a very low priority in the department as a whole.
13.35 The education department appears not to have been consulted about the legal and educational aspects of school age children involved in Fundwell activities. The situation in relation to other professional oversight was the same as with Findown. There was none.

13.36 Some of the conditions in which people, including children, worked were so unfavourable that as noted earlier, Glynis Mellors asked to be transferred elsewhere (see Chapter 7, paragraph 7.44). Apart from the official visits of MSC personnel and a visit on one occasion by Elizabeth Brennan to Duke’s Lodge no evidence was presented of any other managerial or professional oversight of Fundwell.

13.37 Arising out of our consideration of Fundwell we make the following recommendations.

13.38 We recommend that there should be a named person at senior management level with responsibility (a) for ensuring that care and attention is given to the education, career development and working life of children in care, and (b) for the consideration of any policy or practice issues.

13.39 We recommend that the named person referred to in paragraph 13.38 should provide an annual report on the matters for which he has responsibility giving particular attention to:
(a) educational achievements of children in care;
(b) changes in the schools they attend as a consequence of care placement;
(c) special educational needs;
(d) involvement in further education;
(e) work undertaken by school children; and
(f) the employment of children above school age.
Part 5: The Protection of Children

Chapter 14:
Residential Establishments and the Protection of Children

14.1 On 5 October 1990 our Terms of Reference were amended by the addition of the following:
‘To consider whether children and young persons in Staffordshire child care establishments were appropriately protected, as may have been required, from any of the individuals who were subsequently convicted in the summer and autumn of 1989 of sexual offences against children and young persons; and to make any appropriate recommendations.’

14.2 The matter of the protection of children referred to above is totally separate from our investigation and consideration of Pindown.

Concerns

14.3 In July and November 1989 a number of men were sentenced at Worcester and Stafford Crown Courts respectively for their part in what has been described as a gay sex circle preying on young boys. We were told in evidence that there were concerns that some of the men had, before they were arrested, been visiting Staffordshire children’s residential homes and taking out children from them, or arranging to meet the children, for sexual purposes. In addition there was concern that some social work staff may have been aware of what was occurring. As part of the Inquiry we heard a number of witnesses relating to these concerns and we considered such relevant documentation as exists.

Visits

14.4 We were satisfied from the evidence we received that two of the men who were sentenced had each quite separately visited on various occasions a children’s residential establishment in Staffordshire, though not the same one. In the case of the first man we heard evidence that he had visited Riverside, a community home, on a number of occasions. He confirmed in writing to the Inquiry that he had been to Riverside on about six or seven occasions in the company of the parents of a boy who was residing in the home. The purpose was to visit the boy or take him out for the day with the parents. We have concluded on the totality of the evidence that we took into account that the concerns referred to in the previous paragraph have not been substantiated in respect of this man.

14.5 We do not think that the concerns have been substantiated either in respect of the second man. His name appears on a number of occasions in a log book at a residential establishment at 245 Hartshill Road, Stoke-on-Trent in the period between October 1988 and January 1989. He indicated in writing to the Inquiry that he had visited the establishment because he knew one of the residents. Because of the particular circumstances relating to this man, we trace his movements in some detail in the next chapter and make some recommendations arising out of his contacts with the residents and the staff.

Chapter 16

14.6 In Chapter 16 we consider the quite distinct matter of safeguards relating to the provision of accommodation by members of the public for children in care. This arises as a result of our discovery during the Inquiry of what we consider an unfortunate state of affairs concerning some children in care in Staffordshire and a particular convicted sex offender who was not, however, connected in any way with the sex circle referred to in paragraph 14.3 above.
Identities

14.7 We consider it of importance that the identities of the children involved in the matters we have considered are not revealed. As a consequence it is inappropriate to identify the men mentioned above and in the following two chapters. We are well able to consider whether the children were appropriately protected and make recommendations without the necessity of revealing identities. As elsewhere in the report we have defined 'children' as being anyone under 18 years of age.
Chapter 15:

The Visitor to 245 Hartshill Road

15.1 In July 1989, X, then aged 31, was convicted of various offences including buggery and indecent assault and sentenced to a term of imprisonment. Prior to these convictions X had a number of other convictions recorded against him including ones for indecency with children, indecent assault and burglary.

15.2 We are satisfied that for a short time at the end of 1988 he was known to some of the staff at the children's residential home at 245 Hartshill Road, Stoke-on-Trent as a visitor to the premises and to a specific resident."

15.3 As we indicated in the last chapter, in paragraph 14.5, we are satisfied on the evidence we received that X was not visiting the establishment in order to involve any of the residents in sexual activities. We are of the view, however, that he is not the sort of person in any event who should have been permitted access to the establishment. His movements in regard to 245 Hartshill Road in October and November 1988 highlight some of the problems relating to the regulation of a residential establishment and the protection of the residents in it. We make a number of recommendations at the end of this chapter.

245 Hartshill Road

15.4 At the end of October 1988, from the somewhat imprecise records kept it would appear that 245 Hartshill Road had 10 children, 4 boys and 6 girls, resident on the premises. One of the boys was C, then 16 years of age.

15.5 Regarding the circumstances of X's visits to the home, we heard evidence from a number of members of the staff and we were able to examine entries in the relevant log book for the period in question. X wrote to the Inquiry in answer to a questionnaire sent to him. In addition he spoke to a member of the Inquiry team on terms of confidentiality. C, who was resident at 245 Hartshill Road, was also interviewed.

Log Book Entries

15.6 We found entries referring to X in a log book from the home. There are two entries in October 1988 and thirteen in the following month. There are further entries on 19 December 1988 and 1 January 1989. No further entries appear afterwards. On the 11 January 1989 X was arrested and kept in custody. As noted above he was eventually sentenced to imprisonment in July 1989. His name is linked in the log book to C, the 16 year old resident.

15.7 From the oral and documentary evidence we received the following facts emerge. On 26 October 1988, it is recorded in the log book that a parent telephoned the home to say that his son had absconded from home with two other boys, one of whom was C, and that they were in the company of a man, X, who was a child molester. This information, it was noted in the log book, was passed on to the police. Prior to 31 October C returned to 245 Hartshill Road.

15.8 On 31 October 1988, a member of the staff, Graham Toplass, recorded in the log book: 'C – a most unsavoury character visited him tonight, lots of whispering going on (I could not hear a thing I was most annoyed)'. On the following day he added in the log book, 'C – his new found friend's name is (X)'.

15.9 When Graham Toplass first set eyes on X he was 'sneaking into the back door of Hartshill Road'. Graham Toplass left Wade Rogers, another member of staff who had just come on duty, to deal with him. Wade Rogers saw him downstairs in the maisonette in the home and noted that he was much older than the residents and 'he was extremely scruffy . . . he was talking about breaking into various places.' Wade Rogers told us that, 'my immediate response to X horrified me in terms of he just looked not the sort of
person C ought to be communicating to . . . we didn't have a policy, I don't think, of keeping out adults . . . because sometimes they would offer a resource . . . but it was clear that this guy was not going to be a de facto foster parent.' Eventually he told X that he did not want him in the building. He thought that he would be a bad influence on C. He told us that he would have no control over C outside the building because he would just do whatever he wanted. On 1 November 1988 Wade Rogers made the following entry in the log book: 'Spoke to X said he was to (sic) old to visit our kids - if he wanted to continue he must see Phil Price and pass (sic) fill in clearance form. He said O.K. Have said to (C) if he visit (sic) he must do so outside on the forecourt'. Philip Price, the officer in charge of the home, was on leave until the 7 November.

Further Entries

15.10 The following entries then appear in the log book:

1 November 1988: ' (S) entertained . . . C and X in maisonette. . . .'

3 November 1988: 'C-- a peculiar evening for C. His "friend" phoned early evening. At about 8 p.m. the doorbell rang, C went to answer it and disappeared. Returned an hour later.'

4 November 1988: ' . . . allowed visit of X + 2 friends. All sat in lounge. . . . Pleasant evening. X - IS ON A MEGA EGO TRIP.'

5 November 1988: 'Allowed X to visit (C), I did it to find out what the relationship is between them. I'm sorry to say its beynd me. Says he's got nothing to do.'

6 November 1988: (three entries)

'X here, keeping all the children fully occupied mending cars. Working their little "cotton socks" off . . . .'

'Police called for any news. X passed on all info he knew on (S).'

'. . . C.I.D. called to speak to X re (H.) thought he was resident!! . . . .'

The Video

15.11 Also on 6 November 1988 X appeared on a video made by one of the residents inside the home. He appears to have got into the home with C and a video camera, which was used quite frequently by staff and residents, was used to record him 'laughing along with the kids', according to a member of staff.

Return of Philip Price

15.12 On 7 November 1988, Philip Price returned to duty after ten days leave. No one person deportised for him in his absence. The senior person on duty each day was considered apparently to be in charge of the home. Philip Price told us that he noted what had been happening and decided that X would not be allowed to visit. In addition he said that he spoke to C and told him of his decision and pointed out to him that if X wanted to visit he would have to come and see him and be cleared as 'a volunteer' with 'medical clearances, police references and other references because we couldn't allow him to have access to the building'. Wade Rogers also, it would appear, returned from leave at this time and telephoned a contact in the police force to check up on X. He was told that, 'he's done a bit of time . . . he's all right, he's okay, he's not that bad.' The 'bit of time', according to the police officer, had been done for burglary. There was no reference to any sexual matters.

15.13 X did not go and see Philip Price. On the day of Philip Price's return to duty, 7 November, the following entry appears in the handwriting of a member of staff, Louise Doherty: '(C) - Phil permission for night out 7-10 p.m. X collected him . . . '. When asked about this during her evidence to the Inquiry, Louise Doherty said that she was aware of the position regarding X but she was unable to stop him collecting C.

Enquiries

15.14 Louise Doherty had herself made some thorough enquiries about X. She tracked down his probation officer and learnt that he had a conviction for indecent assault and was the associate of two men
who had recently been convicted of serious sexual assaults. She related this information to Philip Price and entered it in capital letters in green ink in the log book on 8 November 1988 under the heading ‘important’. The context made it clear that X was not to be allowed on the premises.

15.15 Further entries then appear as follows:
16 November 1988: ‘Very loud noise of car horn outside announced arrival of X (C) and S were down the stairs and outside before I could protest, they spoke to him briefly from just inside the building, he remained in his car outside. Just in case we ever need it the reg. no. is (it is set out) . . .’
17 November 1988: ‘(C) waiting patiently for his chum (Mr X) who did not turn up . . .’

15.16 On the 21 November 1988, C absconded from the home and was missing until the 10 January 1989 when he was arrested by police and apparently admitted twelve offences. X’s name appears twice more in the log book on 19 December 1988 and 1 January 1989. Both are passing references in the context of C’s continued absence.

15.17 X in response to a request wrote to the Inquiry that he had visited 245 Hartshill Road in 1988-89 because C was there. He added, ‘I pick him up on mensy time (sic) and we ended up in court for theft and burglary.’

Staff Evidence

15.18 A number of members of staff from the home gave evidence to the Inquiry. It was pointed out to us that X was picked out at once as being an undesirable visitor; that it was impossible to control entry to the building because of the numerous entrances and exits; that he was supervised as far as possible; that he was very popular with the young people because he promised them money and rides in his car and it was not easy without causing a disturbance to get him out of the building; that his appearance on the video was entirely innocent; that the police saw him at the home and sought information from him; and that nothing could be done to stop C associating with him outside the home. In addition we were informed that the social services department provided no guidance on the overall problem of undesirable contacts and it was just left to individual initiative: Wade Rogers and Louise Doherty, for example, had made some enquiries about X.

15.19 We were also told that in October and November 1988 X frequently telephoned the home. We have no reason to doubt that this was so.

Conclusion

15.20 Having carefully considered all the evidence given to the Inquiry, we have formed the view that X’s specific purpose in visiting 245 Hartshill Road was not to involve the residents in sexual activities. There was no evidence of any such activities. The facts point, if anything, on the balance of probabilities to X’s aim being to take C out for the purpose of burglary. This is, of course, hardly a happy situation in any event. There is no question, in our view, of any member of the staff having been in any way a party to X’s activities. It would be unrealistic, of course, to dismiss entirely the element of risk to the children from X’s presence in view of his character.

Concerns

15.21 It is necessary to consider the concerns that arise from the above events in a little detail. They are matters that are not necessarily restricted to Hartshill Road or Staffordshire but may well have a much wider application.

15.22 Once X was spotted as an undesirable character there was, to use the words of Philip Price’s legal representative, ‘a muddled approach to the situation’. He added that, ‘it is, perhaps, no coincidence that this occurred whilst the manager was away’. It should also be noted that Staffordshire social services had not issued any written material concerning access to children in care. In the words of Barry O’Neill, the
then director, to the Inquiry, ‘reliance has been placed on the promotion of good practice by the managers of the children’s homes.’ We understand that a draft document is now in existence for consultation and discussion. We were also informed that the Department of Health does not provide specific guidance on the vetting of general visitors to residential homes but, in the light of events in Staffordshire, they are now going to consider the matter.

Protection

15.23 It is trite to observe that the residents of a children’s home are entitled to protection against those who seek to harm them, whether for sexual purposes or otherwise by, for example, involving them in criminal activities. We consider that, included in the measures taken by way of providing protection, some written guidance on this important topic should be provided to the staff of establishments by the social services department. This should encompass such matters as: the regulation and vetting of visitors to the premises; the maintenance of reasonable control of entries and exits in the residential units; the availability of reliable information concerning antecedents in respect of those who are reasonably suspected to be possible sex offenders and a danger to children; and the keeping of proper records concerning visits to the residential establishment.

15.24 Arising from the matters we have considered in this chapter, we make the following recommendations:

Recommendations

15.25 We recommend that in any residential unit for children someone on the staff should be designated to deputise in the absence of the officer in charge. Wherever possible this should be the same person each time and this responsibility should be clearly defined in their job description and recognised financially.

15.26 We recommend that a record should be made each day of all visitors to the children in a residential unit. This record should be available to be seen by all members of staff, for example, by being contained in the daily log or diary.

15.27 We recommend that there should be a method available for social services staff who may need information about possible sex offenders to check with a designated source at any time.

15.28 We recommend that social services and the police should reach agreement and reduce into writing the following:

(a) that members of social services staff who may need information about possible sex offenders who pose a risk to the children for whom they are responsible may telephone or otherwise contact a designated police information source at any time; and

(b) that social services will specify the staff who, save for exceptional circumstances, will be actually communicating with the police information source: for example, the officer in charge of a residential establishment or the designated deputy.

15.29 We recommend that consideration should be given by social services, if appropriate in conjunction with the fire service, to the best means of maintaining reasonable control over entrances and exits in residential units for children; and that clear instructions in writing should then be circulated to the relevant staff.

15.30 We recommend that social services departments should issue written guidance to staff dealing with the topic of the protection of children in residential establishments and, in particular, covering the regulation and vetting of general visitors to such establishments.
Chapter 16:

The Sex Offender as Landlord

16.1 In early 1989, G a boy then aged 16 was charged with offences of dishonesty and remanded on bail to a local authority residential home in Stoke-on-Trent. He was assigned a trainee social worker by social services. He had in the past been in the care of Staffordshire County Council and there was an existing supervision order in force. He was admitted to the residential home and recorded as having been of no fixed abode.

16.2 The following day a number of social workers attended a meeting to discuss G’s situation. It was decided that G should be encouraged to take up a YTS scheme and should be found outside bed and breakfast accommodation. A residential worker at the meeting suggested the local address, telephone number and name of a landlord who could provide such accommodation. He said that this accommodation had been used in the past when children in the care of the local authority had been placed in the community.

16.3 On the same day as the meeting had taken place G and the trainee social worker went to the accommodation, a large house divided into ‘flats’ and ‘bed-sitters’, and met the landlord, a man in his fifties. He did not impress the social worker. She found him to be ‘creepy’ and contrary to what he had said previously over the telephone, the room was not a single one but a shared twin bedded room. G was keen, however, to move in and duly did so. The landlord resided on the premises.

Reservations

16.4 The trainee social worker reported her reservations to the residential worker and to her senior. Later her senior had her own serious reservations after being told by a probation officer that the landlord had a conviction for a Schedule 1 offence (Schedule 1 of the Children and Young Persons Act 1933 contains details of offences against children and young persons with respect to which Special Provisions of the Act apply). G was offered alternative accommodation but chose to remain where he was. Within two months the landlord committed burglary in respect of G and was subsequently convicted of the offence and sentenced to a substantial period of imprisonment. It emerged that one of the landlord’s previous convictions was also for burglary of a teenage boy some years before. For that offence he had received a non-custodial sentence.

16.5 No one in social services inquired into how his accommodation had become acceptable to the local authority. We thought it of sufficient importance to initiate an investigation ourselves at the Inquiry. We had become aware of the matter when we were looking, for a different reason, at G’s spell in care previously. As we indicated in Chapter 14, paragraph 14.6, the landlord had no connection with the members of the so-called sex circle.

The Background

16.6 From the evidence we subsequently received the following facts emerged. In about 1985 the landlord offered his accommodation to the Probation Service in Staffordshire. He was interviewed by an accommodation officer and some ex-prisoners were subsequently placed at his house. The referrals, however, ceased quite soon when there was dissatisfaction with conditions in the accommodation and the landlord’s involvement in criminal matters. No record exists of any formal check by Staffordshire social services with the Probation Service as to the suitability of the accommodation for social services clients.

16.7 It would appear on the balance of probabilities that the landlord was approached about the accommodation by a member of the social services department by telephone during the period between 1986 and 1988. At the end of 1988 the staff at 245 Hartshill Road were looking for accommodation for a teenage boy. We were told by Graham Toplass, a member of the staff, that ‘Pembridge Road (a residential unit) had forwarded this address of (the landlord)’. He added that ‘Phil Price (the officer in
charge of 245 Hartshill Road) gave me the address and he said, "this has come from Pembridge Road... and (they) have told me they've used it and I do believe Probation have used it as well'.

16.8 Graham Toplass told the Inquiry that 'I went to view the accommodation with this young lad but it was unsuitable inasmuch as it was too far away (for him)... it was just a bed-sit. It wasn't too bad, you know, considering some of the accommodation I've viewed with kids.' He said that if it had been suitable, 'my next step, I would have had it checked (to see) if it had been police cleared... Pembridge had said they had used it.' He would have gone to his line manager, Philip Price, to see if it had been cleared also by the social services department.

16.9 At the beginning of January 1989 Wade Rogers, another member of the staff at 245 Hartshill Road, was looking for accommodation for a girl who would shortly reach her eighteenth birthday. He was given the landlord's address by Graham Toplass who told him about his recent visit to it. The girl moved in about a week before the care order in respect of her ceased to have effect. An entry in the log book at 245 Hartshill Road refers to her new landlord as 'a little strange'.

16.10 Philip Price said that he had got the landlord's address from the team manager at Pembridge Road who he thought had got it from a list at the social services office at Unity House in Hanley. Philip Price had viewed the premises himself. He described it as 'not brilliant but it was passable.' He added that 'basically the normal procedure would be that in placing anybody in accommodation in the past we've always gone through a vetting process, which is again not dissimilar to, I suppose, a volunteer process. Well, having received the address from another unit having had that address given to them from Unity House with... an assumption that youngsters had been placed there before:... my assumption was that this address was a legitimate address'. As far as the girl approaching eighteen was concerned, he thought that she 'could make her own decisions'.

16.11 On 17th March 1989, as indicated above in paragraph 16.2, Philip Price produced, at the meeting at Pembridge Road, the landlord's address again as a suggestion for accommodation for G. After meeting the landlord on the same day, Elaine Goodier, G's trainee social worker, reported her reservations about him and the proposed arrangements to a senior social worker, Susan Swinhoe, who was supervising her at the time. She also expressed reservations to Philip Price. She told the Inquiry that she did not feel that the landlord was a trustworthy, responsible person.

16.12 Co-incidentally, on 17 March 1989 the landlord wrote to the Director of Social Services complaining about money owing to him by the girl who was placed by Wade Rogers in his premises. Eventually, he was paid a sum of money by the girl which was sent to him in April 1989 by Philip Price.

16.13 Subsequently, the senior social worker, Susan Swinhoe spoke to a probation officer who told her that the landlord had a Schedule 1 conviction and that he had reservations about him acting as a landlord for young people. About the same time another social worker, Michael Thomas, who was preparing a court report on G, visited his accommodation and formed a very unfavourable view of the landlord.

16.14 Susan Swinhoe spoke to her area officer, Jane Taylor, about the situation. As G was insisting on remaining at the accommodation they considered applying for a Place of Safety Order, which in Susan Swinhoe's view was the only action open to them; Jane Taylor had no recollection of the events. No action was taken.

The Report

16.15 G appeared in the Juvenile Court at the beginning of May 1989 in regard to the outstanding charges of dishonesty. A report from Michael Thomas was before the Court. He referred to the supervision order being in force. Regarding accommodation, he wrote 'he shares his present address with a number of young men... He states that he is quite satisfied in these lodgings and refuses to consider suggestions of alternative accommodation at present.' We note with some surprise the absence of any mention of the information in the hands of the social workers and their concern. Michael Thomas
said in evidence that it might have assisted matters if the court had been aware of the actual situation.

16.16 Shortly after the court appearance it would appear that the landlord's offence against G came to light and he was moved to a residential home.

The Approved List

16.17 We were unable to discover from the social services department the circumstances in which the landlord's accommodation had got on to an approved list in the first place. We saw the details written on an accommodation card kept at Pembridge Road. We were told eventually that the details may have come from a card kept at social services offices at Bradely. We heard from Jill Edge who had been a part-time accommodation officer based at Bradely between 1 March and December 1989. She told us that 'I started the job and I felt like, I'm on my own, I've got to find these names and addresses from out of fresh air,... and I looked in the newspapers, I asked other agencies. There was a woman who had done this sort of work as a side line before and she had got a list but most of them were "do not use under any circumstances", names of places, but you know, as far as teenage accommodation goes... there's nothing worth sending any teenager to.' She recalled visiting the landlord's house. She told the Inquiry that later she used it as a means of deterring a teenager from having his own accommodation. She said that the landlord's 'creepy, the place is cold, it's cluttered, they are all in and out of each others bedrooms and it is not a pleasant place at all.'

16.18 The details of the accommodation were already on a social services list at Pembridge Road well before Jill Edge took up her job. She thought that she had visited the premises in April 1989 or later. It is perhaps a sign of the disarray concerning accommodation that firstly, at about or around the time the matters concerning G were proceeding, two quite separate and unco-ordinated parts of the social services department, one being the actual accommodation officer, were considering the landlord; and secondly, until the Inquiry over 4 year later, no investigation of any kind had been contemplated or carried out into the disturbing sequence of events.

16.19 We were not surprised to hear from one social services witness that 'I am still, even now... unclear if there is a policy on accommodation and vetting or whether there isn't. Since I have been to this Inquiry and various other people have been to this Inquiry there is certainly a lot of searching for a policy.'

16.20 A senior member of the social services department, asked to investigate by the director of social services, informed the Inquiry that the finding of lodgings for children in the care of the local authority is 'a sub facet of boarding out. As such the Department's advice, policy and guidance to social workers is based on the Boarding Out Regulations.' He added, 'local practice (regarding approved lodgings) in relation to police checks have, over a period of time, varied. In many cases the check has simply been contact with the local police station to gather knowledge on the informal network which clearly exists in relation to this kind of matter. This appears to represent the majority of people on the various lists of approved lodgings of localities within the County... other people have appeared on the list from sources that I am not fully able to track down, but who appear to be people who have been vetted by other agencies and particularly by the Probation Service' (emphasis added). We were told that future policy will be based on the boarding out procedure.

16.21 Social services, as noted above, were unable to explain the circumstances in which the landlord's accommodation found its way on to an accommodation list. Three social workers, Elaine Goodier (a trainee), Susan Swinhoe and Michael Thomas, each held serious reservations about the landlord but no decisive action was taken regarding G. An opportunity to enlist the assistance of the Juvenile Court who had granted G bail on conditions was ignored. No formal check at any time was attempted regarding the landlord's antecedents. In the light of these facts we would hope that the social services department will speedily develop a policy and a practice towards accommodation of the kind which G was placed into that is clear, efficient and well-known and co-ordinated with police practice where necessary.
Police Checks

16.22 The matter of police checks raises some difficulties. There is no specific reference in Home Office Circular 101/1988 (Protection of Children: Disclosure of Criminal Background of those with access to children) or in the later Circular 58/1989 to persons offering 'supported lodgings'. It is not easy to bring a resident landlord in the private sector within any of the groups of people connected with the local authority as suggested in the circular: 'directly engaged individuals, whether employees, or paid or unpaid volunteers who have substantial access to children'. We would hope that the Home Office and the Department of Health would clarify or extend, if necessary, the present arrangements so that a local authority considering an agreement with a private sector landlord would be able without difficulty to make an appropriate police check. In addition the consent of the person subject to the check is required. It was pointed out that checks take time and the accommodation may no longer be available by the time the result is known.

16.23 We recognise that a distinction may have to be made between a landlord resident on the premises and a non-resident one. In respect of the time taken for police checks, we were interested to note that in a Home Office survey of Police Force areas in 1988, Staffordshire Police reported a response time of only 5 days to local authority requests and that initial difficulties in the administration of the procedures had been overcome.

16.24 Arising out of the sequence of events regarding G, we make the following recommendations.

Recommendations

16.25 We recommend that in respect of the placing of children in care in lodgings or similar accommodation, social services should in all cases ensure that:

1. there is circulated a clear written procedure covering the vetting of such premises;
2. the premises are inspected and a written record made in respect of them;
3. the landlord is interviewed where practicable and always in the case of a resident landlord, and a written record made;
4. where appropriate, and always in the case of a resident landlord, the landlord's agreement is obtained to make a police check (and such further checks as may be considered prudent);
5. the relevant information obtained and any further facts about the premises, and the respective sources of the data, be recorded in an accommodation register.

16.26 We recommend that the Home Office and the Department of Health clarify or extend, if necessary, the present arrangements concerning the disclosure of the criminal background of those with access to children, so that a local authority, considering an agreement with a private sector landlord in respect of a child in care, is able without difficulty to make an appropriate police check.

Schedule 1 Offenders

16.27 During the course of our consideration of the events concerning G and the landlord we looked at the present arrangements for local authorities to be notified about the movements of Schedule 1 offenders (see paragraph 16.4 above). The landlord received a non-custodial sentence in respect of his earlier conviction for buggery of a teenage boy (a Schedule 1 offence) and would not therefore be within these arrangements: see Department of Health circular, LAC(78)22, which relates to 'Release of Prisoners convicted of offences against children in the home' (emphasis added). He did not serve a prison sentence or a 'young offender' custodial sentence and in addition his offence was not in the home. Consequently the local authority would not have been informed after the earlier offence of his whereabouts if he had in fact been returning to or moving to Staffordshire.

16.28 From 1965 arrangements existed under which prison authorities notified local authority social services departments of the release of men convicted of incest. These arrangements were extended in 1975 to the release on parole of men and women convicted of offences against children in the home. Later
in the same year the Report of the Committee of Inquiry into the Provision and Co-Ordination of Services to the Family of John George Auckland (H.M.S.O.) recommended (paragraph 251) that 'where a prisoner is discharged who has been serving a sentence for an offence against a child ... more information (should be) passed to agencies outside the prison so that they may be aware of any potential risk and take steps to guard against it.' This recommendation and others were implemented in circular LAC(78)22 from the DHSS in 1978. It defined offences against children 'in the home' as being 'in or of the family home or place of residence'.

16.29 The arrangements, therefore, have meant that local authorities have not been alerted by any formal means to the possible or impending discharge to their area of a prisoner convicted of offences against children which were not committed in the prisoner's home or place of residence.

16.30 This situation, in our view, cannot now be justified in the light of local authorities' statutory duties regarding the protection of children, and the guidance given to them.

16.31 We consider that the arrangements should be further widened to include all those convicted of offences against children irrespective of how they were dealt with by the court. The argument that the risks are limited to those who have received an immediate custodial sentence is, in our view, unsustainable. Local authorities should be notified of all convictions occurring of those who are resident or intending to reside in their area. We appreciate that this will involve a considerable increase in administrative action. We believe, however, that it is fully justified in the interests of the protection of children. We think that the one agency involved consistently and with experience of such a process, the Crown Prosecution Service, should be responsible for the notification rather than the court convicting the person.

16.32 We are very aware of the sensitive issues arising out of the notification we propose to local authorities. We would hope that the Department of Health will consider it appropriate to issue some guidance on civil liberties and other relevant issues relating to the discretionary use by the local authority of the information.

Recommendations

16.33 We recommend that revised arrangements are made for local authority social services departments to be notified of all convictions occurring for offences against children by persons residing or intending to reside in their area, irrespective of where the offences were committed and the nature of the disposal by the court.

16.34 We recommend that the notification to local authority social services departments of all convictions occurring for offences against children by persons residing or intending to reside in their area, be undertaken by the Crown Prosecution Service.
Part 6: Professional Issues

Chapter 17:
Management

17.1 Staffordshire social services department in the 1980s was providing services of many kinds to a population of over a million people. By 1989 its budget was £57,000,000 and it employed over 4,000 paid staff. It spent over £6,000,000 on children’s services, though this figure was well below the average for the ‘family’ of local authorities assessed by the Audit Commission.

17.2 Between 1983 and 1989, the period covered by the Inquiry, there were three major re-organisations which affected the child care service. These were in 1983, 1985 and 1989. Management within the social services department thus had to address the additional problems which re-organisation, however desirable, always creates. Financial policies over the years from 1983 to 1987 also required economies which were a major part of the reasons for re-organisation.

17.3 To operate effectively within such dimensions, particularly when resources were traditionally lower than many other local authorities provided, good management was essential at all levels. During the Inquiry we received evidence from witnesses at all levels of management, and from county councillors and the chief executive. We also received evidence from witnesses who were being managed. Amongst them were field and residential social workers and staff in non social work posts.

17.4 From the comprehensive evidence presented to us we are firmly of the view that management in the social services in Staffordshire was inadequate for its task and lacked many of the essential characteristics required to ensure good services to the public.

17.5 We found that there were many staff at all levels who worked extremely hard, in some cases much harder than was desirable for them or for the people they were serving. Vision, leadership, commitment to quality services, and recognition of the need for adequate knowledge, training and skill in the care of children were all seriously lacking.

Senior Managers

17.6 In a large organisation the most senior managers cannot and should not be involved with day to day affairs which have been properly delegated to the next level of senior managers and to the middle and line managers accountable in turn to them. It is important, however, that staff at all levels know who the most senior managers are, their roles in relation to each other and other managers, and that they convey their overall aims and objectives clearly to staff who need to feel valued within the whole organisation. The evidence we received portrayed the most senior managers, including the director, as remote, seen only when, as one witness put it, ‘something very, very bad had gone wrong and when somebody had to do some telling off, or . . . had a big complaint’. One member of staff graphically described the director’s situation as being behind ‘double glazing’ which filtered the noise outside.

17.7 Witnesses said that they perceived the most senior managers as neither involved with staff nor with people who needed services. There was a sense of lack of support for staff from the top levels of management. Councillor Beech, a management consultant, said that ‘there seemed a lack of . . . management support . . . everything seemed to happen at a great distance . . . no dynamic management’. He said that, with reference to residential staff in particular, they ‘don’t . . . get the management support in communication and direction’.

17.8 The most senior management was perceived as making decisions in isolation, without adequate consultation or information gathering either inside the department or outside. In consequence they were ill-informed about the likely effects of their policy decisions. The closure of Riverside (community home
with education) without adequate research was seen as one example and the 1989 re-organisation as another.

17.9 The failure to consult was described by one witness as 'the Staffordshire way' which led to managers having responsibilities and tasks 'imposed' upon them and they in turn 'imposing' responsibilities and tasks upon those accountable to them.

17.10 Barry O'Neill, the former director, looking at the situation in Staffordshire from his own perspective, told us in evidence that he felt let down by middle management. Other witnesses, however, made it clear that they thought that there was a need for clear definition of roles at all levels. They did not know of any procedure for making special reports to higher management.

17.11 John Spurr, deputy director responsible for operations, had weekly meetings with divisional directors, but they also met separately, weekly, with the director. Peter Crockett, the other deputy director, had similar meetings with assistant directors and there were occasional meetings with district managers and team managers. John Spurr had been surprised when eighteen team managers had written on 5 November 1990 to the director of social services. The letter, a copy of which was sent to the Inquiry, listed as areas of great concern:

(a) lack of structure, direction or any coherent philosophy within the department;
(b) inability to follow child protection procedures because of insufficient staffing;
(c) lack of resources to carry out effective work with families;
(d) apparent lack of communication at senior management level;
(e) inadequate training offered to staff dealing with 'this complex area of work';
(f) extremely low level of morale . . . across all districts/disciplines. Staff are left feeling totally unsupported by our senior managers.'

17.12 The letter concluded: 'The Team Managers wish to express their complete lack of confidence in the senior managers of the department'.

Communication

17.13 The director and John Spurr met the staff subsequently. During the course of the Inquiry we were told of similar communications from social workers and others which had been sent to the director and to senior staff at operational level. The responses had, we were told, not been positive and had not, from the staff's point of view, dealt adequately with the problems articulated.

17.14 There was a strongly expressed feeling based on experience, and voiced not only by staff, that it was almost impossible to get through the layer of middle management to communicate with top management. When communications were sent upwards, there was often no response, at least in writing. Correspondence presented to us by NALGO witnesses indicated considerable difficulty in obtaining a response from the director of social services in relation to issues arising from the Cleveland Inquiry. A letter dated 21 December 1988 had been followed up without success and was eventually referred to the chief executive in November 1990.

Complaints Procedure

17.15 The absence of a complaints procedure was raised by a number of witnesses and also by the director of social services in his submission to the Inquiry. Until September 1988 there had been no written guidance available in the department. The director stated that until then it was part of the work of social workers and carers to respond to complaints from children or others on their behalf. If they were unable to do so adequately the complaint might proceed to district or area level, and to headquarters if the nature of the complaint exceeded the scope of the more local staff. There was no regular procedure, however, for recording complaints nor were they filed separately from case files unless they were referred by county councillors, MPs or the Ombudsman.
17.16 A written general complaints procedure was considered by the social services committee in September 1988 and approved subject to discussion with the trade unions. At the meeting, however, the committee considered the language in which the children's procedure was written was not appropriate for their use. A small working party was set up and a revised version submitted in November 1989. That was approved but not implemented until July 1990 because further deliberations about its suitability were going on. Team managers had been asked to discuss the procedure with staff and children. The effectiveness of the document was to be further reviewed towards the end of 1990 or beginning of 1991.

17.17 In his original paper to the committee the director envisaged that complaints might be about staff attitudes, manner or abuse; alleged harassment or discrimination; a decision by a member of staff or panel; a committee policy; an assessment; provision of a service due to lack of resources, ineffective management or professional judgment; failure to deliver a service, or to provide information. In spite of these possible complaints it was not proposed that anyone external to the department should be involved in hearing or deciding on a complaint or helping the complainant.

Management Failure

17.18 Management of the social services department was seen by a number of witnesses to have failed both children and staff by their response to identification of poor physical standards, lack of essential resources, and shortage of staff, and by their unwillingness to confront the reality of unmet need. One witness referred to 'sticking plaster' financial policies. We heard that staff who articulated these issues were told to manage their affairs the best way they could and were seen to be ineffective managers if they persisted in speaking out. The problem of inability to allocate cases through lack of staff to allocate them to, was met with a negative response. Unqualified social workers were carrying not only heavy caseloads but also a high proportion of cases such as child abuse, or adoptions, which required a much higher level of skill than they possessed. There was no departmental guidance on workload management. One manager said in evidence that 'the ethos is if you have problems you are not managing properly. So you (stand) back and evaluate your own management style and maybe you reach the view that its not you but something outside'.

17.19 A number of examples have been referred to in Chapters 4 to 10 of problems such as: very low staffing ratios; buildings which were not adapted for the new tasks they had to accommodate; staff who were not trained for new, or any other, tasks; lack of written objectives or guidelines; and unrealistic expectations. In addition there seemed, at times, to be no real sense of client commitment and a willingness to leave staff to cope with no support, often no information, and totally inadequate resources.

17.20 The Social Services Inspectorate had carried out inspections in 1987 of family centres at The Alders, Tamworth and The Birches, Newcastle-under-Lyme which included a visit to 245 Hatheshill Road, Stoke-on-Trent. In their report, 'Family Centres, a Change of Name or a Change of Practice', they were critical of Staffordshire social services department's management of the initial re-organisation when family centres were established and subsequently. Some of the main points of their criticism were:
   (a) the lack of overall central guidance on how the centres should develop;
   (b) delegation of management of the centres to the areas did not include control of the maintenance budget and repair work which continued to be channelled through the city works department;
   (c) the manner of introduction of family centres meant that there was little opportunity to match resources to perceived need at the outset;
   (d) lack of written guidance or sustained training input for staff;
   (e) staff of centres knew little of each others work and grappled alone with problems which applied throughout the department;
   (f) isolation of family centre team leaders and their ignorance of how other centres functioned;
   (g) absence of standardised procedures and practice guidelines within the department.

17.21 Social services department management appeared to be related more to crises than careful and well-informed planning. There was little sense of direction and little evidence of professional aspirations. More than once we heard evidence of a dismissiveness towards training and research.
17.22 Recruitment policies and practice clearly indicated that filling gaps was more important than obtaining the services of qualified and experienced staff. Some of the holders of unqualified social work posts had, in our opinion, inappropriate experience and education for such work and should not have been expected to carry it out. They had been in some cases volunteers or casual staff who had been ‘insinuated’ into social work posts, as one senior officer described it.

17.23 The effect of so many re-organisations had served to exacerbate many of the problems already noted and others which were associated with them. The former director, Barry O’Neill, made it clear that re-organisations had taken place largely in relation to cost cutting. Lack of adequate intelligence and lack of consultation with staff caused damaging and destructive results in many respects. Potentially good ideas about aspects of the family centres, for example, were overwhelmed by the sheer pressure of too much happening at once coupled with inadequate staffing in terms of numbers, experience and training.

17.24 The last re-organisation in 1989 was ill-understood. It was clear that district client teams were in some cases too small and isolated to be viable. There were many inexperienced managers; too many districts for the management of residential work; and divisional general managers had considerable new commitments with no additional resources. There appeared to have been greater devolement from headquarters to divisions. It was said, however, in evidence that power still rested at headquarters, although there was greater responsibility at divisional level.

17.25 The excessive tinkering with the structure which characterised 1983 to 1989 was not accompanied by realistic statements of aims, objectives, methods, defined information needs, agreed targets or evaluation.

17.26 One newcomer to the department from another local authority described it as ‘like travelling back in time’. There was a lack of policies on specific issues and services. It was clear from some of the witnesses that they were working on a verbally transmitted, impressionistic understanding of the department’s policies. A senior manager taking up a new post told us that ‘I’ve had major problems in finding documents to work off’. In addition meetings were held without minutes or any adequate minutes being taken.

17.27 Many managers in Staffordshire social services department had worked in the department for long periods and had been promoted, in some cases, several times. There was said to be an ‘inward lookingness’, as one witness described it, and resistance to experience and ideas from outside. Offers of help, for example, from the Social Services Inspectorate following critical reports of inspections, were not always welcomed and we heard that members of staff who expressed aspirations to high standards were termed ‘naive’. Open debate and opportunities for staff to meet informally were not encouraged.

17.28 Evidence from both county council and staff witnesses suggested that so long as there was no trouble, a blind eye was turned to some practices.

17.29 Management Training
Although some management training was undertaken this appeared not to be a requirement for a manager, and it was not easy to obtain secondment for it.

17.30 District Advisory Sub-Committees
One of the elements in the social services committee structure was district advisory sub-committees. These committees, as we understand it, had some members who were county councillors, others who were not. Councillor Austin, leader of the Council, explained that ‘basically they get local people involved’ but ‘they have no voting powers. . . . All their opinions are put before the main Committee for discussion’. He felt, however, that although they had been intended to be a ‘communication link’ this had not been as effective as had been hoped: ‘they are looking at the bricks and mortar. . . . They don’t talk about the real problem, which is the children.’
17.31 Statutory Visits
Statutory visits of inspection have already been considered in Chapter 12, paragraph 12.72. The statutory visitors used to provide material for the district advisory sub-committees. This means of providing information was mostly ineffective, however, because reports were limited in scope and style.

17.32 Elected members of the county council also paid visits to residential child care establishments. They concentrated more on bricks and mortar than on 'the effectiveness of the home' as a form of care for children.

17.33 Evaluation
We did not receive any evidence that services provided by the department were evaluated. Records which might have facilitated evaluation were poorly maintained and seriously inadequate.

17.34 Radical Change
The evidence that the inquiry received about the management of Staffordshire social services department contained numerous negative elements. Radical change is needed, in our opinion, if the department is to be more effectively managed in the future. Staffordshire is not, in our view, however, without able and committed people in its social services department. We hope that they will be given an opportunity in the future to work towards the better provision of services to children and their families. It should always be remembered, in the words of Sir Walter Monckton K.C., that 'the “fit person”, local authority or individual, must care for the children as his own: the relationship is a personal one. The duty must neither be evaded nor scamped' (see the O'Neill Report, paragraph 46, HMSO Commd 6636, May 1945).

17.35 We make the following recommendations.

Recommendations

17.36 We recommend that each residential establishment should have a written statement of its agreed role.

17.37 We recommend that adequate consultation should take place with staff in advance of organisational changes.

17.38 We recommend that precise job descriptions should be provided for all professional posts.

17.39 We recommend that a system of caseload management is installed as soon as possible.

17.40 We recommend that a systematic monitoring and evaluation system should be introduced within the social services department.

14.41 We recommend that more posts should be advertised nationally, and in particular senior and managerial appointments.

17.42 We recommend that there should be an agreed staff recruitment policy to attract qualified and experienced staff.

17.43 We recommend that a complaints procedure for staff, foster parents and children should be implemented without delay, and should contain an independent element.

17.44 We recommend that team managers or their equivalents should have regular opportunities to meet with a senior manager who should represent their views at the most senior level of the department.

17.45 We recommend that the preparation of estimates should be carried out in consultation with staff at all managerial levels.
17.46 **We recommend** that the relationship and channels of communication between the social services department and the social services committee should be the subject of a review in order to ensure that the committee receives clear and full information.

17.47 **We recommend** that the role and membership of the social services advisory committees should be examined in order to ensure their effectiveness in the future.

17.48 **We recommend** that residential homes advisers with appropriate experience and training be appointed to provide professional support to residential child care staff.

17.49 **We recommend** that a member of the social services department is specifically made responsible for liaison with the legal department in order to review jointly, on a regular basis, matters which may require specific consideration and advice from the legal department.
Chapter 18:

Supervision

18.1 Supervision is one of the most important links between policy, management and good practice. It also provides an essential service to the social worker who is face to face with the deep needs and tragic circumstances of many people who are consumers of social services. This is particularly so regarding children.

18.2 Supervision is, of course, concerned with establishing that social workers have the necessary knowledge and skills to carry out their tasks. It must also be concerned to ensure that the work load carried by an individual is such that he or she can be expected to maintain good professional standards and achieve whatever positive results are possible. However experienced a worker may be it is possible to become anxious, confused, even frightened by problems and potential difficulties. These feelings can be greatly increased by fatigue through lack of resources and isolation due to lack of support. Good supervision can help to mitigate such difficulties, particularly when combined with positive acknowledgment of good work.

SSI Reports

18.3 The Social Services Inspectorate’s report on their inspection of The Alders and The Birches in 1987 was critical of some of the arrangements for supervision of staff in the family centres. They carried out further inspections of residential child care units in July 1990. In relation to supervision they found that as ‘no clear guidance had been provided in relation to staff supervision, team managers had responded inconsistently to the development needs of their staff. Although when available staff found supervision sessions helpful, they were not aware of the “Staff Supervision – Policy and Guidelines” document which had recently been developed by senior managers.’

18.4 The Social Services Inspectorate ‘considered that individual supervision was not only essential to the development of a largely unqualified staff group, but also provided opportunities to monitor work, provide feedback, identify areas of stress and give advice and guidance to staff’. Supervision opportunities were found to be seriously handicapped by staff shortages and conflicting demands on senior staff.

18.5 We noted that the Social Services Inspectorate’s report on their inspection of child protection services in Staffordshire in May 1990 also contained similar criticisms to those made in the context of residential work: ‘The quality of supervision was dependent upon the skills and other demands made upon individual team managers’. A number had not, until very recently, received any preparation or training for their management role and ‘consequently the model or style of supervision adopted by each . . . tended to “mirror” the best of examples drawn from their own experience of being supervised.’ In addition supervision sessions were said to be scheduled from one session to the next and some workers were unclear when their next supervision would take place.

Supervision Document

18.6 We were told in evidence that until the production of the staff supervision document referred to above, the department had never had one. In 1980 a document entitled ‘Casework with Children in Community Homes – notes of guidance for residential staff’ was produced. We understand that it also was the first one of its kind and no later document was produced to the Inquiry. This document which was ‘to inform staff of the department’s casework policy in matters affecting the life of children in residential care,’ had as its last item in the contents ‘consultation’. It merely consisted of two three line paragraphs which instructed that decisions concerning the care of a child should be discussed with the social worker and at review meetings, or direct with the senior assistant (casework) – child care. There was no suggestion of any supervision on a regular and individual basis.
18.7 The evidence we received about supervision was as critical, if not so extensive, as the evidence on management. One of the explanations given for tolerating the setting up of Pindown at one residential unit was that staff were lacking adequate supervision and support to help them in their very demanding tasks. They became exhausted and depressed and 'clutched at something they thought might help'. One witness described some of the supervision which was available as 'the blind leading the blind'.

18.8 Another witness who was experienced in both field and residential work told us that the 'general level of supervision was poor'. A manager in the area organisation said that residential staff got no supervision at all, and middle managers received none from senior managers.

**System of Supervision**

18.9 The evidence we received points unequivocally to the urgent need for a properly regulated system of supervision throughout the social services department.

18.10 The system would involve supervisors at different levels and the expectation would be that supervision would be available to all staff including managers. Some preparation for the task involved would be needed by those who carry it out unless they have already received such training. It is important that the nature of the task is understood and not interpreted as merely 'doing what comes naturally'. It needs more than encounters in corridors and coffee breaks or an 'open door' policy by managers.

18.11 The process of supervision will include a systematic approach to the worker's responsibilities, allowing for the worker's priorities to be fully considered but not allowing them to set the whole agenda. In the case of fieldwork this would involve working through a caseload so that all elements are examined within a reasonable space of time. With a residential worker it would include an examination of not only the children for whom the worker is particularly responsible but the facets of the job as a whole. All elements of a manager's responsibilities would be considered.

18.12 The supervisor's role will be to help the supervised colleague to relate the realities of the workload to professional standards, departmental requirements, the resources available or needing to be obtained, the needs of the person who is a consumer or the group being managed and the social worker's own ability and understanding. The supervision discussion will include time scales, priorities, written records, thoroughness of approach, interaction with other colleagues, specialist advice, action to be taken, and accountability.

18.13 Other features of supervision will be the clarification of issues, planning and setting targets, considering action, and reviewing and evaluating action already taken.

18.14 The role of supervisor requires a degree of independence, a capacity to help the supervised colleague to stand back and take stock, a sympathetic understanding of stress and its effect, and a firm commitment to good standards in services.

18.15 We make the following recommendations.

**Recommendations**

18.16 We recommend that the social services department should put in place as a matter of urgency a system of supervision.

18.17 We recommend that after a period of one year following the establishment of a system of supervision a review should take place to evaluate the system.
Chapter 19:

Training

19.1 The former director of social services, Barry O’Neill, in his written submission to the Inquiry told us that when he was appointed in 1985 ‘the percentage of relevantly qualified staff . . . was unacceptably low.’ In the day and residential sections of the department a ‘relevant qualification was an exception rather than the rule and the percentage of qualified staff in fieldwork settings was well below 50 per cent’.

19.2 Since 1985 Social Services Inspectorate reports on Staffordshire social services department have drawn attention to a continuing shortage of qualified, or even trained staff. As the former director pointed out to us there was such a longstanding and difficult situation that ‘in the short to medium term it was difficult to see how this could be changed’. Training, other than the secondment of thirteen staff a year to CQSW courses had been given a very low profile. In-service training was ‘virtually non-existent’. One member of staff in 1985 was carrying out such training function as there was for 6,000 employees.

19.3 Since then there has been a welcome injection of central government funding particularly since the Cleveland Inquiry. Some additional staff and resources have been made available to promote the changes of attitudes and skills needed to meet the requirements of the Children Act 1989. The training staff of the department provided information for the Inquiry which included the proposals put forward by Staffordshire to the Department of Health under the Social Services Training Support Programme (Child Care) and the Training Strategy and Review report for 1990/1991.

19.4 It was encouraging to note from the Training Strategy and Review report that the importance was recognised of underpinning very specific training such as child abuse training with basic child care knowledge, principles and practice. It was also encouraging to see courses being arranged for supervision and management.

Spending

19.5 There was an increase in spending on children and families training from about £4,000 in 1988/89 to £92,000 planned for the year from 1 April 1989. It has to be said, however, that this is very small scale for a county the size of Staffordshire which has a major problem. Larger scale remedies are likely to be needed to deal with it.

19.6 A major change is required, in our view, in the attitude towards the need for training at all levels of the social services department and in the committee.

19.7 We were told that the social services department did not have a tradition of respect for academic qualifications. Until very recently no financial recognition of them had been made. It was also very recently that concessions had been made to allow officers to study for degrees in order to enable them to do research within the department.

19.8 We found that people were waiting years to be seconded for full time training. In residential work, because of very poor staffing levels, people did not even have the opportunity to go on the infrequent training events.

Dangers

19.9 Mark Fisher M.F. was deeply concerned by what he saw as the dangers of untrained staff. He spoke of having been told by Philip Price how Pindown staff were ‘taking the children back to the moments of crisis in their lives’ to ‘help them to come to an understanding of the critical moments’. He commented that in his view ‘it seemed to be hideously dangerous for untrained people to be doing that’.

19.10 Training is an essential element in the provision of a service for children in care. It can no longer
be regarded as something for the few senior staff who oversee what large numbers of untrained staff offer to the children. It is also necessary in order to retain existing trained staff and recruit others.

19.11 We make the following recommendation.

Recommendation

19.12 We recommend that a strategy of training for the next five years is developed as a matter of urgency with a particular aim being to increase the numbers of trained and qualified staff in residential care without delay.
Chapter 20:

Staffing

20.1 The quality of child care work in a social services department depends on the quality of the staff and their availability to provide for the children's needs. This is particularly true in residential homes where the task is not only social work but also nurturing and where the contact between the children and the staff is closer than in any other aspect of the child care service.

20.2 Providing a quality service requires an understanding of the children's needs, the demands made upon the staff by those needs, and the kind of resources and supports which are essential to meet them. Some of these issues have already been examined in Chapters 18 and 19 on supervision and training.

20.3 The problems in Staffordshire social services department which led to the Inquiry were in no small measure due to poor staffing policies and practices. These showed little understanding of what was required in an adequate service. They included restrictive advertising, inadequate staff selection procedures, low staffing ratios, dependence on untrained staff, over use of volunteers and casual staff, lack of training, lack of supervision, absence of career structures for residential staff and inadequate budget support.

20.4 Advertising
We understand that there was a tradition of not advertising posts outside the department until they had been advertised internally. Staffordshire is not alone in this kind of arrangement. It reinforced, however, the inward looking nature of the social services department and hindered a healthy flow of new ideas and different experience which candidates from other local authorities and voluntary child care organisations would have brought.

20.5 Promotions
Internal promotions were another aspect of this practice. Whilst the length of time which people stayed in the department gave an element of stability, it also led to an atmosphere of resistance to innovative thinking, however tentative.

20.6 We were told that because people became well known in the department in consequence of this practice, selection procedures for jobs and for promotion were not as rigorous as would have been desirable. A number of witnesses commented critically on the interviewing process which they believed was often merely a formality. They were also aware of the inevitability of references being drawn from the internal sources in such a situation.

20.7 We were concerned from our own study of personnel files to see how lengthy the process of filling vacancies often appeared to be. Some witnesses also commented on this. It seemed not uncommon in some cases for a period of six months to elapse between an application for a post and a letter of appointment. In these circumstances if the post was in a residential setting and was vacant, there were long periods when an already small staff group was further depleted for long periods of time.

20.8 Qualifications
A further feature of the recruitment of staff which was mentioned in evidence was the readiness, if qualified candidates were not immediately available, to appoint unqualified people even if the post was designated as requiring a qualified person. As noted elsewhere in the report (see Chapter 19, paragraph 19.7) training until recently has not been valued in Staffordshire social services and this has in turn led to lack of respect for some of the standards and skills associated with a professional approach. Unhelpful tensions have existed between field social workers, a proportion of whom have been qualified, and residential, less than five per cent of whom have been qualified. Even amongst field social workers the proportion of qualified staff has been much lower than in most other local authorities and in such circumstances individuals attempting to raise standards have sometimes encountered unhelpfully dismissive responses.
20.9 The lack of expectation based on sound professional standards has allowed practices to persist which might in different circumstances have been resisted. One of these has been the long standing understaffing of family centres. When the centres were first established the staffing allocated for the task was unrealistic, (see Chapter 3, paragraph 3.43) and it was not long before the shoe began to pinch. Not only were there insufficient child care staff, but also insufficient domestic staff. Centres were classified as having fifteen beds and given a staffing establishment which even for that number was inadequate. They then had to accommodate twice as many children and try to carry out a large number of other family centre tasks as well. The result was predictable and although, in our view, Pindown could not be justified in any circumstances, it must not be forgotten that the situation at The Birches in autumn 1983 was extremely difficult for the reasons explained above (see Chapter 4, paragraphs 4.25-4.38).

20.10 The same phenomenon could be seen in action at The Alders, at 100 Chell Heath Road and at Heron Cross House. In the main untrained staff, too few in number, lacking any adequate outside support, were trying to cope with changes about which they had not been consulted and for which they had been given no preparation and no additional resources. At The Alders staff voluntarily doubled their shifts to help each other, but became over a period of time exhausted to the point that some clutched at Pindown because it appeared to bring a respite.

20.11 There were times when the residential establishments with which the Inquiry was concerned were left in the charge of one member of staff, sometimes a young woman inexperienced and unqualified. In our view, even if she, or he, had been experienced and qualified, they should not have been on duty alone. In evidence we heard accounts of the dilemma a member of staff faces if something goes wrong in these circumstances. Illness, an accident, someone having a temper tantrum, someone taking an overdose, even just a very distressed child who needs comforting, leaves a member of staff on duty alone with impossible choices. They may not even be able to make a telephone call to obtain help.

20.12 The staffing ratios of the family centres were not improved in the light of experience, no doubt for budgetary reasons. What happened instead was that volunteers, community project workers and the area ‘bank’ of social services aildes hours were used piecemeal in a desperate effort to ‘cover’ the lack of appropriate staffing. They were also much cheaper methods than full time staff. There was correspondence about the minimum level of staff to be left in charge at 245 Harshill Road, and an undertaking was given by Tony Latham that a social services aide would never be left in that situation. It is not possible to know whether this requirement was always carried out, but the impression gained from log book entries was that it may not always have been. At times the level of staffing available was clearly not adequate. There was also a great deal of change. In the first six months from when Pindown started at 245 Harshill Road sixteen different people worked within the unit.

20.13 A consequence of the heavy dependence on community project workers, social services aildes and volunteers was that a number of them, after a period of time, began to be appointed as temporary social work assistants. Later they became social work assistants moving on into social worker posts for which they had had no training. They also had no experience of the work except in the particular setting or settings in which they had originally acted as relief. This, in our view, is an undesirable policy.

20.14 Social Work Grades
Two administrative decisions seem to have increased the staffing problems in the residential homes. The first was the decision to put staff in family centres on to social worker grades. This had the cosmetic effect of equating them with area social workers. The less desirable effect, however, was to make it impossible for them to earn overtime, however many hours they worked. This point was made in evidence on a number of occasions. As one witness said ‘We live on TOIL’ – time off in lieu. Since, however, there were often not enough staff to allow time off in lieu to be taken, it became a problem of accumulating time for which no payment was made and which could not be properly absorbed by the system or the individual member of staff.

20.15 Night Duty
The other issue was related to staff on night duty. We were told in evidence that the number of beds in
establishments had been set at a point where waking night staff would not be needed. The implication was that in another way the service was being, as several witnesses put it 'run on the cheap'. Some of the staff who came and slept in at a residential unit like 245 Hartshill Road or The Alders, were carrying out other jobs during the day. They understandably did not welcome disturbance during the night and may not have been the best choice to handle the getting up and breakfast routine in an establishment with emotionally upset teenagers.

20.16 In the situation which has been noted above, which was long standing and not the subject of review at the time of the Inquiry, staff were not assisted by having little guidance available, poor communications with management, isolation from other establishments, no systematic quality control and little opportunity for staff development or training. One witness referred to the staff themselves as 'victims . . . untrained, unqualified, under-resourced'. We were told that morale was low and that residential staff felt under-valued.

20.17 Structure
Within the residential units the structure was not helpful. A team leader post was supported by a small group of staff but with no deputy, or deputy role available. This point has been discussed in Chapter 15, paragraph 15.12. Not only did this mean that there was an inadequate system for undertaking responsibility, but there was no encouragement to individual staff members to do so.

20.18 There was, in fact, no career structure for residential staff. Acquiring a qualification, if an individual was fortunate enough to be selected for training, was likely to provide a passport out of residential work.

20.19 We were not inquiring into the work of area teams of social workers, but their position was described by some witnesses. They too were gravely under-resourced with unqualified staff carrying cases for which greater knowledge and training were required. Caseloads were heavy. Staff protested but found it difficult to obtain a hearing. In some instances they found arbitrary decisions being made about children for whom they were responsible, because of the authority which appeared to be vested in Tony Latham. They too had not been consulted about major changes organisationally which increased their isolation in some cases and made it difficult to operate a team support system.

20.20 In spite of the many handicaps and difficulties inherent in the way the child care service was run, there were a number of committed people in it who knew that there were better methods and would have welcomed opportunities to use them. Two proposals were made in evidence from residential staff. One was that there should be a system of staff appraisals throughout the department, which would include appraisal of training needed by each individual. The other was that there should be a group of residential support staff, homes advisers, who would give professional support and assist staff in practice matters. This point is the subject of a recommendation in Chapter 17, paragraph 17.48.

20.21 It was clear to us from a study of the log books, financial information, committee papers and the evidence of witnesses that staffing policy in relation to residential child care in Staffordshire required urgent examination and radical improvement in all the matters referred to in this chapter. Such an examination will probably reveal others. Children whose own homes cannot for the time being provide them with the care they are entitled to expect must be cared for well and sensitively by the local authority. To do such a demanding job as caring for children in need, staff themselves need to be valued and supported.

Recommendation

20.22 We recommend that an urgent review of the social services department's staffing policy should be undertaken. The review should, as a minimum, cover the matters raised in this chapter.
Chapter 21:

National Implications

21.1 The Inquiry has raised a number of issues which have, in our view, national implications. They are:
   (a) The control of children in residential care;
   (b) Residential care for children;
   (c) The education of children in care;
   (d) The health of children in care;
   (e) Provision for children in care of 16 years of age or over;
   (f) The protection of children in care from sex offenders.

21.2 Control of Children in Residential Care

A combination of circumstances, certain individuals and a lack of effective safeguards brought fundamental problems to the surface in Cleveland and Rochdale. The same process, although in respect of a quite different problem, occurred in Staffordshire leading to the emergence of the unacceptable practice of Pindown. The kinds of difficulties disclosed are not resolved, however, by Inquiries and cases. We hope that those involved with the control of children in residential care, whether inside local and central government or outside, will maintain a heightened vigilance and concern in the future in the light of the events we have spent many months considering in Staffordshire.

21.3 Residential Care for Children

It is important, in our view, that residential care for children should be focussed on their needs and wishes. The Children Act 1989 places an added emphasis on these aspects. Some children and parents will choose residential care for a variety of good reasons. Residential child care should, in our view, be recognised as an essential part of a range of methods for providing for children whose needs are varied and changing. It should be resourced, staffed, supported and managed accordingly.

21.4 The Education of Children in Care

Chapter 13 contains recommendations about the education and careers of children in care and the need for them to receive more attention in future. The abilities of children in care range, of course, from the very able to those with special educational needs. Their educational needs and achievement have tended to take second place to social and family needs, often to their detriment in later life. This area of child care work should be given, in our view, a much sharper focus nationally.

21.5 The Health of Children in Care

The log books which we examined during the Inquiry revealed ample evidence that the health needs of children in care did not receive in certain residential establishments the attention they required. Medical arrangements for the homes appeared to be patchy and information available on individual children's health was inadequate. Children came into Pindown with potentially dangerous conditions such as asthma, suffered from chest conditions, back pain and stomach disorders, were suspected of epilepsy or had fits, and suffered many minor infections. The staff were slow to call a doctor or ask for advice, and seemed to rely, when they were available, on household remedies which they used on their own initiative. There were occasions when there were no remedies of any kind and staff brought medicines from home.

21.6 Arising from the evidence in the Inquiry and from research which supports it we consider that the health of children in care is an aspect which should receive more attention nationally.

21.7 Provision for Children in Care of 16 years of age or over

A large proportion of the children in Pindown were fourteen and fifteen years old. Some, however, were sixteen and a few seventeen. We formed the view from the evidence we received that the care of children
of sixteen and over lacked any coherent approach to their needs as prospective young adults. Some workers were uncertain about whether a sixteen year old in care on a voluntary basis was in fact still in care. Children of sixteen were put out into lodgings with very little regular support or visiting.

21.8 The needs of those who are 16 or over have, in our view, been inadequately met in the past and there is ample evidence that this is a problem on a wide scale.

21.9 The Protection of Children
In Chapter 14, 15 and 16 we have examined some of the risks presented to children by sex offenders and made recommendations. The issues considered in these chapters have, in our view, a national dimension.
Part 7: Conclusions and Summary of Recommendations

Chapter 22:

Conclusions

22.1 We set out below our conclusions (some of which are repeated from the previous chapters) on the various matters we were asked to consider. A reference, where appropriate, is given to the chapter in which the individual topic is considered.

22.2 Pindown

(i) After considering the totality of the evidence we consider that the vast majority of children who underwent the regime perceived Pindown as a narrow, punitive and harshly restrictive experience. We think that their perceptions were correct (see Chapter 11 and Chapter 12, paragraphs 12.2 to 12.21);

(ii) The children who were in Pindown, in our view suffered in varying degrees the despair and the potentially damaging effects of isolation, the humiliation of having to wear night clothes, knock on the door in order to ‘impair information’ as it was termed, and of having all their personal possessions removed; and the intense frustration and boredom from the lack of communication, companionship with others and recreation (see Chapter 11 and Chapter 12, paragraphs 12.2 to 12.21);

(iii) Pindown contained the worst elements of institutional control: baths on admission, special clothing, strict routine, segregation and isolation, humiliation, and inappropriate bed-times (see Chapter 12, paragraphs 12.44 and 12.46);

(iv) Pindown, in our view, is likely to have stemmed initially from an ill-digested understanding of behavioural psychology; the regime had no theoretical framework and no safeguards (see Chapter 12, paragraphs 12.36 to 12.40);

(v) No psychiatric, psychological or educational advice was obtained before or during the time Pindown was used (see Chapter 12, paragraph 12.30);

(vi) We regard the absence of professional advice in dealing with many children who were disturbed, depressed and in despair as inexplicable (see Chapter 12, paragraph 12.34);

(vii) No legal advice was ever sought by social services despite the fact that in 1984 senior management were aware that some of the practices in the ‘special unit’ at 245 Hartshill Road, Stoke-on-Trent appeared to be in contravention of the Community Homes Regulations 1972 (see Chapter 5, paragraphs 5.22 to 5.25 and paragraphs 5.70 to 5.80);

(viii) We consider that one of the aims of the so-called ‘philosophy’ of Pindown, to saturate the child with attention, was never to any significant extent put into practice; and was in any event a pipe dream due to lack of sufficient staff and lack of qualified and experienced people. We are of the view that in the main staff spent very little time with the children in Pindown (see Chapter 12, paragraph 12.22);

(ix) In the words of Tony Latham, the architect and prime practitioner of Pindown, the regime ‘was based on the principle that we were establishing control’. The impact on the children was, in our view, likely to be wholly negative and was so in that the regime imposed was fundamentally dependent on elements of isolation, humiliation and confrontation (see Chapter 12, paragraph 12.34);

(x) Pindown, in our view, falls decisively outside anything that could properly be considered as good child care practice. It was in all its manifestations intrinsically unethical, unprofessional and unacceptable (see Chapter 12, paragraph 12.56);

(xi) We consider that Pindown was used in breach of regulation 10 of the Community Homes Regulations 1972 (see Chapter 12 paragraphs 12.55 and 12.56);

(xii) The Pindown units, in our opinion, came within the secure accommodation provisions.

(xiii) Staffordshire obtained no approval to provide such accommodation: see regulations 2 and 3 of the Secure Accommodation (no.2) Regulations 1983, paragraph 4 of Annex B to Circular I.A.C (83) 18 and section 21A of the Child Care Act 1980 (see Chapter 12, paragraphs 12.53 and 12.57 to 12.61);

(xiv) Pindown was used in four Staffordshire residential establishments: 245 Hartshill Road,
Stoke-on-Trent; The Birches, Newcastle-under-Lyme; The Alders, Tamworth; and Heron Cross House, Stoke-on-Trent (see Chapter 12, paragraphs 12.25 to 12.29);

(xiv) Pindown was used at 245 Hartshill Road between 3 November 1983 and 2 October 1989; at The Birches in 1988 only: 1 February to 28 March; 29 May to 7 June; and 8 November to 28 November; at The Alders between 20 March and 2 October 1989; and at Heron Cross House between 26 September to 2 October 1989 (see Chapter 12, paragraph 12.29);

(xv) Between November 1983 and October 1989 we do not consider that there was any real variation in the practice of Pindown, save that in May 1988 for a few weeks an attempt was made to introduce at 245 Hartshill Road a so-called ‘positive Pindown’ (see Chapter 12, paragraphs 12.23 and 12.24);

(xvi) No consistent written procedures were specifically applicable to Pindown as such. Some ‘programmes’ relating to Pindown were recorded and a separate Pindown log book came into existence spasmodically alongside the normal log book. Specific documents relating to the ‘philosophies’ and practice of Pindown came into existence between 1983 and 1989 (see Chapter 12, paragraph 12.31 and appendix I);

(xvii) We are of the view that not less than 132 children went into Pindown between 3 November 1983 and 2 October 1989. Because the available records leave a great deal to be desired in many cases, this is probably a conservative figure. The number of boys was 81 and girls 51. The longest continuous period in Pindown was 84 days and the longest overall period was 129 days. A girl, between the age of 11 and 14, went into Pindown on most occasions, twelve in all. The youngest boy put into Pindown was 9 years old and the youngest girl was of the same age (see Chapter 12, paragraph 12.32);

(xviii) There was no professional oversight of Pindown (see Chapter 12, paragraphs 12.65 and 12.66);

(xix) Senior management focussed on the ‘special unit’ or ‘Intensive Training Unit’ at 245 Hartshill Road during 1984 and part of 1985 (see Chapter 5, paragraphs 5.22 to 5.25 and paragraphs 5.70 to 5.80). The concern about the unit then petered out and major potential issues were unresolved. The name Pindown was referred to in documentation circulating apparently in the department in 1986, 1988 and 1989. In 1989 senior management sent Tony Latham’s team into The Alders and Heron Cross House. We were told by the two deputy directors, Peter Crockett and John Spurr, that they had had no detailed knowledge of the nature of the Pindown regime until October 1989. In view of the events of 1984 and 1985 and later 1989 and the prominence of Tony Latham and his work we were somewhat surprised to hear of their ignorance. We consider, however, that if they were not aware of what was actually happening over a period of almost six years, it can only reflect a most serious flaw in the management of the department. John Spurr in his evidence to the Inquiry frankly conceded this fact. The responsibility for this state of affairs must ultimately lie with those at the very top of the department;

(xx) Middle management has, in our view, much to answer for in respect of Pindown. Elizabeth Brennan was principal area officer responsible for 245 Hartshill Road and The Birches between 1983 and 1989 and, in our opinion, was quite aware of Pindown. She told us that she did not know of all its aspects. She accepted that she should have visited 245 Hartshill Road more often. Jane Taylor, who succeeded Tony Latham as area officer in September 1987, expressed her concerns about the confinement of the children to Elizabeth Brennan. Jane Taylor was quite conversant with Pindown and indeed attempted with Peter Nicol-Harper in May 1988 to introduce a variation of it termed ‘Positive Pindown’. Regarding The Alders and Heron Cross House in 1989, the inspiration for the intervention of the Latham team came from senior management;

(xxi) Tony Latham bears responsibility for the creation of Pindown and the use of it between November 1983 and September 1987 and in 1989. He was, as we have indicated above, its architect and its prime practitioner. We have traced in the early chapters of this report the background factors that we believe led to the conditions which provided fertile ground for what occurred in late 1983. We are prepared to accept that Tony Latham, with an excess of enthusiasm and energy, hoped to control those he saw as difficult adolescents by the use of a system designed to provide individualised programming and the development of life and social skills. The grim reality, however, was quite different. As BASW pointed out to the Inquiry (see Chapter 12, paragraph 12.44) what occurred directly contravened the stated objectives. The evidence from contemporary documents, including thousands of pages of log books unequivocally, in our view, demonstrates the unacceptable nature of the regime introduced. We can only think that Tony Latham, a person of drive, energy and ability, who had contributed much in
other areas to Staffordshire, lost sight of those minimum standards of behaviour and professional practice which are essential to a fair and sympathetic approach to children in care. Philip Price for much of the time was his enthusiastic and admiring assistant. We consider that he was, and is, very much under the influence of Tony Latham. Nevertheless he must bear a significant responsibility also. The third member of the team in 1989, Glynis Mellors, also rendered substantial assistance;

(xxii) It is a matter of regret, in our opinion, that so many were prepared to be enthusiastic practitioners of Pindown. We would hope that the frank and explicit nature of the records and comments in the log books only represent a temporary aberration on their part. One cannot, however, erase the knowledge that the active life of Pindown was within a month of six years. We must, however, recognise that the residential staff were carrying out difficult work without being provided by their employers with adequate supervision, support, resources or even proper understanding in many cases of their tasks;

(xxiii) It was said to us that many outside the department were aware of, and by implication, condoned Pindown: magistrates, the police, teachers, probation officers and specifically in December 1987 the Social Services Inspectorate ('SSI'). We deal in Chapter 12, paragraphs 12.74 and 12.75 with the SSI's visit in December 1987. We do not consider that they were informed about Pindown. The evidence we received about the other groups points to some individuals knowing the term 'Pindown' and something of its practice. We are not satisfied to what extent they appreciated the true nature of the regime. One particular document, for example, which we saw, went before a magistrates' court as a report and did not, in our view, disclose the reality of Pindown;

(xxiv) We do not consider that the system of statutory visiting in Staffordshire is an effective one (see Chapter 12, paragraphs 12.72 and 12.73);

(xxv) Those who ultimately brought Pindown to the attention of the wardship court performed, in our view, a considerable public service. We would also like to pay tribute to those witnesses who came to the Inquiry and gave evidence despite having been harassed by various means by as yet unknown people. We are also happy to note that social services has within its department many able and committed people. We hope the future lies in their hands;

(xxvi) The politicians, in our view, must accept some responsibility for the events we investigated. It is the duty of the elected members of Staffordshire County Council to ensure, to the best of their ability, that public services required to be provided by legislation are available for those who need them at a level which is acceptable in the light of current knowledge and professional standards. It appears to us that there was insufficient vigilance on the part of the politicians and too much willingness to accept, without question, what appeared to be cheap remedies for problems. It must, however, be noted that they were not over-supplied with information by the managers;

(xxvii) It has been suggested 'that Pindown' by any other name probably exists the length and breadth of the country, and is probably more prevalent than anyone would officially care to admit'. We received no such admissions in evidence. The practice of Pindown has ceased in Staffordshire. If it exists under any other name elsewhere it should, in our view, be summarily terminated;

(xxviii) We make a number of recommendations arising out of our consideration of Pindown (see Chapter 12, paragraphs 12.76 to 12.85 or Chapter 23, paragraphs 23.2 to 23.10).

22.3 Fundwell

(i) On 30 August 1990, day 24 of the Inquiry, we recommended to the Local Authority that the purely financial matters concerning Fundwell should be the subject of an investigation by the District Auditor. Our recommendation was accepted and the District Auditor subsequently commenced work (see Chapter 1, paragraph 1.20);

(ii) We consider the nature and extent of the Fundwell organisations in Chapter 13, paragraphs 13.2 to 13.8. The organisations and the activities which involved children in care are listed in paragraph 13.7 and also paragraph 13.12;

27 The name of one of Tony Latham's companies but also a word used to encompass all the activities.
(iii) Because precise records were not kept about much of what took place over a period of a decade or more it is not possible to give an exact picture of the nature and extent of all the activities;

(iv) In essence from the mid-1970s until 1987 Tony Latham set up and developed a network of voluntary organisations and private companies which in some instances contracted their services directly back to the social services department and in other instances were concerned with intermediate treatment and other activities in which children were involved in a variety of ways (see Chapter 3, paragraphs 3.47 to 3.56);

(v) The great majority of children who participated in Fundwell did so either as recipients of a service, as employees, as trainees, for the purpose of gaining work experience or as licencees in SHAP houses. There were also a small number of children who were required to carry out certain tasks, usually at Duke's Lodge (home of Tony Latham), associated with the overall programmes in Pinetown. There is little doubt that some of the children considered they were being punished;

(vi) It is quite impossible to compile a list of the children participating in Fundwell activities because there are no records or no reliable records from which to do so;

(vii) It was put to us that the children benefitted from their involvement in Fundwell activities because they had an introduction to work and learned certain simple skills such as the planning of collections and deliveries, receiving money and giving change, and looking after animals. The wide variety of activities was also, it was said, an opportunity to try different types of occupational experience. It must be recognised, in our view, that a number of children were engaged in repetitive labour which sometimes had an element of risk and was often quite heavy and at times unpleasant work. Some children had to work during the evening and at weekends. This was on occasions for small sums of pocket money, £2 or £3, and sometimes for nothing;

(viii) Some of the children in care were still of school age and worked at Duke's Lodge during school hours as well as working there at other times of the day. The Inquiry was told by the Chief Education Officer of Staffordshire that this was not permissible. Even if they had been excluded from school, specific permission would only be given in exceptional circumstances (see Chapter 13, paragraphs 13.23 and 13.24);

(ix) Whilst some of the children in care may have benefitted from their involvement in Fundwell activities, others did not wish to be involved or actively resisted involvement. The evidence from log books, as well as personal evidence from children and other witnesses, clearly indicated that while some who did not wish to take part did not have to, there were others who were required to go. The level of pressure was such that in one or two instances the word coerced is not too strong;

(x) Much of the work at Duke's Lodge was not educational or generally beneficial in other respects. Some of the young people resented being used as a 'general dog's body' and working very hard for little or no reward and without any choice;

(xi) The organisations and activities Tony Latham created and developed were widely known in the social services department to involve children. There was a policy in the department up to 1985, in the words of the former director, Barry O'Neill, 'to let him get on with it and not to interfere as long as he produced the goods'. A number of staff and councillors were not fully aware of the status of the activities and the interests of Tony Latham and others in them. That, in our view, was less his fault than failure of communication at a variety of levels within the social services department and the county council as a whole (see Chapter 13, paragraphs 13.29 and 13.30);

(xii) Tony Latham and Glynis Mellors, who worked alongside him in much of the work related to Fundwell, both worked extremely long hours and with enthusiastic commitment;

(xiii) There was, in our view, no adequate supervision by senior management of what happened in relation to children and Fundwell as distinct from supervision of accounts and some other financial matters (See Chapter 13, paragraph 13.34);

(xiv) There was no professional oversight;

(xv) We make recommendations arising out of our consideration of Fundwell in Chapter 13, paragraphs 13.38 and 13.39 or Chapter 23, paragraphs 23.12 and 23.13.

28 Supportive Housing Accommodation Project
22.4 The Protection of Children

(i) The details of our additional Terms of Reference are set out in Chapter 14, paragraph 14.1;

(ii) The specific matters relating to the protection by staff of children in residential homes from members of the so-called sex ring are dealt with in Chapters 14 and 15;

(iii) We were satisfied from the evidence we received that two men who had been sentenced as part of the sex ring had each, quite separately, visited on various occasions a children’s residential establishment in Staffordshire, though not the same one. We do not consider that the concerns expressed, taking children out of the residential homes or arranging to meet the children resident for sexual purposes have been substantiated in either case (see Chapter 14, paragraphs 14.2 to 14.5);

(iv) We were satisfied that one of the men who visited 245 Hartshill Road, Stoke-on-Trent on a number of occasions should not have been permitted entry to the establishment (see Chapter 15, paragraphs 15.1 to 15.23);

(v) Procedures relating the vetting of visitors to 245 Hartshill Road were not, in our view, satisfactory;

(vi) In addition the procedures relating to the availability of reliable information regarding those who may be reasonably suspected of being sex offenders and a danger to children, are not, in our view, satisfactory (see Chapter 15, paragraphs 15.25 to 15.30 or Chapter 23, paragraphs 23.15 to 23.20, for recommendations arising from our consideration of the above matters);

(vii) We also considered a quite separate matter unconnected with the sex ring. This concerned the protection of a child who was placed in lodgings in respect of which the landlord was a sex offender and a danger to children (see Chapter 16, paragraphs 16.1 to 16.23);

(viii) The procedures relating to the vetting of such accommodation were not, in our view, satisfactory (see Chapter 16, paragraphs 16.25 and 16.26 or Chapter 23, paragraphs 23.22 and 23.23, for recommendations in respect of the procedures);

(ix) We also considered the arrangements relating to the notification of the movements of Schedule 1 offenders to local authorities (see Chapter 16, paragraphs 16.27 to 16.32);

(x) We make recommendations relating to our conclusion that some of the arrangements relating to the notification of the movements of Schedule 1 offenders to local authorities could be improved (see Chapter 16, paragraphs 16.33 and 16.34 or Chapter 23, paragraphs 23.24 and 23.25).

22.5 Professional issues

(i) Management
Management in the social services department in Staffordshire was inadequate for its task and lacked many of the essential characteristics required to ensure good services to the public (see Chapter 17, paragraphs 17.1 to 17.34 and for recommendations: Chapter 17, paragraphs 17.35 to 17.49 or Chapter 23, paragraphs 23.27 to 23.40);

(ii) Supervision
The evidence we received points unequivocally to the urgent need for a properly regulated system of supervision throughout: the social services department (see Chapter 18, paragraphs 18.1 to 18.14 and for recommendations: Chapter 18, paragraphs 18.16 and 18.17 or Chapter 23, paragraphs 23.42 and 23.43);

(iii) Training
A major change is required, in our view, in the attitude towards the need for training at all levels of the social services department and in the committee (see Chapter 19, paragraphs 19.1 to 19.10 and for a recommendation: Chapter 19, paragraph 19.12 or Chapter 23, paragraph 23.45);

(iv) Staffing
An urgent review of staffing policies should, in our view, be undertaken (see Chapter 20, paragraphs 20.1 to 20.21).
Chapter 23:

Summary of Recommendations

23.1 Chapter 12

23.2 We recommend that social services departments regularly scrutinise the measures of control used in residential child care establishments (paragraph 12.77).

23.3 We recommend that those appointed in social services departments to monitor regularly the measures of control used in residential child care establishments should liaise closely with the legal department of the local authority (paragraph 12.78).

23.4 We recommend that social services departments ensure that log books in residential child care establishments are completed in such a way:
   (a) that they disclose who is on duty on the day on which entries are made;
   (b) that all entries are written in appropriate and clear language;
   (c) that all entries are signed with the name of the signatory clearly identified; and
   (d) that all entries are clearly dated (paragraph 12.79).

23.5 We recommend that social services departments ensure that measures of control books in residential child care establishments are completed properly in compliance with the relevant Regulations and that entries are dated and signed with the name of the signatory clearly identified (paragraph 12.80).

23.6 We recommend that the forms used by statutory visitors to residential child care establishments should highlight the question of 'control' and direct the visitor to make specific comments regarding measures of control used (paragraph 12.81).

23.7 We recommend that prior to a visit to a child care establishment by a statutory visitor, there is made available to him or her the previous visitors' completed forms over a period of at least six months (paragraph 12.82).

23.8 We recommend that statutory visitors' reports should go unaltered to the appropriate committee (paragraph 12.83).

23.9 We recommend that statutory visits should be made without advance notice being given to the residential home (paragraph 12.84).

23.10 We recommend that the law regarding the 'control and discipline' of children in residential establishments is amended so that definitions of the circumstances which amount to the restriction of a child's liberty appear in legislative provisions and are not left to the language of guidance in circulars (paragraph 12.85).

23.11 Chapter 13

23.12 We recommend that there should be a named person at senior management level with responsibility (a) for ensuring that care and attention is given to the education, career development and working life of children in care, and (b) for the consideration of any policy or practice issues (paragraph 13.38).

23.13 We recommend that the named person referred to in paragraph 13.38 should provide an annual report on the matters for which he has responsibility giving particular attention to:
   (a) educational achievements of children in care;
   (b) changes in the schools they attend as a consequence of care placement;
   (c) special educational needs;
(d) involvement in further education;
(e) work undertaken by school children; and
(f) the employment of children above school age (see paragraph 13.39)

23.14 Chapter 15

23.15 We recommend that in any residential unit for children someone on the staff should be designated to deputise in the absence of the officer in charge. Wherever possible this should be the same person each time and this responsibility should be clearly defined in their job description and recognised financially (see paragraph 15.25).

23.16 We recommend that a record should be made each day of all visitors to the children in a residential unit. This record should be available to be seen by all members of staff, for example, by being contained in the daily log or diary (see paragraph 15.26).

23.17 We recommend that there should be a method available for social services staff who may need information about possible sex offenders to check with a designated source at any time (paragraph 15.27).

23.18 We recommend that social services and the police should reach agreement and reduce into writing the following:
   (a) that members of social services staff who may need information about possible sex offenders who pose a risk to the children for whom they are responsible may telephone or otherwise contact a designated police information source at any time; and
   (b) that social services will specify the staff who, save for exceptional circumstances, will be actually communicating with the police information source: for example, the officer in charge of a residential establishment or the designated deputy (paragraph 15.28).

23.19 We recommend that consideration should be given by social services, if appropriate in conjunction with the fire service, to the best means of maintaining reasonable control over entrances and exits in residential units for children; and that clear instructions in writing should then be circulated to the relevant staff (paragraph 15.29).

23.20 We recommend that social services departments should issue written guidance to staff dealing with the topic of the protection of children in residential establishments and, in particular, covering the regulation and vetting of general visitors to such establishments (paragraph 15.30).

23.21 Chapter 16

23.22 We recommend that in respect of the placing of children in care in lodgings or similar accommodation, social services should in all cases ensure that:
   (1) there is circulated a clear written procedure covering the vetting of such premises;
   (2) the premises are inspected and a written record made in respect of them;
   (3) the landlord is interviewed where practicable and always in the case of a resident landlord, and a written record made;
   (4) where appropriate, and always in the case of a resident landlord, the landlord's agreement is obtained to make a police check (and such further checks as may be considered prudent);
   (5) the relevant information obtained and any further facts about the premises, and the respective sources of the data, be recorded in an accommodation register (paragraph 16.25).

23.23 We recommend that the Home Office and the Department of Health clarify or extend, if necessary, the present arrangements concerning the disclosure of the criminal background of those with access to children, so that a local authority, considering an agreement with a private sector landlord in respect of a child in care, is able without difficulty to make an appropriate police check (paragraph 16.26).

23.24 We recommend that revised arrangements are made for local authority social services
departments to be notified of all convictions occurring for offences against children by persons residing or intending to reside in their area, irrespective of where the offences were committed and the nature of the disposal by the court (paragraph 16.33).

23.25 We recommend that the notification to local authority social services departments of all convictions occurring for offences against children by persons residing or intending to reside in their area, be undertaken by the Crown Prosecution Service (paragraph 16.34).

23.26 Chapter 17

23.27 We recommend that each residential establishment should have a written statement of its agreed role (paragraph 17.36).

23.28 We recommend that adequate consultation should take place with staff in advance of organisational changes (paragraph 17.37).

23.29 We recommend that precise job descriptions should be provided for all professional posts (paragraph 17.38).

23.30 We recommend that a system of caseload management is installed as soon as possible (paragraph 17.39).

23.31 We recommend that a systematic monitoring and evaluation system should be introduced within the social services department (paragraph 17.40).

23.32 We recommend that more posts should be advertised nationally, and in particular senior and managerial appointments (paragraph 17.41).

23.33 We recommend that there should be an agreed staff recruitment policy to attract qualified and experienced staff (paragraph 17.42).

23.34 We recommend that a complaints procedure for staff, foster parents and children should be implemented without delay, and should contain an independent element (paragraph 17.43).

23.35 We recommend that team managers or their equivalents should have regular opportunities to meet with a senior manager who should represent their views at the most senior level of the department (paragraph 17.44).

23.36 We recommend that the preparation of estimates should be carried out in consultation with staff at all managerial levels (paragraph 17.45).

23.37 We recommend that the relationship and channels of communication between the social services department and the social services committee should be the subject of a review in order to ensure that the committee receives clear and full information (paragraph 17.46).

23.38 We recommend that the role and membership of the social services advisory committees should be examined in order to ensure their effectiveness in the future (paragraph 17.47).

23.39 We recommend that residential homes advisers with appropriate experience and training be appointed to provide professional support to residential child care staff (paragraph 17.48).

23.40 We recommend that a member of the social services department is specifically made responsible for liaison with the legal department in order to review jointly, on a regular basis, matters which may require specific consideration and advice from the legal department (paragraph 17.49).
23.41 Chapter 18

23.42 We recommend that the social services department should put in place as a matter of urgency a system of supervision (paragraph 18.16).

23.43 We recommend that after a period of one year following the establishment of a system of supervision a review should take place to evaluate the system (paragraph 18.17).

23.44 Chapter 19

23.45 We recommend that a strategy of training for the next five years is developed as a matter of urgency with a particular aim being to increase the numbers of trained and qualified staff in residential care without delay (paragraph 19.12).

23.46 Chapter 20

23.47 We recommend that an urgent review of the social services department's staffing policy should be undertaken. The review should, as a minimum, cover the matters raised in chapter 20 (paragraph 20.22).
Appendix A:

Members of the Inquiry

- Allan Levy Q.C., LL.B
  Barrister
  Assistant Recorder
  Hon. Legal Adviser, National Children's Bureau
  Member of the Council of Justice
  Member of the Council of the Medico-Legal Society
  Author and editor.

- Barbara Kahan O.B.E., M.A. (Cantab) M (Univ)
  Chair of the National Children's Bureau
  Director of the Gatsby Project
  Independent consultant in child care to service agencies and The Open University
  Professional adviser to House of Commons Social Services Committee 1983-1990
  Author and editor
  Formerly in senior management of social services in local and central government
Appendix B: Terms of Reference

STAFFORDSHIRE CHILD CARE INQUIRY

Terms of Reference

General Terms of Reference

1. To review the treatment and care of young persons at 245 Hartshill Road, Stoke-on-Trent, at "The Birches", Newcastle-under-Lyme, and at any other location where the practice known as "pin down" may have been used.

2. To consider any participation by young persons in care in the activities of undertakings not owned by the County Council and known as "Fundwell" and to consider the need for any further investigation of the general activities of such undertakings and their relationship with the County Council and to recommend or carry out such investigation as may be required.

3. To ensure that complaints received relating to the matters mentioned in paragraph 1 are thoroughly investigated and considered and are seen to have been so investigated and considered.

4. To draw out the strengths and weaknesses and legality of the practice and procedures in use in relation to the matters mentioned in paragraphs 1 and 2.

5. To reach conclusions and to make any recommendations necessary to allay public concern and maintain public confidence in the Social Services Department and its protection of the interests of children and young persons and of the public.

Particular matters for consideration

6. The establishment of methods of working which take full account of the need to obtain full and accurate information on all matters under review, whilst at the same time ensuring necessary consideration and protection of the interests of children in care, complainants and staff.

7. The collection, collation and consideration of all items of written evidence including court records, case papers, records of residential establishments, reports of visits to homes and management records of the Department and Council.

8. In relation to the practice known as "pin down":-

   (a) The nature of the practice, the amount of staff contact and the nature of engagement, and the way the practice varied over the period it was used.

   (b) The places and periods over which the practice was used.

   (c) The nature and extent of any psychiatric, psychological or educational advice obtained before or after the practice was established.

   (d) What written procedures were applicable.

   (e) What children were subject to "pin down" with information about age, sex and length of time in "pin down".

   (f) How far it is possible to assess any impact of "pin down" on those children and the nature of that impact.

   (g) The managerial and professional oversight of "pin down".

9. In relation to participation by young people in care in the activities of undertakings not owned by the County Council and known as "Fundwell".

   (a) The nature and extent of the organisations generally known or associated together as "Fundwell" and in which children and young persons participated.
(b) The nature and extent of the participation by young children and young persons in these organisations whether as employees, trainees on work experience placements, as tenants or licencees or otherwise.

(c) A list of all the children participating with information about age, sex and length of participation.

(d) The benefits or disadvantages resulting from the participation of children and young persons in these activities including any educational implications.

(e) The managerial and professional oversight of such participation and any conflicts of interests of staff which might have arisen in connection with such participation.

10. Any associated matters of concern to the Inquiry, including the adequacy or otherwise of the complaints procedures in use within the department.

11. Whether at any point in the Inquiry the panel consider that the method of working adopted is inadequate for the issues at stake and should be substituted by a Public Inquiry or any other method of procedure.

12. Whether at any point in the Inquiry the panel consider that they have established matters which should be reported to the County Council as requiring immediate disciplinary action and any subsequent effect on the working of the Inquiry.

13. To note the County Council's intention to make public the full report of the Inquiry and to provide the Secretary of State for Health with a copy.
14. To consider whether children and young persons resident in Staffordshire child care establishments were appropriately protected, as may have been required, from any of the individuals who were subsequently convicted in the summer and autumn of 1989 of sexual offences against children and young persons.

15. To make any appropriate recommendations.
Appendix C:

List of Representatives of Parties

Hugh Howard of Messrs. Howard and Tain acted as solicitor to the Inquiry

<table>
<thead>
<tr>
<th>Party</th>
<th>Representative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Barry O’Neill</td>
<td>Margaret Isley of</td>
</tr>
<tr>
<td>John Spurr</td>
<td>Messrs. Hand Morgan and Owen</td>
</tr>
<tr>
<td>Elizabeth Brennan</td>
<td>David Kidney of</td>
</tr>
<tr>
<td></td>
<td>Messrs. Wainwrights</td>
</tr>
<tr>
<td>Jane Taylor</td>
<td>Neil Robinson of</td>
</tr>
<tr>
<td></td>
<td>Messrs. Nowell Meller and Nowell</td>
</tr>
<tr>
<td>Philip Warrilow</td>
<td>John Allen of NALGO</td>
</tr>
<tr>
<td>Tony Latham</td>
<td>John Trotter of Messrs.</td>
</tr>
<tr>
<td>Philip Price</td>
<td>Bates Wells and Braithwaite</td>
</tr>
<tr>
<td>Glynis Mellors</td>
<td></td>
</tr>
<tr>
<td>Michael Hurley</td>
<td>Patricia McManus of</td>
</tr>
<tr>
<td></td>
<td>Messrs. Ollier, Jones, McManus</td>
</tr>
<tr>
<td>Some Wards of Court</td>
<td>Michael Nicholls, solicitor in the Official Solicitor’s Department</td>
</tr>
</tbody>
</table>
Appendix D:

List of People who gave oral evidence
(excluding children, parents and those who requested not to be named)

Mark Fisher M.P.
Councillor W. F. Austin
Councillor N. Beach
Councillor C. Jebb
Councillor M. Poulter
Councillor R. Roberts
Councillor A. Thomas
Councillor I. Wise

Bernard Price, County Clerk and Chief Executive, Staffordshire County Council
Elaine Taylor, solicitor, Staffordshire County Council
John Mytton, solicitor, Staffordshire County Council
John Taylor, Treasurer's Department, Staffordshire County Council
P. J. Hunter, Chief Education Officer, Staffordshire

Staffordshire social services department:

David Allen
Susan Arnold
John Aston
Paul Boylan
Elizabeth Brennan
Alan Carney
Paul Carter
Peter Crockett
Janet Daniels
Damian Doherty
Louise Doherty
Rose Gibbs
Lesley Gilford
David Heath
Frederick Hill
Eileen Ironside
Tony Latham
Christopher Lucas
Linda Machin
Glynis Mellors
Philip Owen

Anthony Pearce
George Pierpoint
Laurence Poultney
Philip Price
Jaime Rodriguez
Wade Rogers
Roger Rowland
Robert Smith
Margaret Spooner
John Spurr
Brendan Sullivans
Susan Swinhoe
Jane Taylor
Michael Thomas
Graham Thornclow
William Tomlinson
Graham Toplass
Christopher Walley
Jane Walton
Philip Warrilow
Pauline Whitchurst

Former members of Staffordshire social services:

Jill Edge
Christine Evans
Elaine Goodier
Michael Murphy

Peter Nicol-Harper
Barry O'Neil
Eileen Robinson
Audrey Williams
Organisations and Individuals:

Gail Tucker  
Christopher Andrews

William Bottomley  
Martin Westward

John Allen  
Andrew Standon

Michael Hurley

Richard Clough M.B.E.

Ian Milner  
James Stewart

Dr David Foreman, consultant psychiatrist
Dr Edna Irwin, consultant psychiatrist
Sarah Lasenby, guardian-ad-litem
Professor Norman Tutt, director of social services, Leeds City Council
Kevin Williams, solicitor

British Association of Social Workers (BASW)
Former members of the Manpower Services Commission (MSC)
National Association of Local Government Officers (NALGO)
National Association of Young People in Care (NAYPIC)
Social Care Association (SCA)
Social Services Inspectorate (SSI)
Appendix E:

Documentary Evidence (selected)

(1) STAFFORDSHIRE

(a) Documents from residential homes:

- Log books
- Measures of Control books
- Admissions and discharges registers
- Daily record sheets
- Accident books
- Visitors books
- Residential establishments files
- Menu books

(b) Other Documents:

- Personnel files
- Children’s case records
- Selected social services committee papers and reports 1980-1990
- Financial information and budget papers 1977-1990
- Information on training programmes and budgets
- Fundwell accounts and other papers
- Some notes of senior staff meetings
- Children and Families Departmental Procedures (1980)
- Child Protection Departmental Procedures (1990)

(2) REPORTS, PAPERS ETC:

- The O’Neill Report by Sir Walter Monckton K.C. HMSO, Cmnd 6636 (1945);

- The Auckland Report by P. J. M. Kennedy Q.C. and others, HMSO, 1975;

- Home Office Memorandum on the Conduct of Children’s Homes, HMSO, 1966;

- Report of the Committee on Local Authority and Allied Personal Social Services, HMSO, Cmnd 3703, 1968;


- Care and Treatment in a Planned Environment: A report on the Community Homes Project, HMSO, 1970;

187
Absconding from Approved Schools: A Home Office Research Unit Report, HMSO, 1971;


Locking up Children: Secure provision within the child care system – S. Millham, R. Bullock, K. Hosie, Saxon House, 1978;


Mental Health Act Commission: Guidance for Responsible Medical Officers Consent to Treatment – Enclosure to DDL(84)4, 1984;

Behaviour Modification – More or less intervention? B. Hudson, Childright No. 6, April 1984;

Committee to examine the application of Behaviour Modification at Nyandi – Report to the Director, Department of Community Welfare, Western Australia, 1984 (see also 1987 post);

Second Report from the House of Commons Social Services Committee Session 1983-1984: Children in Care, vol.1 HMSO, 360-1;


Inspection of Community Homes, SSI, DHSS, September 1985;

Social Work Decisions in Child Care: Recent Research findings and their implications; DHSS, HMSO, 1985;

Children’s Homes, David Berridge, Blackwells, 1985;
- Young People under Pressure: Runaways and Others, Briefing Paper, No. 1 (The Children's Society), 1986;

- Staff . . . Finding them, Choosing them, Keeping them. Edited by B. Kahan, SCA, 1986;

Secure Accommodation for Children and Young Persons Guidance for Local Authorities, DHSS and SSI, 1986;

- Bridges over Troubled Waters – NHS Health Advisory Service, 1986;

- Children in Custody: G. Stewart & N. Tutt, Avebury, 1987;

- The 'Karinga' Adolescent and Parent Community Support Unit: A Programme Evaluation, A. McMullan and J. Duffy, Nyandi, 1987;

- Young People under Pressure: Somewhere to live, Briefing Paper, No.2 (The Children's Society), 1987;

- Juvenile Justice Project Report No.2: The Route from Care to Custody, Prison Reform Trust, 1988;

- The Characteristics of Young People in Youth Treatment Centres, Dartington Social Research Unit, 1988;

- Family Centres – A Change of Name or a Change of Practice, SSI, Department of Health, 1988;

- Inspection of Youth Treatment Service Overview, Report, SSI, Department of Health, 1988;


- Young People under Pressure: Juvenile Justice, Diversion from Custody, Briefing Paper, No.3. (The Children's Society), 1988;


— Child Care Research, Policy and Practice – edited by B. Kahan, Hodder and Stoughton, 1989;


— The experiences and careers of young people leaving the Youth Treatment Centres, Dartington Social Research Unit, 1989;

— Alternative Care Careers: The experience of very difficult adolescents outside youth treatment centre provision, Dartington Social Research Unit, 1989;

— The British Psychological Society Division of Clinical Psychology: Guidelines for the professional practice of Clinical Psychology, 1990;

— Management Development: Guidance for Local Authority Social Services Departments, SSI, 1990;

— The Power to Care in Children’s Homes – N. Baldwin – Avebury, Gower, 1990;


— NACRO Briefing – Juvenile Crime Section – Unruly Certificates: Implications for Practice, 1990;

— Child Care Policy: Putting it in writing – D. Robbins, CRESEP, University of Bath, HMSO, 1990;

— SSI/HMI Inspection of Children’s Homes in Staffordshire, SSI, Department of Health, 1990;

— SSI Inspection of Children’s Homes in Staffordshire – Supplementary Report, Department of Health, 1990;


— Report of a Review by Her Majesty’s Chief Inspector of Prisons for England and Wales of Suicide and Self Harm in Prison Service Establishments in England and Wales, Home Department, HMSO, Cm 1383, 1990;

(3) **WRITTEN SUBMISSIONS TO THE INQUIRY**

— John Allen, NALGO (Staffordshire);
— Dr Susan Bailey, consultant forensic psychiatrist;

— British Association of Social Workers;

— Elizabeth Brennan, Staffordshire social services;

— The Children's Legal Centre;

— Roy Hudson, Deputy Clerk, Staffordshire County Council;

— Michael Hurley (NAYPIC);

— IRCHIN (Independent Representation for Children in Need);

— Tony Latham, Staffordshire social services;

— Dr Lowenstein, psychologist;

— Glynis Mellors, Staffordshire social services;

— Professor S. Millham, Dartington Social Research Unit;

— John Mytton, solicitor, Staffordshire County Council;

— National Association for the Care and Resettlement of Offenders (NACRO);

— Official Solicitor to the Supreme Court;

— Pauline Oliver, director of social services, Lancashire County Council;

— Barry O'Neill, Staffordshire social services;

— Philip Price, Staffordshire social services;

— Bernard Ramsey, Staffordshire social services;

— Robert Smith, Staffordshire social services;
— John Spurr, Staffordshire social services;

— Jane Taylor, Staffordshire social services;

— Professor Norman Tutt, director of social services, Leeds City Council;

— David Walton, Chief Probation Officer, Staffordshire Probation Service;

— Lady Wagner, National Institute for Social Work;

— Nicholas White, solicitor, Staffordshire County Council.

(4) LEGAL REFERENCES CONSIDERED DURING THE INQUIRY

— The Bill of Rights 1688;

— Children and Young Persons Act 1933, First Schedule;

— Children Act 1948, Part VI;

— Children and Young Persons Act 1969;

— Local Authority Social Services Act 1970;

— Child Care Act 1980;

— Children Act 1989, Part VI and the Fourth Schedule;

— The Prison Rules 1964 (S.I. 1964, No.388);

— The Community Homes Regulations 1972 (S.I. 1972, No.319);

— The Naval Detention Quarters Rules 1973 (S.I. 1973, No.270);

— The Imprisonment and Detention (Army) Rules 1979 (S.I. 1979, No.1456);
— The Secure Accommodation (No.2) Regulations 1983 (S.I. 1983, No.1808);

— The Children's Homes (Control and Discipline) Regulations 1990 (S.I. 1990, No.87);

— DHSS Circular No.78/1972;

— Local Authority Circular LAC(83) 18, Annex B;


— Children Act 1989: Consultation Paper, No.18: Homes (Guidance and Regulations), Department of Health, 1990;


— Weldon v Home Office [1990] 3 WLR 465 C.A;

— Middleweek v Chief Constable of Merseyside [1990] 3 WLR 481;

Appendix F: The Pindown Documents

Appendix F, Document 1

The concept of any rota is to meet the needs of client groups, achieve maximum output from staff during the working week, plus job satisfaction. This needs to include the very primary tasks, plus good residential practice to clients. All staff need to work to this end.

The rota currently devised is to achieve and maximise all the things I see important in developing and furthering an already exciting family centre concept.

To generalise re the rota on a day to day basis:-

1.) Sleeping in duties are to be covered in the main by senior staff, to satisfy the out of hours cover for the total family centre. This by no means is to deny the fact that assistants are not capable, as we all know they are and have been covering this for some time satisfactorily; but with the emphasis on onsleeping in staff, I see assistants being the second sleeping in for special cases etc. or relief during holiday sickness etc.

I also envisage assistants covering a lot of the outside support work, possible development of evening care of non residents, as well as rota support to clients resident.

2.) On average, staff covering sleeping in duties will cover 6 a month which is a 20% reduction on the current rota. It also means there should be time available for those with a demanding workload to plan their workload more effectively.

3.) The opportunity for casework records etc. will be available one day a week which will be on their 9-5 day being at The Birches where telephone, plus hopefully conclusive environment to work on cases, will be available, plus effective planning of oneworking week.

4.) (12:30 – 8:30) days will initially have staff meeting times Friday (12:30 – 2:30) after which plans to cover outside visits to clients should have been made where necessary.

Under no circumstances should staff plan outside visits when on sleeping in duties at Hartshill Road, as this is likely to effect the positive running of the unit which will be dealing with approximately 8-10 clients at any time to begin with who will be working to individual programmes (some yet to be devised) and require maximum support from all staff involved. If this is not the case, and 50% of the team are missing, the whole programme will become inconsistent, fail to be a positive developing experience and cause considerable pressure to staff remaining on duty.

5.) Duty Days (7:15 – 1:15) will be a day when staff will attend morning management meeting, plus individual casework discussion (could this be supervision) 9:15 – 11:15.

I will be an expectation that a case per morning or development session will take place during this time (and be up to date).

After 11:15 it may be possible for the opportunity of client visits until end of rota, but one must also consider the fact that a support to the schooling programme may be required for difficult individuals who may need isolation from the schoolroom, also lunch time support.

(12:30 – 1:15).

195
This is only a brief outline of why the attached rota format has been devised. It is likely to change as initial problems are resolved and after all staff & myself have had the benefit of seeing it work for a few weeks.

(245 HARTSHILL ROAD)

Over the past eighteen months we have seen considerable changes in our dealings with clients. The move to Hartshill Road is to bring together the staff team in following this concept through. Some staff members have an advantage due to the fact that they have been based there and running it for some time. But with an increase in numbers and a further use of other parts of the building everyone will be facing new challenges.

Generally there will be six separate areas within the building offering a variety of different approaches requiring different handling techniques:

1.) Main landing will be for those children who have developed to a point of help skills but require firm consistent handling with a positive base to operate from, plus positive relationships.

2.) Flat downstairs will accommodate 2 residents who have reached a reasonable stage in their development requiring less staff input and more decision making.

3.) Special unit - to be treated separately from all other units at all times with very specially devised plans which should be adhered to at all times and not changed without approval of review.

It is envisaged that all residents will receive a weekly review, some with family, others with social workers etc.

4.) Schoolroom - adjacent to main kitchen will operate on the following times: Monday to Friday 9:00am to 4:00pm

<table>
<thead>
<tr>
<th>Breaks</th>
<th>10:30-10:45</th>
<th>Louise</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>12:30-1:15</td>
<td>Louise &amp; staff</td>
</tr>
<tr>
<td></td>
<td>2:30-2:45</td>
<td>Louise</td>
</tr>
</tbody>
</table>

Louise will have responsibility for the daily schooling programme and the setting of any school work for outside clients or special unit residents.

5.) Dining area - will be adjacent to schoolroom where all main meals should be taken except for those on special self help programmes.

6.) The Flat - Currently occupied by Amanda will become a flexible resource in any way seen appropriate by myself or area officer.

Here should be 2 staff on duty at all times except for sleeping in, one being a senior.

The emphasis of the unit should be on working with the clients positively where appropriate to achieve the aims of individual programmes, e.g.,

- Menu planning
- Budgeting
- Washing, ironing, mending
- Cleaning of bedroom
- Counselling
I do not wish to find the little office as a congregating point as it is unnecessary. What I want to see develop is staff alongside clients achieving and striving towards the individuals programme.

I see no need for any staff to be based in the little office unless by special arrangement to oversee the special cases within special unit, and this will be identified in morning management meeting.

The morning management meeting will also involve a representative from the community programme based in Hartshill Road, but they will not be the responsibility of duty staff, they will remain a separate entity.

The day to day running and routine needs to be discussed and finalised within the staff meeting to obtain everyone's point of view.

. Defining boundaries
. Support workers - cook & cleaner
. Clothing
. Day to day upkeep of building
. Finances
. Mealtimes
. Bedtimes
. Visitors
. Telephone
. Equipment
. Etc etc etc

I feel discussions on how to put a total package together will help resolve many of the anxieties that are facing the total staff team in making this work.

I see the move as another exciting development and hope that all staff involved will use their usual enthusiasm and commitment to help put together positively the next stage of family centre concept.
Appendix F, Document 2

ROUTINE OF THE INTENSIVE TRAINING UNIT

ON ADMISSION ALL RESIDENTS WILL BE EXPECTED TO BATHE AND HAVE A HAIR WASH.

DEPENDANT UPON THE STATE OF THEIR CLOTHES (WHICH IN NEARLY ALL CASES WILL NEED ATTENTION) THE RESIDENT WILL BE EXPECTED TO WASH AND DRY ALL CLOTHING (THE EXCEPTION WILL BE THAT IF ADMITTED OVERNIGHT THAT THIS TASK SHOULD BE COMPLETED FOLLOWING MORNING).

AT THE EARLIEST POSSIBLE TIME RESIDENTS WILL BE EXPLAINED THE "RULES OF THE HOUSE" WHICH ARE:

NO WANDERING AROUND MAIN SEMI-STAFFED BUILDING WITHOUT PERMISSION AND/OR SUPERVISION.

NO SMOKING WITHOUT PERMISSION.

NO TELEVISION WITHOUT PERMISSION.

NO RADIO WITHOUT PERMISSION.

NO MAKING DRINKS WITHOUT PERMISSION.

NO COMMUNICATING OUT OF WINDOWS WITHOUT PERMISSION.

DO AS IS TOLD.

The training part of the unit will be linked to social and life skills, behavioural and educational and so the individual programmes will contain aspects of each.

Residents will be expected to provide for themselves by carrying out all domestic tasks themselves i.e., cooking, washing, ironing, hoovering et.

Staff will be involved throughout a residents stay in observing and assessing the individual and the programme of training will slowly expand to trust and responsibility.

The early part of a programme will usually consist of pre-set "getting up" and "bedtimes" as follows:

RISE AT 7.00am.    BEDTIME 8.00pm.

The individual programme will be in every case constantly overseen by Tony/Phil and one if not both, will be regularly involved at least every two days in a review with the resident, this enabling the programme to be modified as needs arise.

All staff should keep an accurate daily log of events and observations. In cases where "punishments" are imposed these should be carried out strictly in accordance with the community home regulations and recorded accurately.

Leave will be granted according to progress, co-operation and achievement in respect of the residents individual training programme. Details of the approved leave will be completed on the leave form (copy of which is included in these guidelines) the leave form can only be completed and authorised by either Tony or Phil.
TO ALL STAFF, SEMI-STAFFED - 245 HARTSHILL ROAD

FOR PARTICULAR NOTICE TO ALL STAFF IN THE MAIN SEMI-STAFFED BUILDING IN THE INTENSIVE TRAINING UNIT

PLEASE NOTE THE FOLLOWING INSTRUCTIONS:

1. SEMI-STAFFED RESIDENTS SHOULD NOT AT ANY TIME BE ASSOCIATING WITH RESIDENTS IN THE INTENSIVE TRAINING UNIT.

2. SEMI-STAFFED RESIDENTS SHOULD AT NO TIME BE MAKING OR RECEIVING CALLS ON THE SEMI-STAFFED OFFICE TELEPHONE. CALLS TO SOCIAL WORKERS AND PARENTS CAN BE MADE AT STAFF DISCRETION - BUT THESE SHOULD BE LOGGED DOWN ON EVERY OCCASION IN THE BOOK PROVIDED BY THE TELEPHONE. ON THE OCCASIONS WHEN THE PHONE IS PERMITTED THE PHONE IN THE STAFF SLEEPING IN ROOM SHOULD BE USED.

3. IN THE EVENT OF AN INCOMING CALL FOR A SEMI-STAFFED RESIDENT (WHICH SHOULD ONLY BE FROM SOCIAL WORKERS, PARENTS OR AT STAFF DISCRETION) THESE CALLS SHOULD BE TAKEN ON THE TELEPHONE IN THE SLEEPING IN ROOM AND NOT IN THE OFFICE.

NO INCOMING CALLS SHOULD BE ALLOWED FOR RESIDENTS IN THE INTENSIVE TRAINING UNIT UNLESS AGREED PREVIOUSLY BY TONY OR PHIL.

4. SHARON SHOULD UNDER NO CIRCUMSTANCES BE ALLOWED IN THE INTENSIVE TRAINING UNIT AND THE BABY ALARM WILL BE FIXED PERMANENTLY TO PREVENT THE NEED FOR THIS TO HAPPEN.

5. RESIDENTS IN THE INTENSIVE TRAINING UNIT SHOULD NOT BE FOUND WANDERING WITHOUT SUPERVISION IN THE MAIN PART OF THE SEMI-STAFFED UNIT.

THE PHILOSOPHY BEHIND THE INTENSIVE TRAINING UNIT IS UNDERMINED IF THE "RULES OF THE ESTABLISHMENT" ARE NOT STRICTLY ADHERED TO.

RESIDENTS SHOULD BE ABLE TO FUNCTION IN THE INTENSIVE TRAINING UNIT WITHOUT HAVING TO USE FACILITIES OF THE MAIN SEMI-STAFFED UNIT - I.E., WASHING, BATHING, COOKING, WASHING UP ETC., ETC. IF FACILITIES ARE INADEQUATE TO ACHIEVE THIS I WOULD ASK STAFF TO NOTIFY ME IMMEDIATELY.

THE PASSING OF CIGARETTES AND MESSAGES AND OTHER "GOODIES" IS OBVIOUSLY REGULARLY HAPPENING AND THIS SHOULD BE REDUCED TO AN ABSOLUTE MINIMUM.

THE PROGRAMMES FOR INDIVIDUAL RESIDENTS AT THE INTENSIVE TRAINING UNIT IS WORKED OUT SPECIFICALLY AND IN DETAIL BY TONY/PHIL AND SHOULD NOT BE DEVIAITED FROM UNDER ANY CIRCUMSTANCES WITHOUT THEIR PRIOR APPROVAL.

TONY AND PHIL SHOULD BE CONTACTED AT HOME IF ANY POINTS REGARDING RESIDENTS NEED SOME CLARIFICATION:

TEL. NO. - TONY - 644605 or 658751
PHIL - 615985

OBVIOUSLY IT IS EASY FOR THE RESIDENTS OF THE INTENSIVE TRAINING UNIT TO ABSCOND IF LEFT UNSUPERVISED AND I WOULD THEREFORE ASK THAT THE OCCASIONS WHEN THEY ARE LEFT UNSUPERVISED BE TO THE MINIMUM TO AVOID THIS SITUATION ARISING. IN THE MAIN SUPERVISION OF THE INTENSIVE TRAINING IS ACHIEVED SEPERATELY FROM THAT OF THE MAIN SEMI-STAFFED UNIT BUT OBVIOUSLY THERE WILL BE TIMES WHEN JOINT SUPERVISION IS APPROPRIATE.
APPENDIX 1.

BASIC PROGRAMME

A total loss of all privileges e.g. television, radio, cigarettes, visitors (other than family and Social Workers) no nights out.

7.00 a.m. Rise and bath
7.30 a.m. Breakfast to be taken in room
8.00 a.m. Supervised activities and individual sessions
12.30 p.m. Lunch to be taken in room
1.00 p.m. Supervised activities and individual sessions
5.00 p.m. Evening meal to be taken in room
6.00 p.m. Bath
7.00 p.m. Lights out and bed

Visitors to be allowed by prior arrangement.

Privileges are to be earned through co-operation with staff and decided upon at specified review times. Failure to sustain co-operation will automatically lose the right for privileges and the basic programme will again be enforced e.g. later bedtimes taken off - cigarettes withdrawn etc.
DAILY TASKS - INTENSIVE TRAINING UNIT

These jobs are to be done either by Intensive Training Unit residents or by staff on duty:

- carpets to be hoovered morning and night,
- dishes to be washed after each meal and put away,
- bins to be emptied and washed out,
- rooms to be dusted and kept tidy,
- corridors to be kept clear at all times,
- bath, sink and toilet to be cleaned daily including bathroom floor,
- beds to be made on getting up,
- underwear to be washed daily and changed,
- cleaning of shoes (where appropriate),
- ashtrays washed and emptied (where appropriate).

WEEKLY TASKS

- reviews will be done each Tuesday, it is expected that the staff on duty will be present together with the Area Officer, Team Leader, Keyworker and/or Social Worker, parent where appropriate,
- all washing to be done e.g., washed, dried and ironed, including towels, tea cloths, sheets etc.; no clothes to be worn un-ironed
- cleaning of windows,
- washing down of paintwork, window ledges, door frames, skirting boards, window frames etc.,
- bedding to be topped and bottomed,
- nightwear to be changed,
- hoovering under beds and all other furniture in room,
- polishing of all wooden furniture.

OTHER TASKS - FORTNIGHTLY/MONTHLY

- washing down of walls,
- washing of light shades,
- washing, drying and ironing of all curtains,
- cleaning of cutlery e.g., knives, forks spoons, (supervised)

These lists are not exclusive nor exhaustive and staff are reminded to ensure that these jobs are done properly, not rushed and one to a reasonable standard.
DAILY TASKS.

These jobs to be done either by Unit residents or by staff on duty:

carpet to be hoovered morning and night,
dishes to be washed after each meal and put away,
bins to be taken out and emptied,
rooms to be dusted and kept tidy,
corridors to be kept clear at all times,
bathroom, sink and toilet to be cleaned daily including bathroom floor,
beds to be made on getting up,
underwear to be washed daily and changed,
cleaning of shoes (where appropriate).

WEEKLY TASKS.

As this will be done weekly, it is expected that staff on duty will be present together with the Team Leader, Keyworker and/or Social Worker, parent where appropriate.
all washing to be done e.g. washed, dried and ironed; including towels, teacloths, sheets etc.; no clothes to be worn un-ironed,
cleaning of windows,
washing down of paintwork, window ledges, door frames, skirting boards, window frames etc.
baking to be topped and bottomed,
nightwear to be changed,
hoovering under beds and all other furniture in room,
polishing of all wooden furniture.

OTHER TASKS - fortnightly/monthly.

- washing down of walls,
- washing of light shades,
- washing, drying and ironing of all curtains,
- cleaning of cutlery e.g., knives, forks, spoons (supervised).

These lists are not exclusive nor exhaustive and staff are reminded to ensure that these jobs are done properly, not rushed and done to a reasonable standard.
TO ALL STAFF 245 HARTSHILL ROAD

FOR PARTICULAR NOTICE OF ALL STAFF ON THE MAIN LANDING AND THOSE IN THE PIN DOWN UNIT.

PLEASE NOTE THE FOLLOWING INSTRUCTIONS.

245 RESIDENTS SHOULD NOT AT ANY TIME BE ASSOCIATING WITH RESIDENTS IN THE PIN
DOWN UNIT.

245 RESIDENTS SHOULD AT NO TIME BE MAKING OR RECEIVING CALLS ON THE DUTY OFFICE
TELEPHONE. CALLS TO SOCIAL WORKERS AND PARENTS CAN BE MADE AT STAFF DISCRETION -
BUT THESE SHOULD BE LOGGED DOWN ON EVERY OCCASION IN THE BOOK PROVIDED BY THE
TELEPHONE. ON THE OCCASIONS WHEN THE PHONE IS PERMITTED THE PHONE IN THE STAFF
SLEEPING IN ROOM SHOULD BE USED.

IN THE EVENT OF AN INCOMING CALL FOR A RESIDENT (WHICH SHOULD ONLY BE FROM SOCIAL
WORKERS, PARENTS OR AT STAFF DISCRETION) THESE CALLS SHOULD BE TAKEN ON THE TELEPHONE
IN THE SLEEPING IN ROOM AND NOT IN THE OFFICE.

INCOMING CALLS SHOULD BE ALLOWED FOR RESIDENTS IN THE UNIT UNLESS AGREED
PREVIOUSLY BY THE TEAM LEADER.

RESIDENTS IN THE PIN DOWN UNIT SHOULD NOT BE FOUND WANDERING WITHOUT SUPERVISION
IN THE MAIN PART OF THE 245 UNIT.

THE PHILOSOPHY BEHIND THE PIN DOWN UNIT IS UNDERMINED IF THE "RULES OF THE
ESTABLISHMENT" ARE NOT STRICTLY ADHERED TO.

RESIDENTS SHOULD BE ABLE TO FUNCTION IN THE UNIT WITHOUT HAVING TO USE FACILITIES
OF THE MAIN UNIT - i.e., WASHING, BATHING... IF FACILITIES ARE INADEQUATE TO ACHIEVE
THIS I WOULD ASK STAFF TO NOTIFY ME IMMEDIATELY.

THE PASSING OF CIGARETTES AND OTHER NOODLES AND OTHER "GOODIES" MUST NOT HAPPEN.

THE PROGRAMME FOR INDIVIDUAL RESIDENTS AT THE UNIT IS WORKED OUT SPECIFICALLY
AND IN DETAIL BY TEAM LEADER AND SHOULD NOT BE DEViated FROM UNDER ANY CIRCUMSTANCES
WITHOUT PRIOR APPROVAL.

OBVIOUSLY IT IS EASY FOR THE RESIDENTS OF THE PIN DOWN UNIT TO ABSCOND IF LEFT
UNSUPERVISED AND I WOULD THEREFORE ASK THAT THE OCCASIONS WHEN THEY ARE LEFT
UNSUPERVISED BE CUT TO THE MINIMUM TO AVOID THIS SITUATION ARISING. IN THE MAIN
SUPERVISION OF THE INTENSIVE TRAINING IS ACHIEVED SEPARATELY FROM THAT OF THE MAIN
UNIT BUT OBVIOUSLY THERE WILL BE TIMES WHEN JOINT SUPERVISION IS APPROPRIATE.
Appendix F, Document 3

INTENSIVE TRAINING UNIT

This book is to remain in the Intensive Training Unit office and all staff are asked to make themselves fully conversant with the contents.

A.D. Latham
TO ALL STAFF, SEMI-STAFFED - 245 HARTSHILL ROAD

FOR PARTICULAR NOTICE TO ALL STAFF IN THE MAIN SEMI-STAFFED BUILDING IN THE INTENSIVE TRAINING UNIT

PLEASE NOTE THE FOLLOWING INSTRUCTIONS:

1. SEMI-STAFFED RESIDENTS SHOULD NOT AT ANY TIME BE ASSOCIATING WITH RESIDENTS IN THE INTENSIVE TRAINING UNIT.

2. SEMI-STAFFED RESIDENTS SHOULD AT NO TIME BE MAKING OR RECEIVING CALLS ON THE SEMI-STAFFED OFFICE TELEPHONE. CALLS TO SOCIAL WORKERS AND PARENTS CAN BE MADE AT STAFF DISCRETION - BUT THESE SHOULD BE LOGGED DOWN ON EVERY OCCASION IN THE BOOK PROVIDED BY THE TELEPHONE. ON THE OCCASIONS WHEN THE PHONE IS PERMITTED THE PHONE IN THE STAFF SLEEPING IN ROOM SHOULD BE USED.

3. IN THE EVENT OF AN INCOMING CALL FOR A SEMI-STAFFED RESIDENT (WHICH SHOULD ONLY BE FROM SOCIAL WORKERS, PARENTS OR AT STAFF DISCRETION) THESE CALLS SHOULD BE TAKEN ON THE TELEPHONE IN THE SLEEPING IN ROOM AND NOT IN THE OFFICE.

   NO INCOMING CALLS SHOULD BE ALLOWED FOR RESIDENTS IN THE INTENSIVE TRAINING UNIT UNLESS AGREED PREVIOUSLY BY TONY OR PHIL.

4. SHARON SHOULD UNDER NO CIRCUMSTANCES BE ALLOWED IN THE INTENSIVE TRAINING UNIT AND THE BABY ALARM WILL BE FIXED PERMANENTLY TO PREVENT THE NEED FOR THIS TO HAPPEN.

5. RESIDENTS IN THE INTENSIVE TRAINING UNIT SHOULD NOT BE FOUND WANDERING WITHOUT SUPERVISION IN THE MAIN PART OF THE SEMI-STAFFED UNIT.

THE PHILOSOPHY BEHIND THE INTENSIVE TRAINING UNIT IS UNDERMINED IF THE "RULES OF THE ESTABLISHMENT" ARE NOT STRICTLY ADHERED TO.

RESIDENTS SHOULD BE ABLE TO FUNCTION IN THE INTENSIVE TRAINING UNIT WITHOUT HAVING TO USE FACILITIES OF THE MAIN SEMI-STAFFED UNIT - I.E., WASHING, BATHING, COOKING, WASHING UP ETC., ETC. IF FACILITIES ARE INADEQUATE TO ACHIEVE THIS I WOULD ASK STAFF TO NOTIFY ME IMMEDIATELY.

THE PASSING OF CIGARETTES AND MESSAGES AND OTHER "GOODIES" IS OBVIOUSLY REGULARLY HAPPENING AND THIS SHOULD BE REDUCED TO AN ABSOLUTE MINIMUM.

THE PROGRAMMES FOR INDIVIDUAL RESIDENTS AT THE INTENSIVE TRAINING UNIT IS WORKED OUT SPECIFICALLY AND IN DETAIL BY TONY/PHIL AND SHOULD NOT BE DEVIATED FROM UNDER ANY CIRCUMSTANCES WITHOUT THEIR PRIOR APPROVAL.

TONY AND PHIL SHOULD BE CONTACTED AT HOME IF ANY POINTS REGARDING RESIDENTS NEED SOME CLARIFICATION:

   TEL. NO. - TONY - 644805 or 658751
   PHIL - 615985

OBVIOUSLY IT IS EASY FOR THE RESIDENTS OF THE INTENSIVE TRAINING UNIT TO ABSCOND IF LEFT UNSUPERVISED AND I WOULD THEREFORE ASK THAT THE OCCASIONS WHEN THEY ARE LEFT UNSUPERVISED BE CUT TO THE MINIMUM TO AVOID THIS SITUATION ARISING. IN THE MAIN SUPERVISION OF THE INTENSIVE TRAINING IS ACHIEVED SEPARATELY FROM THAT OF THE MAIN SEMI-STAFFED UNIT. BUT OBVIOUSLY THERE WILL BE TIMES WHEN JOINT SUPERVISION IS APPROPRIATE.
ON ADMISSION ALL RESIDENTS WILL BE EXPECTED TO BATH AND HAVE A HAIR WASH

DEPENDANT UPON THE STATE OF THEIR CLOTHES (WHICH IN NEARLY ALL CASES
WILL NEED ATTENTION) THE RESIDENT WILL BE EXPECTED TO WASH AND DRY
ALL CLOTHING (THE EXCEPTION WILL BE TAKEN IF ADMITTED OVERNIGHT THAT
THIS TASK SHOULD BE COMPLETED FOLLOWING MORNING).

AT THE EARLIEST POSSIBLE TIME RESIDENTS WILL BE EXPLAINED THE "RULES
OF THE HOUSE" WHICH ARE:

NO WANDERING AROUND MAIN SEMI-STAFFED BUILDING WITHOUT PERMISSION
AND/OR SUPERVISION.

NO SMOKING WITHOUT PERMISSION.

NO TELEVISION WITHOUT PERMISSION.

NO RADIO WITHOUT PERMISSION.

NO MAKING DRINKS WITHOUT PERMISSION.

NO COMMUNICATING OUT OF WINDOWS WITHOUT PERMISSION.

DO AS IS TOLD.

The training part of the unit will be linked to social and life skills,
behavioural and educational and so the individual programmes will
contain aspects of each.

Residents will be expected to provide for themselves by carrying out
all domestic tasks themselves i.e., cooking, washing, ironing, hoovering et

Staff will be involved throughout a residents stay in observing and
assessing the individual and the programme of training will slowly
expand to trust and responsibility.

The early part of a programme will usually consist of pre-set "getting
up" and "bedtimes" as follows:

RISE AT 7.00am.        BEDTIME 8.00pm.

The individual programme will be in every case constantly overseen by
Tony/Phil and one if not both, will be regularly involved at least
every two days in a review with the resident, this enabling the
programme to be modified as needs arise.

All staff should keep an accurate daily log of events and observations.
In cases where "punishments" are imposed these should be carried out
strictly in accordance with the community home regulations and recorded
accurately.

Leave will be granted according to progress, co-operation and achieve-
ment in respect of the residents individual training programme.
Details of the approved leave will be completed on the leave form
(copy of which is included in these guidelines) the leave form can
only be completed and authorised by either Tony or Phil.
DAILY TASKS - INTENSIVE TRAINING UNIT

These jobs are to be done either by Intensive Training Unit residents or by staff on duty:
- carpets to be hoovered morning and night,
- dishes to be washed after each meal and put away,
- bins to be emptied and washed out,
- rooms to be dusted and kept tidy,
- corridors to be kept clear at all times,
- bath, sink and toilet to be cleaned daily including bathroom floor,
- beds to be made on getting up,
- underwear to be washed daily and changed,
- cleaning of shoes (where appropriate),
- ashtrays washed and emptied (where appropriate).

WEEKLY TASKS

- reviews will be done each Tuesday, it is expected that the staff on duty will be present together with the Area Officer, Team Leader, Keyworker and/or Social Worker, parent where appropriate,
- all washing to be done e.g., washed, dried and ironed, including towels, teatowels, sheets etc., no clothes to be worn un-ironed
- cleaning of windows,
- washing down of paintwork, window ledges, door frames, skirting boards, window frames etc.,
- bedding to be topped and bottomed,
- nightwear to be changed,
- hoovering under beds and all other furniture in room,
- polishing of all wooden furniture.

OTHER TASKS - FORTNIGHTLY/MONTHLY

- washing down of walls,
- washing of light shades,
- washing, drying and ironing of all curtains,
- cleaning of cutlery e.g., knives, forks, spoons, (supervised)

These lists are not exclusive nor exhaustive and staff are reminded to ensure that these jobs are done properly, not rushed and one to a reasonable standard.
ROUTINE OF THE INTENSIVE TRAINING UNIT

ON ADMISSION ALL RESIDENTS WILL BE EXPECTED TO BATH AND HAVE A HAIR WASH

DEPENDANT UPON THE STATE OF THEIR CLOTHES (WHICH IN NEARLY ALL CASES WILL NEED ATTENTION) THE RESIDENT WILL BE EXPECTED TO WASH AND DRY ALL CLOTHING (THE EXCEPTION WILL BE THAT IF ADMITTED OVERNIGHT THAT THIS TASK SHOULD BE COMPLETED FOLLOWING MORNING).

AT THE EARLIEST POSSIBLE TIME RESIDENTS WILL BE EXPLAINED THE "RULES OF THE HOUSE" WHICH ARE:

NO WANDERING AROUND MAIN SEMI-STAFFED BUILDING WITHOUT PERMISSION AND/OR SUPERVISION.

NO SMOKING WITHOUT PERMISSION.

NO TELEVISION WITHOUT PERMISSION.

NO RADIO WITHOUT PERMISSION.

NO MAKING DRINKS WITHOUT PERMISSION.

NO COMMUNICATING OUT OF WINDOWS WITHOUT PERMISSION.

DO AS IS TOLD.

The training part of the unit will be linked to social and life skills, behavioural and educational and so the individual programmes will contain aspects of each.

Residents will be expected to provide for themselves by carrying out all domestic tasks themselves i.e., cooking, washing, ironing, hoovering etc.

Staff will be involved throughout a residents stay in observing and assessing the individual and the programme of training will slowly expand to trust and responsibility.

The early part of a programme will usually consist of pre-set "getting up" and "bedtimes" as follows:

RISE AT 7.00am.   BEDTIME 8.00pm.

The individual programme will be in every case constantly overseen by Tony/Phil and one if not both, will be regularly involved at least every two days in a review with the resident, this enabling the programme to be modified as needs arise.

All staff should keep an accurate daily log of events and observations. In cases where "punishments" are imposed these should be carried out strictly in accordance with the community home regulations and recorded accurately.

Leave will be granted according to progress, co-operation and achievement in respect of the residents individual training programme. Details of the approved leave will be completed on the leave form (copy of which is included in these guidelines) the leave form can only be completed and authorised by either Tony or Phil.
APPENDIX 1.

BASIC PROGRAMME

A total loss of all privileges e.g. television, radio, cigarettes, visitors (other than family and Social Workers) no nights out.

7.00 a.m. Rise and bath

7.30 a.m. Breakfast to be taken in room

8.00 a.m. Supervised activities and individual sessions

12.30 p.m. Lunch to be taken in room

1.00 p.m. Supervised activities and individual sessions

5.00 p.m. Evening meal to be taken in room

6.00 p.m. Bath

7.00 p.m. Lights out and bed

Visitors to be allowed by prior arrangement.

Privileges are to be earned through co-operation with staff and decided upon at specified review times. Failure to sustain co-operation will automatically lose the right for privileges and the basic programme will again be enforced e.g. later bedtimes taken off - cigarettes withdrawn etc.
CODE OF INSTRUCTIONS - ENCLOSURE TO CENTRAL OFFICE CIRCULAR NO. 16/79 DATED
10TH JANUARY, 1979

COMMUNITY HOMES REGULATIONS, 1972

REGULATION 10 - CONTROL

The authorised measures of control to maintain discipline in Community Homes are given below. They are not to be exceeded.

Officers-in-Charge must ensure that all the staff of the Home read this circular and understand its instructions.

If there are any doubts or misunderstandings or need for clarification the Director of Social Services should be consulted promptly.

1. The control of a Community Home shall be maintained on the basis of good personal and professional relationships between the staff and the children resident in the Home.

   This does not mean that standards need be lax nor attitudes or staff unduly permissive. Control and discipline is essential to the good development of a child as well as to good order. It does mean that the control of children's behaviour, individually and in groups, should be maintained primarily by the personal influence achieved through gaining their confidence and respect.

2. Control by the use of personal and professional relationships with children is not always sufficient to maintain discipline and sanctions or other means of control may have to be used. Sanctions are penalties for unacceptable behaviour, but in appropriate circumstances rewards can be given to encourage good behaviour - both have their place in maintaining discipline.

   Penalties can be applied, with the prior agreement of the Officer-in-Charge, in the form of the temporary denial of privileges or the imposition of an unwelcome chore. The guiding principle in applying sanctions is fairness and consistency and the aim should be to make the child realise that adherence to acceptable forms of conduct is desirable. Penalties must be only in the form described as follows:-

   (i) Forfeiture of privileges

   (ii) Loss or restriction of recreation, such as exclusion for special treats, organised trips, visits to football matches, watching television, etc. but not to include loss of visits to or from relatives and not to include loss of any necessary recreational activity.

   (iii) Reduction of pocket money, but only as a contribution to the cost of restitution in cases of wilful damage.

   (iv) Imposition of a minor but unwelcome chore.

   (v) The smacking of the bare hands of children up to the age of 10 years, where no other forms of control is likely to be effective, provided that the smacking is carried out by the Officer-in-Charge of the Home or other persons designated by the Officer-in-Charge for that purpose. To be effective this punishment should be carried out at the time the offence is committed or discovered or immediately afterwards.
3. With the specific exceptions set out in paragraph 4 below, corporal punishment is not permitted as a way of controlling, correcting or punishing the behaviour of any child in the care of the County Council for any reason. Corporal punishment means the infliction of pain or discomfort on another person by any means as a form of punishment or chastisement.

4. The exceptions to this rule are (a) as described in paragraph 2 (iv) above and (b) at Chadwell Observation and Assessment Centre and Riverside Community Home School only, where its use is subject to the following conditions:

   (i) No corporal punishment shall be administered by any person except the Officer-in-Charge of the Home or in his absence from duty the Deputy Officer-in-Charge.

   (ii) No corporal punishment shall be administered to girls.

   (iii) No corporal punishment shall be administered to a boy who has reached school-leaving age.

   (iv) No corporal punishment shall be administered to a boy except caning of the posterior of the boy with a cane approved by the Secretary of State applied over the boy’s ordinary clothing to the extent of six strokes or less.

   (v) No caning shall be administered in the presence of another child.

   (vi) No corporal punishment shall be administered, without the sanction of the Medical Officer to the home, to any child known to have any physical or mental disability.

5. To conform with the requirement contained in paragraph (4) of Regulation 10 of the Community Homes Regulations all instances in which additional measures of control (i.e. those described in paragraph 2 (i) to (v)) and paragraphs 3 and 4) have been used, must be recorded at the time "in a permanent form by the person in charge of the Home and the record shall be kept in the House".

Any application of measures of control should therefore be recorded in an appropriate record book specially maintained for the purpose - the "Measures of Control Record Book". In this book there should be recorded not only all instances of corporal punishment (which can only be appropriate at Riverside and Chadwell), but also all the measures detailed in paragraph 2 above whenever it has been necessary to impose any of them.
Staffordshire County Council

60 Foregate Street, Stafford ST16 2PV
Telephone J121 Extension 7030

Mrs. E. Brennan,
Principal Area Officer,
Newcastle.

My ref 4/NPC/FH/MHF
Your ref
Date 22nd November, 1984

Dear Mrs. Brennan,

245 HARTSHILL ROAD, STOKE-ON-TRENT

I write with reference to the short stay facilities currently operating in the maisonette at 245 Hartshill Road.

Whilst I fully appreciate the positive work in progress, I have decided after lengthy discussion on the matter, to lay down a number of safeguards for children and staff which must be adhered to at all times.

The instructions are as follows:-

1. Control implied or imposed by staff should at all times be implied or imposed in a manner consistent with good child care practice.

2. No more than 10 children's beds are to be utilised at any one time at Hartshill Road, this number to include a maximum of 4 in the staff maisonette.

3. The use of the terms special or intensive should be discontinued.

4. Statutory Visitors must be given access as required, to the maisonette and all parts of the building.

5. The minimum level of staff cover at Hartshill Road, should be Residential Care Officer Grade 2 or Social Work Assistant Level 2. If semi-staffed staff are used in connection with the activities in the maisonette they should be made fully aware of their responsibilities in this respect.

6. In normal circumstances, only one sleeping-in allowance per night will be paid at Hartshill Road. If circumstances arise that warrant a second person sleeping-in, clearance must be obtained on each occasion from Central Office.
7. All measures of control taken must comply with the Community Homes Regulation 10, Control, and should be recorded in the appropriate book.

8. The practice of staff sleeping in the same room as children or on the landing outside the room must be discontinued.

9. The use of additional recreation when defined as a punishment must be discontinued.

10. No internal doors in the unit must be locked at any time, including the door leading from the maisonette to the main establishment.

The practice of the removal of a child's clothes and the substitution of pyjamas or P.E. kit, etc., to deter absconding, falls outside the Community Homes Regulations. However, I wish to give this matter more general consideration before I issue a final instruction. I would ask you, therefore, to attempt in the intervening period not to use this practice, pending further guidance.

Will you please formally acknowledge the receipt of these instructions and ensure that all staff connected with the unit are made fully aware of them.

Yours sincerely,

[Signature]

Paul [Name]

Director of Social Services
Mr B.J. O'Neill, C.S.W.,
Director of Social Services,
Social Services Department,
69, Foregate Street,
Stafford.

Copy to Mr. A.R. Latham, Area Officer, (Children).


Dear Mr. O'Neill,

245, Hartshill Road,

I apologise for the delay in replying to your letter. Certainly the matter has been discussed with all the relevant staff concerned with the unit, and they are fully aware of the points you have raised.

Since you wrote your letter, there have been one or two developments.

Point 6 Mr. Spurr has agreed that I approve the sleeping-in allowance for the unit as it is impossible to obtain clearance on each occasion from Central Office. This I will watch carefully.

The only point I find difficult to accept is Point No. 10. The purpose of locking this is not to secure the children within the unit. This is not possible as in the corridor from that door to the unit, there is a fire door to the yard at the back. The purpose of locking this door is that the big general room is used by I.T., we have a lot of children who have no other connections other than I.T. in that building, and it stops them from wandering in areas which does not concern them. This, therefore, helps security and as you are already aware, security is a matter of great concern to us. I would be grateful if this instruction could be reviewed.

Yours sincerely,

E.A.P. Brennan
MRS. E.J.P. BRENNAN, B.A.(Gen) Dip.A.Soc.S.,
Principal Area Social Services Officer,
Newcastle Principal Area Office,
The Holborn,
Castle Hill Road,
Newcastle
STJ 2SX
Telephone: Newcastle 611411
Copy for Mr. A. R. Latham, Area Officer, Children

File < 14 14

Mrs. E. Brennan,
Principal Area Officer,
Newcastle.

4/FH/ShW EPB/WH 9th May 1985

Dear Mrs. Brennan,

245 HARTSHILL ROAD

Thank you for your letter of the 25th March acknowledging the instructions in respect of the unit at 245 Hartshill Road.

I note that the only point that you find difficult to accept is the instruction (point 10) to leave unlocked the door separating the unit from the main establishment.

After further consideration I would inform you that I am agreeable to the locking of this door by the use of the existing yale lock which will enable the door to be opened from the unit side as required but not from the establishment side. I would further ask you to make arrangements to remove the key to the mortice lock on this door. This arrangement should get round the problem of security but will continue to enable children to leave the unit by this door when necessary.

Yours sincerely,

[Signature]

Director of Social Services

215
Distribution:
Lists A, C, M
and 5 to Child Care Section.

Circular No. 138/86

My ref. 4/ER/JW

Date 26th June, 1986

Dear Sir/Madam,

RESTRICTION OF THE LIBERTY OF CHILDREN IN CARE

I should be pleased if you would ensure that the following information is passed to all of your Child Care staff involved in fieldwork or at residential establishments. It is important that all staff are familiar with the legal situation concerning the restriction of liberty of children in care.

I have received a publication from the Social Services Inspectorate entitled "Secure Accommodation for Children and Young Persons: Guidance for Local Authorities 1986". I do not propose distribution of this publication, but should you, or the Area Officer (Child Care) wish to have sight of it, please contact Mrs. B. Robinson, Assistant Director (Children and Families).

I would, however, draw the following points from the publication to your attention, and I should be pleased if you would ensure that there is no breach of the legal requirements governing restriction of liberty of children in care.

The Secure Accommodation (No. 2) Regulations 1983, define secure accommodation simply as "accommodation provided for the purpose of restricting the liberty of children". The Community Homes Regulations, 1972, provide the statutory framework for the management and conduct of Secure Accommodation. There is no approved Secure Accommodation in Staffordshire.

In order to safeguard the rights of the individual child and to assist those responsible for the running of Community Homes, it is essential that there is a clear understanding of what constitutes the restriction of liberty of a child. Measures may be taken in many community homes - either through staff practices or by physical means, e.g. locking doors, windows, etc. - which are intended for a variety of purposes such as preventing intruders, keeping young children safe, but which also have the effect of restricting the liberty of children. As a general rule, you should be guided by reference to ordinary, or normal domestic experience when assessing such practices within a Community Home.

The following forms of the restriction of liberty of children in care are not permitted except in accommodation approved for use as secure accommodation by the Secretary of State (of which there is none in Staffordshire):

Cont....
(a) The locking of a child or children in a single room at any time, even when accompanied by a responsible adult or adults.

(b) The locking of internal doors to confine a child or children in a certain section of a home, even when accompanied by a responsible adult or adults.

The following procedures will not be considered as constituting the restriction of the liberty of children, though they should be adopted only where they are acceptable to the Fire Prevention Officer, and consistent with building regulations, and conducive to a domestic atmosphere within the home:

(a) The locking of external doors and gates at night, consistent with normal domestic security.

(b) The locking of external doors and gates during the daytime where the purpose is to prevent intruders from gaining access to the home, provided that children are not prevented from going out.

(c) The securing of windows.

Control imposed or implied by staff or other responsible adults will not be considered to constitute the restriction of liberty, though control must always be imposed or implied in a manner consistent with good child care practices and Departmental Control Regulations.

Procedures designed to ensure the safety of children, which also have the effect of restricting their liberty may not be adopted unless they have been drawn to the attention of the Secretary of State, who will decide whether such procedures are acceptable. The Assistant Director (Children and Families) should be approached whenever doubt exists. (LAC[68]18 refers)

Yours faithfully,

[Signature]

Director of Social Services
To: List A
Plus
Principal Area Officers
Assistant Director (Child Care)
Officer-in-Charge, Riverside
Officer-in-Charge, Tan-y-Bryn
Central Office - Statutory Visitors

My ref. 4/ER/JW Your ref Date 25th October, 1986-

Circular No:

Dear Sir/Madam,

COMMUNITY HOMES REGULATIONS 1972
REGULATION 10 - CONTROL
SECURE ACCOMMODATION (NO.2) REGULATIONS 1982

Regulation 10 of the Community Homes Regulations requires annual review of the authorised measures of control. The Social Services Committee, at their meeting on 3rd June, 1986, confirmed their approval of the existing instructions to staff in regard to Regulation 10 of the Community Homes Regulations with the exception of Paragraph 4 (which had relevance to Riverside only). You will also note that in issuing the revised procedures, I have taken the opportunity to incorporate instructions relating to the restriction of the liberty of children in care as recently circulated. I now attach copies of the revised authorised instructions to staff, and I should be pleased if you would ensure that these are read and understood by all staff of establishments for children and that they each sign to confirm this; instructions for methods of recording that this requirement is observed are included.

Principal Area Officers are requested to distribute 2 copies per establishment to all residential child care establishments in their Area, and one copy to the Area Officer (Child Care), retaining a further copy for their information.

I should be pleased if you would ensure that the permanent records, as required, are maintained and that all measures of control are entered and authorised at the proper level, in the format suggested.

Yours faithfully,

B.J. O’NEILL, C.S.W.
Director of Social Services

69, Foregate Street, Stafford ST16 2PY
Telephone Stafford (0785) 3121 Ext.
Please ask for 7025
Mrs. E. Robinson

Director of Social Services

218
Community Homes Regulations 1972
Regulation 10 - Control - as reviewed and approved by the
Social Services Committee, 3rd June, 1982
Secure Accommodation (No.2) Regulations 1983

Two copies of the revised code of procedure are enclosed - one for easy access
and the other for record purposes as indicated below. The revised code
supersedes the previous instructions on the subject which were set out in my
Circular No. 16/79.

It is essential that it should be possible to verify that all staff of Community
Homes who are involved in any way with the care of children have had their
attention drawn to the approved measures of control. The record copy must be
retained in a separate file together with a permanent record of staff signatures
indicating that they have seen and fully understood the instructions. A copy
of a suitable pro-forma for this purpose is given below at (i). Care should be
taken to ensure that all newly appointed child care staff sign as having seen
the code immediately they take up duty, and have the regulations explained to
them in detail.

All Community Homes must also maintain a permanent record of all measures
of control as listed in paragraph 2 in the procedures or any other measures of any
kind, signed as indicated in the pro-forma, below at (ii). Any pocket money
withheld in respect of wilful damage (Para 2(iii)) must be paid into County
Funds and not paid direct elsewhere without the personal consent of the
Principal Area Officer in the circumstances of the case. The record of
measures of control must be made available to Statutory Visitors or other
Authorised Officers when required.

(i) Community Homes Regulations 1972
Regulation 10 - Control
Secure Accommodation (No.2) Regulations 1983

PRO-FORMA

To be signed by all staff involved in child care in Community Homes

I certify that I have read the Code of Instruction regarding the measures
submitted for the maintenance of discipline in Community Homes on the Social
Services Committee at their meeting on 3rd August, 1986, and that I understand
the limitations on the imposition of restriction of freedom of children.

<table>
<thead>
<tr>
<th>Date</th>
<th>Signature</th>
<th>Date</th>
<th>Signature</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
</table>

(ii) Community Homes Regulations 1972 - Regulation 10 - Control
Secure Accommodation (No.2) Regulations 1983
Record of Measures of Control

<table>
<thead>
<tr>
<th>Date</th>
<th>Name of Child Involved</th>
<th>Measure of Control Applied</th>
<th>Applied By</th>
<th>Signature of Authorising Officer</th>
</tr>
</thead>
</table>

(i)
COMMUNITY HOMES REGULATIONS 1972
REGULATION 10 - CONTROL (See Appendix 'A')

The authorised measures of control to maintain discipline in Community Homes are given below. They are not to be exceeded.

Team Leaders and Officers-in-Charge must ensure that all the staff of the Home read this circular, understand its instructions, and sign to confirm this. Further instructions for methods of recording this procedure are attached. (See Appendix 'A'). Team Leaders or Officers-in-Charge are responsible for control procedures within their establishments.

If there are any doubts or misunderstandings or need for clarification, the Assistant Director (Child Care) should be consulted promptly.

1. The control of a Community Home shall be maintained on the basis of good personal and professional relationships between the staff and the children resident in the Home assisted and supported by good management.

This does not mean that standards need be lax nor attitudes of staff unduly permissive. Control and discipline is essential to the good development of a child as well as to good order. It does mean that the control of children's behaviour, individually and in groups, should be maintained primarily by the personal influence achieved through gaining their confidence and respect.

2. Control by the use of personal and professional relationships with children is not always sufficient to maintain discipline and sanctions or other means of control may have to be used. Sanctions are penalties for unacceptable behaviour, but in appropriate circumstances rewards can be given to encourage good behaviour - both have their place in maintaining discipline.

Penalties can be applied, with the prior agreement of the Team Leader or Officer-in-Charge, in the form of the temporary denial of privileges or the imposition of an unwelcome chore. The guiding principle in applying sanctions is fairness and consistency and the aim should be to make the child realise that adherence to acceptable forms of conduct is desirable. Penalties must always be recorded in a permanent record book and only be in the form described as follows:

(i) Forfeiture of privileges.

(ii) Loss or restriction of recreation, such as exclusion from special treats, organised trips, visits to football matches, watching television, etc. but not to include loss of visits to or from relatives and not to include loss of any necessary recreational activity.

(iii) Reduction of pocket money, but only as a contribution to the cost of restitution in cases of wilful damage.

(iv) Imposition of a minor but unwelcome chore.

(v) The smacking of the bare hands of children up to the age of 10 years, where no other forms of control is likely to be effective, provided that the smacking is carried out by the Team Leader or the Officer who is in charge at the time. To be effective this punishment should be carried out at the time the offence is committed or discovered or immediately afterwards.

(ii)
3. With the specific exceptions set out in paragraph 2 (v) above, corporal punishment is not permitted as a way of controlling, correcting or punishing the behaviour of any child in the care of the County Council for any reason. Corporal punishment means the infliction of pain or discomfort on another person by any means as a form of punishment, chastisement, or restraint.

4. Necessary physical restraints on behaviour should be administered to girls by female staff only, except in exceptional circumstances with the specific consent of the Officer who is in charge at the time of the incident.

5. To conform with the requirement contained in paragraph (4) of Regulation 10 of the Community Homes Regulations all instances in which additional measures of control (i.e. those described in paragraph 2(i) to (v) and paragraph 4 have been used, must be recorded at the time in a permanent form by the person in charge of the home and the record shall be kept in the home. (This applies to all Community Homes, and all records must be available for inspection by Headquarters Staff when required.)
Secure Accommodation (No2) Regulations 1983
Secure Accommodation for Children and Young Persons: Guidance for Local Authorities 1988 (See Appendix B)

6. All staff must be familiar with the requirements of the Secure Accommodation (No.2) Regulations 1983, and the limitations on the imposition of restrictions of the liberty of children in care. (See attached Circular 138/88). Under the regulations the following forms of restriction are not permitted

(a) The locking of a child or children in a single room at any time, even when accompanied by a responsible adult or adults.

(b) The locking of internal doors to confine a child or children in a certain section of a home, even when accompanied by a responsible adult or adults.

The following procedures will not be considered as constituting the restriction of the liberty of children, though they should be adopted only where they are acceptable to the Fire Prevention Officer, and consistent with building regulations, and conducive to a domestic atmosphere within the home:

(a) The locking of external doors and gates at night, consistent with normal domestic security.

(b) The locking of external doors and gates during the daytime where the purpose is to prevent intruders from gaining access to the home, provided that children are not prevented from going out.

(c) The securing of windows.

Control imposed or implied by staff or other responsible adults will not be considered to constitute the restriction of liberty, though control must always be imposed or implied in a manner consistent with good child care practices and Departmental Control Regulations.

Procedures designed to ensure the safety of children which also have the effect of restricting their liberty may not be adopted unless they have been drawn to the attention of the Secretary of State, who will decide whether such procedure are acceptable. The Assistant Director (Children and Families) should be approached whenever doubt exists (LAC[83]18 refers).
PRINCIPLES BEHIND THE USE OF THE TIME OUT UNIT AT

245 HARTSHILL ROAD

Description of Unit

No. 245 Hartshill Road is a 10 bed residential unit, its operation is confined to two floors offering living accommodation together with two ex staff flats available for special needs use.

Traditionally that use has been confined to one flat being used for independent living training, the other flat has been used as a 'time out' or crisis intervention unit.

Although a community unit, one of three residential units within the juvenile justice scheme, 245 Hartshill Road, because of its physical characteristics and staff commitment, has offered support to colleagues at other Local Authority residential units. That support is by way of offering accommodation to young people presenting particularly disruptive, disturbed behaviour.

Philosophy

Residential child care units are increasingly facing the prospect of having to accommodate young people whose outlook on life is one of disenchantment, dissatisfaction, anti-authoritarian and fear. Typically they have no purpose or future and have often reacted negatively to any attempts at structuring their lives.

The concept 'pin down' is based on the belief that in order to affect any positive changes in our clients' response to their circumstances we have to establish a relationship with them: To achieve that end a structure of communication, understanding and trust has to be established.

Separating physically a young person from the group and offering an individual programme with intensive staff input is an integral element in achieving this goal.

Alternatives

Too frequently the care system and courts are faced with the prospect of remanding young people to custody or requests from the Local Authority for secure orders.

Either order leaves social workers with the prospect of working with their clients isolated from their community and home environment and the young person experiences being included on the criminal or behavioural tariff.
Referrals

Most referrals are from residential child care establishments experiencing behaviour difficulties for which they find it difficult to provide proper care for their residents. Traditionally, intensive programmes are offered for young people on a day basis. In such circumstances social workers would be attempting to maintain a client at home.

All referrals are considered within the context of minimal intervention and rehabilitation to the referring unit or community.

Framework of Operation

a) The ability to set an arena where the young person would be available for a long enough period to engage. It is difficult to address positive working with any young person who persistently abandons, or who is so disruptive, criminally intent, aggressive or presenting of other similar problems.

b) To enable the structure to have sufficient flexibility to accommodate the opportunity for sanctions and rewards - and working in the main towards the opportunity for the young persons return home at the earliest possible time.

c) To use the opportunity to confront and deal with the young person over issues in their lives requiring major address, i.e. Absconding, aggression, breakdown of relationships at home or elsewhere, non-school attendance either by refusal or exclusion, serious criminal behaviour, etc.

d) The purpose of such intensity is to saturate the young person, and to produce contracts or plans as quickly as possible to allow speedy progress to be made in achieving realistic plans in the young persons life. The child's commitment, as well as the families commitment, as with other professionals is an essential requirement to enable the plan to work. The concentration of effort by all concerned on the young person allows progress to be made which is not always readily made otherwise as a result of differing priorities.

The structure is serious, and designed to concentrate on the issues needed to be addressed. Its framework is controlled by very regular review procedures, usually daily, followed by at least a full review meeting of all interested individuals where at all possible weekly.

THE YOUNG PERSON IS PARTICIPANT IN ALL MEETINGS AND DISCUSSIONS, as it is considered an integral part of the working out with the young person to be at all times "up front" and "direct".

The basic structure/framework is as follows:

a) All young persons will firstly be required to have bath, and at the earliest possible opportunity will be medically examined (in the case of new admissions to care, or where it is felt it is necessary). Bathing and hairwash will be a regular morning and evening routine. The young person will be expected to knock on the UNLOCKED DOOR for staff's attention. Both these requirements demonstrate adherence to basic rules in the early stages.
b) All young persons will be expected to wear appropriate nightwear, pyjamas, etc. This does reduce the young persons motivation to running off and clothes are introduced very quickly when basic trust and commitment to stay in the programme and address issues is achieved. This is reviewed daily.

c) The working day commences at 7.00 a.m. with bath etc., followed by breakfast in their own room, followed by set work tasks, education type projects, meetings, constructive discussion time etc. In the early stages of the programme all meals are taken in their own room, some with staff, some without. Bedtime is 7.00 p.m.

d) Television, radio, etc. are earned and assessed daily. Usually these are earned by contracting time out for such opportunities either at home or other places.

e) Cigarettes, Reading material, etc., are individually contracted in the daily reviews.

f) Family visits, social worker visits are planned and encouraged to achieve differing objectives in the young persons plan. At no time is access by any authorised persons to the young person denied, the reverse is often true that an active encouragement is consciously made to involve parents, extended family and any other significant persons.

g) Review meetings can be often heated and charged with emotive feelings by the young person and their families. The need to use the role play within such meetings is a sound requirement to their success, i.e. Positive and negative relationships with the different persons working in the contract. However at all times an attempt is always made to identify workers in the plan to positively support the young person and assist them in producing a realistic working contract.

by Chris Walley
British Telecom,  
Stoke on Trent Area,  
35 Stafford Street,  
Hanley,  
Stoke on Trent.  
ST1 1BA.

8/REH/KW  

Dear Sirs,

245 HARTSHILL ROAD, STOKE ON TRENT - INSTALLATION OF ADDITIONAL LINE

The above Establishment is used by this Department as an annexe to our Family Centre, and due to the special work carried out at this Establishment the single line telephone system has been overloaded for some time.

In view of the above, I would be pleased if you could make the necessary arrangements for the installation of an additional telephone line as soon as possible.

Please contact Miss C. Taylor at 245 Hartshill Road to arrange a convenient date for your visit. The telephone number is Stoke on Trent 46699.

Yours faithfully,

[Signature]

Director of Social Services
INTERMEDIATE TREATMENT - PREVENTATIVE AND REHABILITATION WORK

It is impossible to divorce Intermediate Treatment from the strategy arising from the re-organisation of the Child Care system in relative terms to the ethos behind the Family Centre concept. In fact, it is the keystone to implementing, sustaining and resolving the difficulties surrounding the elements needed for a successful rehabilitation or preventative programme of work with both children and families. Formerly, one of the biggest downfalls of any such programme was to look at a situation in too much isolation and to attempt to treat the effect without treating the cause. This became evident in the embryonic stages of the re-organisation and the resurrection of the I.T. programme in Newcastle. A decision was made to treat both cause and effect simultaneously, not only from within the Community but also from within the residential setting. From this approach there emerged a substantial increase in the number of children being admitted into care on a voluntary basis. From a statistical point of view, the decision appeared to have been an incorrect one at that period, fears very quickly dissipated.

It was learned that each child had similar problems giving rise to similar effects but the causes were identified as being very different. As a result, it became necessary to draw up complex individual programmes and contracts to reintroduce both child and family into an acceptable environment from which both could operate effectively. Consequently, it was necessary to remove the complex type programmes into a setting more equipped and designed to cater towards a resolve, as opposed to operating from a general base where specialist work was impotent due to:

a) the lack of uniformity and approach,

b) the demands and interactions of other children, and

c) the adverse effect some of these more difficult children were imposing upon others.

A unit was set up detached from the main part of the residential building based at 245 Hartshill Road. In those days it was referred to as the special unit (Currently, known as the Offense Training Unit). This section of the building was recognised as the place where problematical children were placed. Being totally isolated and self-contained it enabled its residents to be observed, assessed, appraised and programmes developed. Above all, it enabled at times hard line punishment and reward tactics to be adopted without influence, prejudice or inconsistency. The unit was manned predominantly by the Intermediate Treatment Manager in its early days. However, as this so-called 'radical practice' of preventative and rehabilitation work was acknowledged the demand grew and further staff were drafted into its operations. A family, could be catered for within the unit in cases where it was pertinent to assess the interaction between parent and child. Occasionally, it was used for 'crash-pad' purposes. It was and still is a pliant and very important tool to use in many cases. Examples of the type of programmes and contracts devised are attached to this section for further explanation and guidance.
PREVENTATIVE AND REHABILITATION WORK - (cont'd)

To explain the evolution of these types of contracts* and programmes it is important to note that these were devised as a result of combined expertise and experience from three areas - Social Work, Residential Work and Community Work. Although the overall knowledge and experience was there to produce programmes to meet individual needs, these could not be implemented without the liaison and support of the other Birch's Family Centre staff and voluntary sector. Had E.T. been diagnosed to be what other areas classify as preventative work i.e. preventing admissions into care; preventing further criminal re-offending, a means of recourse at the disposal of the courts etc., the emphasis of the voluntary sector would not have featured as heavily. However, in Newcastle it was seen that any form of preventative or rehabilitation work should not be acted upon solely at the point of crisis. Indeed, steps should be taken well before this point to enable problems to be nipped in the bud. Hence, the wide age range of participants within the whole of the IT scene, coupled with counselling, ongoing assessment and appraisal via family meetings and reviews were introduced. This method enabled work towards resolving the many and diverse problems being encountered by families, schools, statutory agencies and the Courts.

It became important for the Courts and agencies dealing with problematic children and offenders in Newcastle, to understand and recognise the options available in dealing with these clients thus avoiding an unnecessary toppling over the tariff scale. This meant the acceptance of flexible approaches in dealing with common problems other than those channels normally enforced, for example, Detention Centre, Youth Custody, Care Orders. Meetings took place with the local Magistrates benches to discuss the provisions which could be made available to them when dealing with children placed before them. Regular reports back to the magistrates Court regarding progress of individuals were made via the Social Services Department and Probation Service.

Individual contracts and programmes were not only drawn up for the benefit of the Court, Social Services Department and Probation Service, but also for parents and schools. The contracts and programmes would denote punishment and rewards, immediate courses of action, specific goals, specific expectations, specific sanctions, time limits and controlled disciplines to be enforced by the appointed person. This enabled sanctions to be exercised not only by the Social Services Department or other agencies such as the Probation Service and Court but also parents and schools or others needing to develop this recognition from the individual client. Contracts largely remained static in content, but programmes needed to be fluid. Weekly reviews with the family and/or individual appraised and evaluated progress and if necessary new criteria were introduced. The majority of this work has to be scheduled in the evening to cater for parents being able to regularly participate. Benefits and privileges are earned by the child away from the scenario of care, as all too often, care in time of dispute at home always appears to be the glamorous option. Care is presented as a totally negative experience.
PREVENTATIVE AND REHABILITATION WORK - (cont'd)

which brings for discussion yet another issue.

Intermediate Treatment can either be a positive or negative experience dependant upon the analogy placed upon its interpretation. Positive I.T. is all the 'nice' things - holidays, camps, visits to places of interest etc. Negative I.T. is ensuring the participant clearly identifies, comes to terms with and works through his problems and is not allowed to take the easy way out. To be able to run both types of Intermediate Treatment there has to be clear boundaries set between the two. This is where the voluntary sector plays an extremely important role in providing the pleasant I.T. experiences. This work is comparatively easy as opposed to the negative I.T. work. The Intermediate Treatment Manager was initially involved in running various I.T. activity groups and counselling groups. The development of negative I.T. meant that the Intermediate Treatment Manager had to pull out of being a practitioner to develop the resources and man power to operate heavy end Intermediate Treatment programmes. This was possible due to the assistance of the Birches Family Centre staff and Social Services Aides becoming more confident, flexible and understanding of the type of work necessary to avoid receptions into care and further re-offending. Over the last twelve months the practitioners of this type of I.T. is done solely by Birches Family Centre staff in conjunction with the voluntary sector. The Intermediate Treatment Managers role is to provide and develop through the voluntary agencies the resources to be able to continue and offer the needs to implement individual programmes. Close liaison with the voluntary sector is essential in this respect.

*The meaning of contracts in this text refers to a framework of criteria laid down by which the individual needs to operate to succeed.
Appendix F, Document 5

IT IS ESSENTIAL THAT EACH CULDO IS MADE AWARE OF
THESE RULES AT THE TIME OF THEIR ADMISSION.

1. CLOTHES MUST BE REMOVED AND STORED IN THE
OFFICE, ON ARRIVAL, ALONG WITH MONEY, CIGARETTES
AND PERSONAL POSSESSIONS.

2. EACH CULDO MUST BATH AND WASH THEIR HAIR,
REGARDLESS OF THE TIME OF DAY (OR NIGHT), ON ARRIVAL.

3. RESIDENTS ARE ALLOWED NIGHT UNDERWEAR AND
DRESSING GOWN. NO FOOTWEAR OF ANY DESCRIPTION.

4. ALL MEALS MUST BE Eaten IN THE BEDROOM.
IF A CULDO WISHES TO GO TO THE BATHROOM, HAVE A DRINK
OR IMPACT INFORMATION THEY MUST KNOCK ON THE
BEDROOM DOOR AND WAIT FOR OUR STAFF TO ANSWER.

5. RESIDENTS MUST NOT COMMUNICATE WITH EACHOTHER.

6. RESIDENTS ARE NOT ALLOWED PERSONAL POSSESSIONS (E.G.
JEWELRY, BOOKS, MAKE-UP ETC.)

7. RESIDENTS ARE NOT ALLOWED TELEVISION, MUSIC,
MAGAZINES, CIGARETTES OR TELEPHONE CALLS. VISITS
FROM SOCIAL WORKERS ARE PERMISSION OF TEAMS
WISHING TO VISIT MUST ARRANGE THIS THROUGH THE
TEAM LEADER.

8. DURING THE DAY RESIDENTS SHOULD COMPLETE ANY
SCHOOL WORK AS SET—ADHERING STRICLY TO A 9AM-5PM
WORKING DAY WITH APPROPRIATE MEAL/DRINK BREAKS.
ALL BOOKS & WRITING MATERIALS SHOULD BE
REMOVED AFTER 4PM.

9. RESIDENTS RISE AT 7AM (INCLUDING WEEKENDS)
HAVE A BATH & WASH THEIR HAIR.

10. RESIDENTS MUST BE IN BED BY 7PM
(INCLUDING WEEKENDS) AFTER HAVING A BATH.
Appendix F, Document 6

INTRODUCTION

While I recognize that most people working in the arena of Social Work may have difficulty in coming to terms with the working practices of a pin down unit, i.e., possible infringements of rights, civil liberties etc., it has become necessary to devise such a unit within the structure of the 245 Community Unit. Past experiences have led us to believe that it offers a platform to begin some positive work with individuals and is a resource continually used and requested by other agencies for initial observations of the more difficult individuals.

The flexible use of this unit has enabled it to be a part of the many varied contracts formulated from the community unit through the family meetings. I enclose a statement of its expected operation to all staff working in this particular part of the unit.

READ
THE EARLIEST POSSIBLE TIME RESIDENTS WILL BE MADE AWARE OF THE "RULES OF THE

ABE" WHICH ARE:

WANDERING AROUND MAIN BUILDING WITHOUT PERMISSION AND/OR SUPERVISION.
SMOKING WITHOUT PERMISSION.
RADIO WITHOUT PERMISSION.
MAKING DRINKS WITHOUT PERMISSION.
COMMUNICATING OUT OF WINDOWS WITHOUT PERMISSION.

AS IS TOLD,

A training part of the unit will be linked to social and life skills, behavioural
domestic tasks themselves i.e., cooking, washing, ironing, hoovering etc.

All will be involved throughout a resident's stay in observing and assessing the
individual and the programme of training will slowly expand to trust and responsibility.

An individual programme will be in every case constantly overseen by the Team Leader
Intro Worker and if not both, will be regularly involved at least every two days in a
review with the resident, thus enabling the programme to be modified as the need arises.

All staff should keep an accurate daily log of events and observations. In cases where
punishments" are imposed these should be carried out strictly in accordance with the
Community home regulations and recorded accurately.

Leave will be granted according to progress, co-operation and achievement in respect of
the resident's individual training programme. Details of the approved leave will be
completed on the leave form (copy of which is included in these guidelines) the leave
form can only be completed and authorised by Team Leader.
THESE INSTRUCTIONS ARE TO BE CARRIED OUT BY ALL STAFF COVERING THE PIN DOWN UNIT WITHOUT FAIL. FOLLOWING THESE SIMPLE GUIDELINES WILL ENSURE CONSISTENCY IN WORKING THROUGH INDIVIDUAL PROGRAMMES FOR THE BENEFIT OF THE CHILDREN CONCERNED.

The Pin Down Unit is independent from the 245 accommodation and should be out of bounds to residents or visitors (unless prior arrangements for visitors have been made).

The door in the corridor to the Unit is to be kept closed at all times. No-one other than Unit staff are allowed into the Unit unless in cases of emergencies or by prior consent of the Team Leader.

Unit bedroom doors should remain closed at all times. Residents requiring to leave the room for any purpose must initially knock on the door and wait for the response from the member of staff on duty. No other person apart from the member of staff on duty should respond to the individual call.

Individual programmes will be devised upon entry as far as practically possible. In the event of the programme not having been established e.g., admitted late at night etc., instructions will be given to staff upon reception. The individual programme will be established the following morning during the management meeting.

Programmes will be designed by the Team Leader or other designated person. Likewise for the revision of programmes which will be done on a daily basis with the exception of Saturdays and Sundays. Requests for any privileges/freedoms which are asked for by the individual must initially turned down. Unit staff are requested to make a note of all requests and inform the individual that these will be discussed the following day for consideration. There must be no leeway given whatsoever.

Log books should be completed in detail and accurate records kept of things such as:-

- requests made by the individual,
- telephone calls received and made,
- attitude of individual e.g., highlighting difficulties encountered implementing the programme, co-operation received, conversations held, sickness/medical problems etc.
- details of privileges earned,
- details of any revision of the previous day's programme.
- visitors names and the duration of the visit,
- details of passes out etc.

Residential files should be completed daily by extracting information from the log book and expanding upon it in more detail, e.g., describing incidents, conversations, reactions to programme etc. A copy of the daily programme will be inserted in this file by the Unit staff on duty each morning following the management meeting enabling follow on staff or the individuals case worker to identify the point the individual has reached in the programme.

All medication should be noted when received and administered. This should be entered into the medicine record book held in the duty office.

Anyone requiring emergency medical treatment should be dealt with on the following lines:

A call should be made to the Doctors surgery for an appointment to be made. Reference to the appointment should be made to the individuals keyworker to enable him/her to escort the individual, or to make alternative arrangements.

Outside surgery hours - a call should still be made to the Doctors surgery (only in the case of emergency) where an answering message will be given indicating to whom the call should be made.

Individuals requiring emergency treatment i.e., Accident Unit or call for the ambulance should be dealt with under normal emergency procedures. Should Unit staff require assistance and no other staff are in the building a request for assistance should be made to the Birches Family Centre.

All accidents should be reported in triplicate and entered in the accident book.

All medical files relating to children in the Unit will be kept in the Unit office until such time that the individual is discharged. Initially, it will be the responsibility of the centre worker to ensure the individual to the Doctors. However Unit staff escorting individuals to the G.P should in all cases extract the Medical record card and ask for it to be completed by the G.P before leaving the surgery.

Outside visitors to an individual in the Unit must not be allowed unless it has been approved by the Team Leader. All visits that have not been approved by the Team
Leader should not be allowed to take place. Staff are instructed to inform the caller that their request to visit will be discussed the following morning and must contact the Unit after 9.30 am. the following morning, whereupon, they will be advised according.

In the event of such requests being made over the weekend the same principle should apply, but staff are asked to contact the Team Leader for a decision to be made in cases of difficulty or at the weekends if in doubt.

12. Individuals on remand or on bail to 245 Hartshill Road, in the Unit are on direct instruction from the Court to abide by certain conditions appertaining to their bail as offered by the Team Leader. It is imperative that all Unit staff ensure that these programmes are worked to the letter and in the event of difficulties you should contact the Team Leader immediately.

No-one in the Pin Down Programme should be left unsupervised. Staff should ask for assistance in the cases of emergency only by another member of staff (245 duty officer if they are called from their station of duty.

4. All staff rotas are the sole responsibility of the Team Leader. Changes of rota'd hours should be referred directly to the Team Leader for a decision to be made if alternative cover is required. Staff should not automatically assume that this will be granted and to avoid disappointment arrangements as far as possible should be made after the approval from the Team Leader has been given. (an example of this)

5. Unit staff are responsible whilst on duty for, checks will be made by the Team Leader.

The cleaning of the Unit block is a daily task and should be done morning and night.

6. Any education/paperwork done by individuals is to be marked daily. All paper and pencils etc., should be removed on completion of the exercise/education programme. All marked work should be kept in a folder indicating in separate pouches the subjects undertaken.

7. All punishments imposed should be strictly carried out after approval by the Team Leader in accordance with the Community Home Regulations. (Copy attached).

These instructions have been made for your benefit and for the benefit of the individual. Strict adherence is necessary by all Unit staff to ensure consistency of approach.

Good communication and reducing the rate of programme failure.

235
TO ALL STAFF 245 HARTMILL ROAD

FOR PARTICULAR NOTICE OF ALL STAFF ON THE MAIN LANDING AND THOSE IN THE PIN DOWN UNIT.

PLEASE NOTE THE FOLLOWING INSTRUCTIONS.

245 RESIDENTS SHOULD NOT AT ANY TIME BE ASSOCIATING WITH RESIDENTS IN THE PIN DOWN UNIT.

245 RESIDENTS SHOULD AT NO TIME BE MAKING OR RECEIVING CALLS ON THE DUTY OFFICE TELEPHONE. CALLS TO SOCIAL WORKERS AND PARENTS CAN BE MADE AT STAFF DISCRETION - BUT THESE SHOULD BE LOGGED DOWN ON EVERY OCCASION IN THE BOOK PROVIDED BY THE TELEPHONE. ON THE OCCASIONS WHEN THE PHONE IS PERMITTED THE PHONE IN THE STAFF SLEEPING IN ROOM SHOULD BE USED.

IN THE EVENT OF AN INCOMING CALL FOR A RESIDENT (WHICH SHOULD ONLY BE FROM SOCIAL WORKERS, PARENTS OR AT STAFF DISCRETION) THESE CALLS SHOULD BE TAKEN ON THE TELEPHONE IN THE SLEEPING IN ROOM AND NOT IN THE OFFICE.

NO INCOMING CALLS SHOULD BE ALLOWED FOR RESIDENTS IN THE UNIT UNLESS AGREED PREVIOUSLY BY THE TEAM LEADER.

RESIDENTS IN THE PIN DOWN UNIT SHOULD NOT BE FOUND WANDERING WITHOUT SUPERVISION IN THE MAIN PART OF THE 245 UNIT.

THE PHILOSOPHY BEHIND THE PIN DOWN UNIT IS UNDERMINED IF THE "RULES OF THE ESTABLISHMENT" ARE NOT STRICTLY ADHERED TO.

RESIDENTS SHOULD BE ABLE TO FUNCTION IN THE UNIT WITHOUT HAVING TO USE FACILITIES OF THE MAIN UNIT - i.e., WASHING, BATHING, .. IF FACILITIES ARE INADEQUATE TO ACHIEVE THIS I WOULD ASK STAFF TO NOTIFY ME IMMEDIATELY.

THE PASSING OF CIGARETTES AND OTHER MSSAGES AND OTHER "GOODIES" MUST NOT HAPPEN.

THE PROGRAMMES FOR INDIVIDUAL RESIDENTS AT THE UNIT IS WORKED OUT SPECIFICALLY AND IN DETAIL BY TEAM LEADER AND SHOULD NOT BE DEVIATED FROM UNLESS ANY CIRCUMSTANCES WITHOUT PRIOR APPROVAL.

OBVIOUSLY IT IS EASY FOR THE RESIDENTS OF THE PIN DOWN UNIT TO ABANDON IF LEFT UNSUPERVISED AND I WOULD THEREFORE ASK THAT THE OCCASIONS WHEN THEY ARE LEFT UNSUPERVISED BE CUT TO THE MINIMUM TO AVOID THIS SITUATION ARISING. IN THE MAIN SUPERVISION OF THE INTENSIVE TRAINING IS ACHIEVED SEPARATELY FROM THAT OF THE MAIN UNIT BUT OBVIOUSLY THERE WILL BE TIMES WHEN JOINT SUPERVISION IS APPROPRIATE.
DAILY TASKS.

These jobs to be done either by Unit residents or by staff on duty:
- carpets to be hoovered morning and night,
- dishes to be washed after each meal and put away,
- bins to be washed out and emptied,
- rooms to be dusted and kept tidy,
- corridors to be kept clean at all times,
- bath, sink and toilet to be cleaned daily including bathroom floor,
- beds to be made on getting up,
- underwear to be washed daily and changed,
- cleaning of shoes (where appropriate).

FAMILY TASKS.

Reviews will be done weekly, it is expected that staff on duty will be present together with the Team Leader, Keyworker and/or Social Worker, parent where appropriate, all washing to be done e.g. washed, dried and ironed, including towels, tea cloths, sheets, etc., no clothes to be worn un-ironed.
- cleaning of windows,
- washing down of paintwork, window ledges, door frames, skirting boards, window frames etc.
- bedding to be topped and bottomed,
- nightwear to be changed,
- hoovering under beds and all other furniture in room,
- polishing of all wooden furniture.

OTHER TASKS—FORTNIGHTLY/MONTHLY.
- washing down of walls,
- washing of light shades,
- washing, drying and ironing of all curtains,
- cleaning of cutlery e.g., knives, forks, spoons (supervised).

These lists are not exclusive nor exhaustive and staff are reminded to ensure that these jobs are done properly, not rushed and done to a reasonable standard.
1. The individual should be asked to bathe and wash hair immediately upon arrival. In the case of someone being received at an unsociable hour staff are asked to 4 discretion by gauging the cleanliness of the person. Staff are made it is their responsibility to ensure that the individual is leaving properly.

2. All daytime clothes and shoes are to be removed and locked up in the smallest cupboard.

3. Nightwear should be given to the individual to wear until further notice.

4. The individual is to be placed in a bedroom.

5. Waking and besiging are as follows and staff are asked to ensure that these are enforced:
   - Waking up by 7.00 am
   - Bedtime by 7.00 pm.

   In certain cases the waking time may be earlier and this will be indicated on individual programmes.

6. Breakfast initially is to be prepared by staff and should be taken to the individual for them to eat in their room. Dishes should be washed and dried by the individual using the bathroom facility on instruction from staff.

7. Lunch will be provided by 12noon and should be taken between 12 noon and 1.00pm. to be eaten in their room. Only one hour is permitted for lunch.

8. A break for 10 minutes is allowed mid-morning and afternoon. A cup of tea, co a cold drink may be given.

9. Supper will be delivered by 205 and should be given at 7.00 pm together with a drink.

10. No other privileges are allowed. Privileges have to be earned and staff are not to deviate from the individual programmes. Therefore, it is necessary to ensure:
    - removal of all personal effects, handbags, cash, cigarettes etc.
    - the room should not contain books, paper, pens, games etc.
    - that there is to be no communication out of the windows.
    - that above all the individual does as he/she is told.

11. A bath should be taken daily and hair washed not less than twice a week.

Any addition/alteration to this procedure will be indicated at Management level, where staff will be informed of such changes to be implemented.
Appendix F, Document 7

INTRODUCTION

A request was received in early March 1989 from the then Acting Principal Area Officer following concern from the Area Officer, Children & Families, that a situation was arising at Tamworth Family Centre, which appeared to highlight a management problem. These problems appeared to centre around a difficult nucleus of young people; staff morale was low and the Area Officer had found it necessary to support the Centre in practical caring terms. Following this request, Mr. Crockett, Deputy Director, agreed that support would be given in the form of a team of three people to assist and advise wherever necessary.

A meeting was held with the Area Officer, Children & Families, and shortly afterwards a full staff meeting. One of the members of the team actively joined the staff rota and became involved with day-to-day management.
Routines and General Management Practices

Staff engaged in the Family Centre at all levels were experiencing control difficulties, lack of morale, confidence and enthusiasm. Staff had lost direction, not only with regard to providing child care practices, but also in the day-to-day organisation and management of their shifts and duties. The aspect of child care practices will be discussed later, but it is important to highlight the other areas of concern.

Inconsistency and prolonged periods of duty without days off produced a lot of discontent amongst the staff team. This was as a result of a poorly designed rota system and the inadequate pairing off of senior and junior staff. Consequently, staff felt it necessary to claim all their time off in lieu and were not prepared to offer anything over and above their normal hours and work to aid the smooth-running of the Family Centre. In fact, staff who had carried vast amounts of time off in lieu were given as much as five weeks off at a time, and it had been granted by the Team Leader that these staff could take the time off at the same time, thus reducing the staff team as a whole by fifty per cent. The remaining staff carried the burden and pressures of the Centre, which by this time were beginning to escalate out of all proportion. Needless to say, one member of staff took sick leave for three/four weeks and other staff since have taken quite lengthy periods of sickness away from work. Three full-time staff resigned and left the Family Centre in mid-April 1989 and since then the rota has had to operate on a shoe-string basis virtually from week to week. This was the case until mid-June when a full four week rota was introduced and additional full-time, temporary and casual staff were appointed. However, noticeably the rota system was not followed on and staff had to devise their own rota for a short time whilst the Team Manager took annual leave.

During the period April to July 1989, the additional necessity of waking night staff also had its toll upon already tired staff. Staff were expected to not only work their normal working hours, but also to cover for waking night duty. In many cases this meant that staff undertook duties in excess of 24 hour shifts. At no time during this period were advertisements placed for waking night staff. The lucrative financial rewards of waking night payment ensured participation of all the staff team, but over-tiredness soon came and team uniformity began to suffer. Appointments have now been made on a permanent basis which will result in a full staff complement being reached by August 1989. As stated earlier, there are still problems in operating an adequate staff rota due to the lack of forward planning by the Team Manager. Where it has been felt both appropriate and necessary, domestic staff and other County Council staff have been periodically used to shore up the running of the Centre.

Routine domestic and household duties have been hindered as a result of drafting in domestic staff on to the residential rota. This has applied pressure to staff directly and indirectly in trying to keep the building in its desired pristine condition. This in turn has applied pressure on the residents, resulting in staff being manipulated and behavioural and control difficulties, with the majority of the residents becoming more and more evident.
At a meeting held at Tamworth Family Centre in March 1989, the residents currently at that time had a number of constructive criticisms to offer. These being poor meals, clothing difficulties, lack of outdoor and indoor amenities, infrequent visits by their social workers and no clearly identifiable future plans. Upon examination of these issues it was learned that the Team Leader had no direct oversight or control over meal planning, clothing and outdoor/indoor amenities and relied solely upon the recommendation of the Administration Officer. Since the departure of the Administrative Officer the Team Leader has delegated the oversight of the clothing budget to one of the Family Centre Social Workers and food provision ordering to the Day Care Organiser. Both these aspects are still fraught with problems. Cash is rarely available for residents to purchase clothing and an official order is used in the main for this purpose. There is a lot of food wastage and the cook is constantly having to make ends meet with whatever goods are available.

Sundry petty cash expenditure and pocket money allocation is now controlled via liaison with the Area Office Administrator. Financial balancing difficulties do exist due to the primitive execution of financial procedures. Advice was given on this particular point, but anomalies still arise. This is largely due to poor daily oversight by the Team Manager in obtaining the correct procedure from her staff and not being able to advise staff generally on the expectations of this particular task. In other words, there are no set guidelines or procedures for correct recording and administration. Still financial difficulties arise when ad hoc outings with the children are not properly planned in advance and staff and Team Manager alike are both at fault upon this point.

It was very evident that rota staff needed to have their shift duty plans more clearly defined. An introduction was made of a morning management meeting between Team Manager and senior staff on duty. A simple aide memoir was used to cover all salient points: a copy of the format is attached. Regretfully, this procedure is not used regularly by the Team Manager and is often left to senior staff to complete. The Team Manager needs to recognise the importance of such a briefing session with her staff to install into them the requirements of the shift. More forward planning is required between Team Manager and staff for all to gain and develop a sense of purpose and a clear identification of role within the Family Centre.

Staff meetings in the past have not been used as a constructive tool, neither have they been used as a foundation stone for team building. Procedures, policies and practices are discussed and a decision made, but all too often it is never carried out or has been rescinded in certain situations by either the Team Manager or a member of staff to suit their needs or desires. This type of action does not create a practice to aid team building, uniformity of approach or staff development. The result is staff are afraid of making decisions or go out on a limb and leave their colleagues wide open to abuse and criticism. Staff meetings have been incorporated in the rota, which was drafted as a role on roll off rota for all staff. These meetings were scheduled to take place each Thursday from 1.00p.m. to 3.00p.m. where it was an expectation that all staff attend. Whether or not this time will be rota'd on the ad hoc rota is a question to be asked and followed up.
Regular staff supervision/development sessions need also to be featured into the rota. This point will be discussed later in the report.

Whilst resident Social Workers lost direction it is also fair to add that the Team Manager's role within the Family Centre is not clearly defined or structured. The Team Manager role is not used in a way to promote effective management; neither does it allow for the development of an effective staff team, nor the development of relationships and liaison with the Area Officer in terms of preventative and rehabilitation work with children and their families. In terms of its affect on the client group and staff group, the Team Manager's role is misused and misunderstood. The following outcomes are what it is producing:

(a) The staff team generally across the board were individually asked for their opinions as to the before and after changes of the help from Headquarters. The following points were a consensus of opinion.

1. When staff appointed they have never received an induction into the aspect of work they are expected to undertake. They are given additional hours over and above occasionally, no instructions as to how the Family Centre is expected to function, how to complete internal forms, sleep-ins, fire procedures, improper training, lack of communication between shifts.

2. Irregular staff meetings.

3. Lack of supervision sessions (this varied between staff interviewed but worked an average of 1 each 9 months). Lack of proper structure to supervision; often supervision turned into discussing other colleagues' personal problems.

4. Lack of internal structures, procedures and communication, e.g. referral practice and procedure
   - Liaison with Family Centre and Area Office
   - ad hoc changes in philosophy and approach
   - procedure manual to form basic management/organisation of the Centre
   - allocation of tasks need, e.g. whose going to do rota, savings, clothing, food ordering, take staff meetings, organise mini-bus services/repairs, who cooks meal when the cook is off, etc.
   - procedural and sanction guidelines to deal with the more difficult young people
   - to be more open and honest with children and to make them more responsible for their actions and behaviour
   - more clearly identifiable and exercised basic house rules
   - inadequate rota
   - lack of finances
   - lack of structure in the following
     (a) children's reviews
     (b) children's care plans
     (c) children on remand

Amendment
(d) children excluded from school
(e) children excluded from all available Y.T.S.

forward planning
semi-independent scene, good idea but requires better
supervision and planning
do not always receive admission documentation except for
kids admitted via the Emergency Day Team
regular children's group meetings
better liaison with the following needed

(a) Juvenile Justice Team
(b) Stafford Support Unit
(c) Area Office
(d) Long stay/other Family Centre

clearer defined role of attached worker
more thought and communication into avoiding admissions,
in terms of preventative care programmes.

5. Need a strong Team Leader, do not get support from Team
Leader in right way. Reduced support from Central Office
showing signs of things slipping backwards re staff
enthusiasm and motivation, control being lost staff
feeling unhappy. Not had good effective management - no
leadership from the top. Team Leader a nice person but is
not a boss. Not convincing enough in offering support or
direction. Had better professional support and approach
from Area Office. Staff would look for alternative job
if something came along but out of Tamworth.

6. Staff feel that children exploit and play off situations
between themselves and Team Leader due to Team Leader
undermining the sanctions staff employ. Therefore they
feel that they do not have any effective control of
residents. Staff feel uneasy in the way whom have to work
with their attached child.

7. Recognition of the continued use of a pin down unit but
only to be used in extreme cases. Needs proper plans and
clearly thinking through before operation. Staff feel
that if Team Leader not strong enough kids will be put in
for nothing.

8. Reviews are a good system. Previously not family
involvement. Forces the attached worker and social worker
to get things done. Sets a scene for the child to say
what they want. Kids being told outside reviews
speculative ideas of future which creates false hopes and
expectations. Already reviews are taking second best.
No-one knows whose chairing the review or which room to
use. No real honest speaking done in some reviews if held
by Area Office or Family Centre Team Leader.

9. Don't know what Juvenile Justice is about.
10. Need to develop better independent living situations in family Centre and other community resources e.g. supported housing schemes.

11. Support Unit required in Tamworth as younger children learning bad behaviour and ways of older more difficult children.

12. Family Centre to take and be responsible for its own cases able to visit families at home and be given scope to work with them. Time should be allowed on rota to let this happen. Time should be a rota to allow you to work on a 1:1 basis with your attached child.

13. Meetings are only held at crisis point.

14. There are always constant interruptions during meetings and reviews: this not fair on children or family.

15. Lack of staffing, e.g. waking night staff, casual workers, volunteers, etc.

16. Special meetings held in Conference Room for 'hob-nobs' children having the left overs and staff having to act as waitresses. People coming to the building should see it as it is or not at all and come when the children are here and not at school.

17. Need to develop a multi-agency approach.

18. More consideration should come from Central Office and consultation with the ground workers when policy changes are being considered as being implemented as opposed to a fait accompli.

19. Building not really adequate for a Family Centre and Nursery combined. Like the changes to the building but the Activity Room is isolated, the nursery becomes a barrier due to being located in between.

20. Need strong person to undertake supervision sessions who has field work experience. There are barriers between attached worker and Team Leader and the children see this and staff feel undermined. Team Leader spends more time with attached worker children than staff and it is all positive things she gives them. Team Leader gives unrealistic expectations and obtains good behaviour by buying it.

21. A better element of training, especially in general residential care practices, but supplemented with specific areas, e.g. behaviour modification, group work, statutory regulations and continuous updating.

244
22. One person cannot do two people's jobs, supervise kids, transport kids, supply refreshments, and wait on conferences, clean, etc.

23. Not enough equipment, e.g. cups, saucers, cutlery, cooking utensils and equipment.

24. The kitchen should be made totally out of bounds for children.

25. Difficulties do arise from multi-functional use of building, e.g. dual use of cooking facilities, laundry, children have nowhere to play outside when they are off school because the play area is out of bounds for them between 8.30 - 5.00 p.m. for nursery use.

26. The Family Centre won't change until Team Leader is appointed who can manage and control. The Family Centre is not doing what they are set up to do. You are not allowed to do your job properly, staff have left because of this.

The standpoint of the Team Leader needs to be altered to bring about any changes to the points raised above. However, the question needs to be addressed as to whether or not the Team Leader has the ability and skills to be able to effect change. This would now seem to be the case following the recent confirmation of her position as Team Manager. The following points are recommended areas of immediate improvement in the Team Manager's position at Tamworth Family Centre:

- To be seen as actively and constructively managing, directing and planning the future development of the Family Centre and community resources.

- To be withdrawn from the day to day running of the establishment in 'practical care terms' and to allow staff a better opportunity to work closer with individuals (and resident group) thus taking a greater responsibility for the running of the shift.

- To actively encourage members of staff through training and staff meetings, the opportunities to make decisions and to follow through plans for themselves.

- To offer staff regularly set supervision sessions to monitor case loads and help develop staff relationships with attached children as opposed to dealing with situations single-handedly.

- To develop a manual of good procedure in conjunction with staff to take into consideration the Family Centre concept.

- To develop and foster a closer working environment with the Area Office Teams and to ensure that the Family Centre Guidelines and procedures are clearly understood. For example, referral guidelines, review meetings, family meetings, statutory reviews on residents, individual care plans, after-care/rehabilitation/preventative plans, etc.
For a time control within the Family Centre was restored but since input from Headquarters has dissipated control, confidence and staff morale has yet again plummeted. The input and availability of the Team Manager to interject when crises were apparent was excessive, but this has been considerably curbed. Regrettably, no other support systems or procedural guidelines have been adopted and if anything withdrawal has been too quick, not planned and timed accurately enough therefore leaving the staff team, fifty per cent of them new to the job very much in the lurch.

It is felt that the current Family Centre staff are definitely genuinely concerned about the quality of care offered and that on a whole, the staff team could compliment each other well if structures, guidelines and support are introduced. It has become apparent over the last four months that this may never be achieved to reach its fullest potential and with the divisionalisation restructuring may never be reached due to inadequacies at Senior Management level. Family Centre staff recognise this. Area office staff recognise this, but somehow the two fail to come together to help resolve the problem. There is a very poor professional working relationship between the two parties. Meetings held with both parties highlighted glaring gaps in the working approaches of individuals alongside a number of situations that were in desperate need of change. There appeared and it is still evident that there is no over emphasis that Area Social Workers were the people with all the resolve and had the final word when decisions were being made. Little, or in some instances, no consultation was made with their residential counterparts. The Area Officer made attempts to address this issue and to bridge the gap but was faced with a statement from a Social Worker quoted as "I will not attend those meetings if the Team Leader is present." (Those meetings being weekly child care management meetings held with the Area Officer). This embargo continued from March 1988 until the adoption of divisionalisation. It is now understood that the Team Manager has a weekly meeting with the District Manager and counterparts. Other issues upon this matter will be highlighted further in this report.

**INDIVIDUAL CARE PLANS AND PROGRAMMES FOR RESIDENTS AND THE RESOURCES AVAILABLE TO PROMOTE THE CONCEPT OF FAMILY CENTRE PHILOSOPHY AND ASSOCIATED INFRASTRUCTURES.**

It was evident immediately that individual care plans for residents had not been formulated. Admissions to the Family Centre appeared to just 'slip' and seldom with all the necessary admission documentation completed. In fact it was later established that some of the previous admission documents had merely been photocopied and the date altered to suffice. Consequently, the whole process from preventing an admission, to admissions and the discharge of residents needed to be examined. Initially, it was decided that the basis would be to closely examine the residents currently residing at the Family Centre who were known to have behavioural problems and appeared beyond control.

The Family Centre considered itself as a dumping ground directing its criticisms to the Area Office Social Workers. Conversely, Area Office Social Workers feel that children referred to the Family Centre deteriorated socially, emotionally and behaviourally and that any referral was a last resort for their client. Needless to say, in many cases when clients were referred to the Centre the situations and
circumstances had become so fraught and uncontrolled having been held together loosely in the community that heavy handed intervention work was required. This echoed the need for a structured systematic approach and universal understanding of the facilities and resources at the disposal of the Family Centre. At this point a decision was made to avoid any further admissions until some issues had been addressed relating to current residents, the possibility of working alongside a de-skilled staff team unable to function realistically and to try and unite Family Centre and Area Office in formulating care plans. Alongside this parents and/or guardians were asked to attend meetings to discuss their child's future and to evaluate the social work practice to date. It took six weeks to formulate all the meetings, which considering the only common ground being that of a 'cry for help' from all concerned, was little more than a token gesture. No-one would specifically take on these meetings with any form of enthusiasm save the people drafted in from Head Office. Family Centre staff attended and so did the parents and child, but attendance was poor from the area and scathing at the times they did attend. Any form of constructive help for the families appeared to come from one direction alone, that being the Family Centre staff. Irrespective of this negative attitude and commitment from the Area the meetings went ahead and decisions were made and plans formulated.

Since this initial approach other children have been admitted to the Family Centre. The procedure for admissions had already been set but sadly this process did not continue in any form of consistency. For example, care plans identified with specific goals, \textit{hows}, \textit{whys}, etc. were seen as 'confidential' by the Area Social Worker and therefore should not be openly made available for discussion at a children's/family review. The referral/review process became an up-hill battle, but when input was high from Central Office the barriers existing began to crumble.

To be able to effect some of the individual programmes it was necessary to look critically at the use of the building and to establish what adjustments could be made to accommodate the needs of the individuals and thus increase the flexibility of programmes. The building itself, not purpose-built, appeared on face value to cater for anything and everything with the exception of the residents, they being an after-thought. The building itself was not homely and conducive to a relaxed and inviting atmosphere where children, parents and social workers could work comfortably together. This still being the case, there being only two easy chairs and no settee). The building accommodated a conference room which was used for pre-approved foster parent groups, foster parent meetings, case conferences, for all the area disciplines, access visits, team meetings, training sessions, parents visiting, children's meetings, Directors' meetings, parties, etc. which almost daily in some shape or form invaded the life-style of the residents. It was initially agreed that the conference room be used for an activity room and that an alternative venue would be sought. Previously, residents had little opportunity to pursue centre-based activities, as the room they used to occupy was sited on the main bedrooms landing attached to a small music room and television room. The conversion of the activity room did have its problems, which has resulted in the room now being taken off the residents because of minor damage. From observation the problems have not been totally addressed and yet again the clients have suffered. Perhaps a better supervisory element and constructive relationship building and activities with the residents
may have eliminated a vast number of the problems. The fact of re-siting these activities is totally unacceptable. The front dining room was converted to a television lounge room. This has now been reverted back to a dining room because of the hinderance from the nursery element.

The total concept of being able to separate residents from the general bedroom quarters has been lost. Currently twelve residents, except for meals, live basically on one floor like sardines. Too much emphasis is placed on a pristine palatial presentation of the building as opposed to working directly with clients and getting them to recognise values. It is easier to take away as opposed to comfort issues.

Young people on the semi-independent programmes have use of a supper kitchen when they can store and prepare their own meals under supervision. Because of rota deficiencies the element of supervision has been lax and build up to proper training in this area minimal. An additional dining room facility was created in an attached room whereby they could invite friends and family. As a result of the re-arranging of some of the rooms, this facility has been taken away. Initially, these changes were viewed positively by the residents and they could see the benefits of these type of programmes in relation to being able to cater and support themselves independently in the future. The budget allowance allocated was in accordance with £22.85 per week. Attached workers initially oversaw the administration of this allowance. However, the novelty started to wear off as accurate supervision and guidance began to falter and other issues began to take precedence.

Other children's programmes were made as variable and flexible as was required to ensure a progressive movement out of the care scene. Children were placed on shared care plans, week-end and overnight stays at home, etc. In certain aspects the working together of area and residential social workers benefited and grew but conventional social work soon became to the fore again when controversial or unauthodox practices became apparent, this was irrespective of whether or not it was in the child's best interest.

There is another area which needs to be assessed, evaluated and developed within the community. That being more on points from the Family Centre. This prompts the consideration over and above the boarding-out scenario of building in resources to acquire and accommodate supportive housing. Within the area of Tamworth currently, children residing in care and not wishing to or are unable to return home for whatever reason, do not see any realistic move on points, in particular the teenagers, and are confronted with the possibility of a long-term stay in the Family Centre. The shared resources of the long stay unit and support unit, which has to serve South East and mid-staffs area, will not be able to accommodate the increasing number of young people who are finding themselves in this situation.

In some cases progress has been achieved with regard to individual care plans, but it is generally felt that this area will quickly deteriorate in the future. Growth and development in the areas monitored relating to individual care plans needs to be constantly re-assessed and created, otherwise a stagnation point is going to be reached by both residents and staff and saturation will cause yet again embroilment.
Within this section it is also necessary to consider the Family Centre's involvement in preventative individual care plans, but in doing so, working towards a closer professional relationship with those who share many years of experience. Yet again, the building up of relationships is all too important not only internally, but also on an external basis. Little communication of any quality exists at Tamworth. It needs to be understood, known and recognised, what options are available in dealing with young people to avoid, not only an unnecessary toting up on the Knott scale but also receptions into care. This would mean the development of and acceptance of flexible approaches by all concerned in dealing with common problems. It would mean that individual plans and programmes were not only drawn up for the benefit of the court, Social Services Department and Probation Service, but also for parents and schools. Programmes and plans would need to denote punishments and rewards, immediate courses of action, specific goals, specific sanctions, time limits and controlled disciplines. Little headway has been secured in this area of work at Tamworth.

CLIENT CENTRED APPROACHES

INDIVIDUAL CHILDREN'S REVIEWS

As referred to earlier in this report client centred approaches were not being catered for such areas including:

1. Group meetings with residents.
2. Individual reviews or Family Meetings.
3. Alternative approaches to client care and therapy.
4. Segregation of difficult youngsters.
5. New style of rota to include the above.
6. Control of casework.
7. Enhancement of effective residential practices in a positive and negative way.
8. The use of contracts or programmes with clarity of purpose once individual need was established.
9. Communication aids, i.e. individual programme file with up-date as a daily aide memoire to duty staff.
10. Joint meetings of area and residential social workers.

It was felt appropriate to arrange children's reviews immediately to enable:

- The child/family's background history to be clearly identified and understood by all parties, especially in ensuring the child's understanding of why they were in care.

- To openly address any problems either the parent, child or Family Centre were experiencing and to look at resolves jointly.

- To begin to formulate care plans and programmes for the young person's future.

Reviews on children were expected to incorporate all relevant people, especially those with a direct concern for the child's welfare. In
addition, other people attended for whom the child himself felt or saw as being important to them, e.g. schools, brothers, sisters, etc. As the reviews proceeded, it was necessary to re-assess the expansion or reduction of the number of participants as issues became either highlighted or resolved. It was also felt important that reviews were chaired consistently by someone who had the power to make and direct decisions. Initially, Central Office staff ensured reviews as a training area backcloth for both the Area Officer and Team Leader. The Area Officer at the time made every effort to sustain a comment to these reviews, but at times through poor management and organisaton of time and lack of communication between parties concerned reviews became double booked or other more pressing issues took precedence. It is fair to honestly point out that the Area Officer had little back-up at this time by his senior social workers. On occasions too, the Team Leader was not always available because of having done waking night duty and had been on daily rota duty.

The ethos behind these reviews was to promote constructive well planned meetings to enable the child not only to freely participate but also to acknowledge that his/her future was not being forgotten. Honesty was a key feature at all reviews and it was stated that children should not be precluded from hearing about realities in their lives. This issue was a difficult one to confront at Tamworth, basically because of the protective stance Area Social Workers took over the handling of their clients, and at times point blank refusal to either follow a review’s outcome and total non-co-operation occasionally brought about a very poor professional stance and respect for their colleagues. Because of this attitude children saw professional disagreement which turned into false hopes and expectations from their social workers and consequently, social worker/client relationship deteriorated and the whole purpose of the review lost. On certain individual cases there was also a loss of credibility for Family Centre staff and Area Social Workers, as well as for the Police and Families concerned.

Reviews are still being used as part of an ongoing evaluation of care plans. Although the emphasis on its original purpose has been lost. Children being discharged from the Centre are not having follow-up reviews between Family Centre and parents/foster parents/guardians as a means of support or to monitor problems and progress. The intense work with children has therefore been cut off without explanation or thought and they have had yet another ‘life-line’ cut to leave them floating in the community again to either sink, swim or be rescued. Rescued could be in the terms of another unnecessary admission to care.

It had been hoped that with the onset of divisionalisation some of the salient points raised above would have been addressed, unfortunately, the problems still exist. As care plans and reviews are seen as being a weak link so too are statutory reviews and case conferences. In some of the case files examined it was noted that statutory and mandatory County Council practices had not been adhered to, this included children who were on the Child Protection Register.

Following the successful introduction some years ago of a specialised unit at 245 Harthill Road, the profound problems being created by certain youngsters at Tamworth promoted an introduction of this case in Tamworth. Special unit with all its mystiques basically challenges the
concept of positive care ideals and consequently is often misinterpreted
and has been quoted as a 'lock up' unit. The Special Unit operates on a
number of basic philosophies.

The isolation of a young person to a room away from the main core
of the building, where loss of privileges are asserted.

The young person is supervised 24 hours a day under a contract
basis whereby issues, problems and relationships can be
confronted. Care is presented as a totally negative experience
initially ensuring that the participant can clearly identify their
problems, come to terms with them through counselling and time
out sessions with appointed staff, and is encouraged to work
through the problems by not being allowed to take the easy way
out.

To ensure that work with the children on these lines is planned
and clearly structured, it needs to include family contact,
participation and agreement to the sanctions employed (where
applicable) and the opportunity for the child to learn how
privileges are earned and how co-operation brings rewards.

Special unit should seldom be used. It should be a last resort and not
be used liberally to exert heavy handed discipline or sanctions to
children. Family Centre staff have worked with its philosophies and have
seen what rewards and changes it brings in children when all else fails.
Area Office Social Workers generally do not agree with its operation but
are unable to offer alternatives. Save secure units. The closure of
Riverside is already having its effect on Family Centres and Support
Units. Everyone in the residential field is recognising that there is a
need for something to bring back control and good practice in residential
establishments. Does special unit fill part of this need? Tamworth
has got to decide for itself.

There is little oversight of Family Centre Social Workers from either the
Team Leader or Area Office Senior Social Workers in the control of
individual cases. In fact none of the Family Centre staff have
responsibility of a case load at the time of writing this report.
Children are nominated to Family Centre staff upon entry but the Social
Worker is always area-based. As a result of this, there are never ending
parages in establishing who does what in this shared role. Because of
the difficulties over the last few months at Tamworth and the reticence
of Area Social Workers towards the Family Centre, it is fair to say that
the Family Centre Social Workers have been merely seen as residential
workers. Credibility between the two social work practitioners is low,
it is also extremely isolated through poor communication channels and
lack of understanding of each other's role. Through the weekly reviews
held on each child roles can be channelled to some degree, but the greyer
areas of social work practices still remain unresolved, and often to such
a great extent that it is not in the interest of the child or family.
Social Workers at the Family Centre feel that they are caretakers only,
unable to make decisions or act upon situations without first contacting
the Social Worker to ratify their actions. Area Office Social Workers
then feel that the Family Centre staff are inundating them with imbecile
questions. The question of the effective role of the Team Leader in this
situation also needs to be addressed. A greater degree of control over


case work needs to be brought in for the Social Workers at the Family Centre to be able to direct and state responsibility for them. Currently, there are cases which Family Centre staff could take over. This begs the question though of adequate supervision practices, staff development, training and who is going to be responsible for them?

It is generally felt that to build staff motivation, enthusiasm and development of social work practice, more direct control of case work is required. However, there may have to be certain restrictions placed upon the type of cases for which they can be given full control due to the fact of there not being a qualified social worker currently on the staff team. However, District Managers and Team Manager counterparts have got to consider whether or not it is going to be beneficial to invest time with the Family Centre Team to:

- Improve their basic knowledge and practices of social work
- To reduce the amount of time Area Social Workers will eventually have to put into routine-type cases.
- To improve the quality of relationship between both child and practitioners.

A point to bear in mind is that unless the person responsible for the oversight of the Family Centre Social Worker is well respected and can operate a fair but firm management stance, problems will arise all too quickly. A better degree of professionalism has got to be strived for in Tamworth generally. Should the Family Centre take on a case load or shouldn't it? Should the Team Manager be responsible for carrying a case load and therefore receive a better grounding to field work practices to pass on to her team? Who should prepare the S.E.R. for children appearing before the Courts? Should the Family Centre provide an assessment and observation report for the Court? Should the Family Centre prepare preventative and rehabilitation programmes for the Court? Or do these reports really have to be undertaken by the Juvenile Justice Team?

It is felt that the Family Centre should be encouraged to take control of or at least a greater control of cases referred to the Centre, irrespective of whether the children are resident or non-resident (i.e. following discharge or preventative work).

Little headway has been made in this area, so the questions still remain unanswered, who is going to address these issues?

None of the children had ever worked to an individually designed contract. Ad hoc contracts had been put together previously and had been levelled as total dictates as opposed to structured progressive rewards. In some cases previously designed contracts were totally unrealistic, seldom reviewed or appraised and the child was doomed to failure from day one. In many of the reviews, therefore, the word contract initially was looked on unfavourably, not only by the children, but also by Area and Family Centre Social Workers. Realistic contracts were put together with children, families, social workers, schools and Family Centre staff where clear expectations were defined and understood. The contract which was reviewed weekly promoted everyone to pull together towards the common
goal. Failure to do so by any individual whether child, social worker or parent etc. had to be explained and the necessary reprimands would be heard by all. This tactic was used to encourage honesty and the courage of one's convictions on all sides. More importantly, the children could see fairness being played right across the board. Unfortunately, this approach deviated from its purpose when chaired inconsistently which resulted all too often in both the children and Family Centre Social Workers feeling palmed off as unheard. The resistance referred to earlier soon became apparent and eventually staff, children and families alike began to feel that these meetings were a waste of time, likewise 'why bother having a contract if my social worker doesn’t want to know' was often a statement made by many residents.

Contracts are still being set up with children at Tamworth. Possibly this is the only area which has seen to produce a consistent approach at the Family Centre and be accepted as a good model to use.

In March a joint group meeting (children's meeting) was held at the Family Centre between the children and staff to try and gauge what the children felt about the way the Centre was run. As mentioned earlier, there were a number of constructive criticisms levelled. At this meeting only three out of the five residents attended. The other two were absconders but they had been asked to attend via outside links. It became obvious that all five of the residents (the absconders attended later) that situations had gone too far and they themselves were seeking a resolve. Life to them at the Family Centre was getting intolerable. Unfortunately, through bad management and organisation, and despite constant reminders the next group meeting did not take place until 23.4.89. Regrettably, children's group meetings still do not take place on a regular basis, and when they do happen the children see them as being a farce 'because nothing happens'.

On exploration of effective residential practices, yes there were basic house rules to hand. They only problem being that they had not been revised, new staff had not seen them and the staff team don't unitedly work towards them. Meeting after meeting took place to try and establish an agreed or acceptable basic house rule criteria, but a new one was never formulated. Good residential practice went out of the window together with a united team front from the Family Centre staff. Children recognised this and exploited the situations, played staff off against another including the Team Manager and generally caused mayhem. This type of scene is still operating today.

The duty rota still is a source of great discontent with the staff team and is being currently worked as ten days on four days off basis. A rota was drawn up to take into consideration staff feelings, but also to effectively run and control the Centre based on a staff complement of 84. The feeling and consensus of opinion from staff was good: this lasted for one month only. It fell apart when the Team Manager went on holiday, one handed the rota up to a community nurse.

Communication aids have been discussed time and time again in respect of management practices and casework practices. Everyone thinks these are 'good ideas' but no-one manages to use them. At times they are used not consistently and yet again this builds up frustration.
Encouraging joint meetings between area and residential workers is still a major concern to tackle and until such time as someone is prepared to confront this issue never the twain shall meet in a united professional way.

RESUME

Considerable time and effort was directed into all the areas of concern at Tamworth. Staff training sessions, management sessions, staff development sessions and basic residential good practice routines established to bring back control. Due to the lack of direct client and management control the road was an uphill battle. As support was gradually withdrawn noticeably changes in good practices began to revert to its original state of confusion, frustration and anxiety. The support staff from Central Office consider that aspects of their input has had limited success. This is a very sad affair, not only for the clients and their families, but also for the staff and department alike.

RMAN.CHC
S/LD/HQ
12 September, 1989
Appendix F, Document 8

The need to work with young people who present difficulties within residential centres/family centres has been a long standing problem. It has become increasingly recognised that the disruption caused by persistent absconding, verbal and physical attacks against staff and other children, and the youngsters who are particularly volatile within these centres need to have the opportunity to be worked within programmes individually tailored, closely supervised, and well structured and controlled. Constant reviewing with as many of the persons in the young person's life needs to be integral in its organisation, and the full and involved cooperation of the young person, family, social worker, extended family and any other significant persons needs to be secured.

The framework for this type of work must address the issues of:

a) The ability to set an arena where the young person would be available for a long enough period to engage. It is difficult to address positive working with any young person who persistently absconds, or who is so disruptive, criminally intent, aggressive or presenting of other similar problems.

b) To enable the structure to have sufficient flexibility to accommodate the opportunity for sanctions and rewards - and working in the main towards the opportunity for the young persons return home at the earliest possible time.

c) To use the opportunity to confront and deal with the young person over issues in their lives requiring major address. i.e. Absconding, aggression, breakdown of relationships at home or elsewhere, non-school attendance either by refusal or exclusion, serious criminal behaviour etc.

d) The purpose of such intensity is to saturate the young person, and to produce contracts or plans as quickly as possible to allow speedy progress to be made in achieving realistic plans in the young persons life. The child's commitment, as well as the families commitment, as with other professionals is an essential requirement to enable the plan to work. The concentration of effort by all concerned on the young person allows progress to be made which is not always readily made otherwise as a result of differing priorities.

The structure is serious, and designed to concentrate on the issues needed to be addressed. Its framework is controlled by very regular review procedures, usually daily, followed by at least a full review meeting of all interested individuals where at all possible weekly.

THE YOUNG PERSON IS PARTICIPANT IN ALL MEETINGS AND DISCUSSIONS, as it is considered an integral part of the working out with the young person to be at all times "up front" and "direct"

The basic structure/framework is as follows:

a) All young persons will firstly be required to have bath, and at the earliest possible opportunity will be medically examined (in the case of new admissions to care, or where it is felt it is necessary) Bathing and hairwash will be a regular morning and evening routine. The young person will be expected to knock on the UNLOCKED DOOR for staffs attention. Both these requirements demonstrate adherence to basic rules in the early stages.

b) All young persons will be expected to wear appropriate nightwear, pyjamas etc. This does reduce the young persons motivation to running off and clothes are introduced very quickly when basic trust and commitment to stay in the programme and address issues is achieved. This is reviewed daily.

c) The working day commences at 7.00am, with bath etc., followed by breakfast in their own room, followed by set work tasks, education type projects, meetings, constructive discussion time etc. In the early stages of the programme all meals are taken in their own room, some with staff, some without. Bedtime is 7.00pm.
d) Television, Radio etc are earned and assessed daily. Usually these are earned by contracting time out for such opportunities either at home or other places.

e) Cigarettes, Reading material etc., are individually contracted in the daily reviews.

f) Family visits, social worker visits are planned and encouraged to achieve differing objectives in the young persons plan. At no time is access by any authorised persons to the young person denied, the reverse is often true that an active encouragement is consciously made to involve parents, extended family and any other significant persons.

g) Review meetings can be often heated and charged with emotive feelings by the young person and their families. The need to use the role play within such meetings is a sound requirement to their success in Positive and negative relationships with the different persons working in the contract. However at all times an attempt is always made to identify workers in the plan to positively support the young person and assist them in producing a realistic working contract.
Appendix G: Tony Latham’s memorandum 8 November 1983

URGENT AND IMPORTANT

To All Staff:

The Birches Family Centre
Semi-staffed unit
Westmorland Avenue
Intermediate Treatment Centre
Special Unit

WITHOUT EXCEPTION

I now emphasize that all staff wishing to apply punishment or lack of
privileges to children within the Family Centre/Semi-staffed Unit/
Westmorland Avenue/Intermediate Treatment Unit/Special Unit must do so
only

AFTER PRIOR AGREEMENT BY AREA OFFICER (MYSELF) OR TEAM LEADER

It is a requirement under the Community Homes Regulations that
punishments can only be administered after prior consultation with

AREA OFFICER OR TEAM LEADER

I am however prepared to take responsibility for the Senior Shift Leader
to deal with MINOR PROBLEMS within the establishments as long as a proper
record has been kept of the way, incidents have been dealt with on the
occasions when myself or the Team Leader are not available - HOWEVER
AS SOON AS POSSIBLE AFTER THE EVENT THE AREA OFFICER OR TEAM LEADER SHOULD
BE INFORMED AND THE PUNISHMENT BOOK COMPLETED ACCORDINGLY

I WILL NOT EXPECT THAT ALL LOSS OF PRIVILEGES OR PUNISHMENT WILL BE
PROPERLY RECORDED IN THE PUNISHMENT BOOK

The semi-staffed unit will be expected to seek prior agreement regarding
loss of privileges or punishment through either the AREA OFFICER or
TEAM LEADER - in their absence or unavailability the SENIOR SHIFT LEADER

A SEPARATE PUNISHMENT BOOK IS REQUIRED FOR EACH ESTABLISHMENT

I INTEND TO EXAMINE CLOSELY THE METHODS OF CONTROL CARRIED OUT IN ALL
ESTABLISHMENTS BY STAFF AND WILL BE EXAMINING REGULARLY WITH THE TEAM LEADERS
THE APPROPRIATENESS OF THE MEASURES

PLEASE TAKE CAREFUL NOTE OF THIS INSTRUCTION

TONY LATHAM
AREA OFFICER
8.11.83

257
Appendix H: Correspondence 1984-1985 (Fred Hill etc.)

Mr. K. F. Cockett, Assistant Director, (Service Delivery)

Mr. F. Hill, Senior Assistant, (Child Care)

THE BIRCHES AND 245 HARTSHILL ROAD

During my visit to the Birches on the 16th February 1984 details were supplied by the Area Officer regarding the transfer for short periods of persistent absconders at The Birches to 245 Hartshill Road.

I am particularly concerned that some of the practices outlined to me appear to be in contravention of the Community Homes regulations on control although the basic idea of the transfer is laudable.

As you may be aware a bedroom and sitting room at Hartshill Road are occasionally used to accommodate a maximum of 4 children with a member of staff from The Birches in continuous attendance. The facility is used when a child needs to be withdrawn from the group at The Birches following persistent absconding, to undergo a programme of behaviour modification.

On occasions the member of staff has slept in the same room as the children and although no one is locked in one basic aim is to discourage the child from further absconding by a staff present at all times.

As a further deterrent in this respect each child is initially required to wash his clothes and these are not returned for periods of up to 36 hours during which time the child is clothed in pyjamas or PE kit.

A number of further measures are taken including the loss of privileges, loss of recreation, the imposition of household chores (the children do all their own cleaning and cooking), withdrawal and transfer of pocket money into children's savings and additional education and recreation. The recreation takes the form of physical exercises.

I am informed that the child's school in each case are asked to co-operate and where it is felt that further absconding could take place the child is kept away from school for a short period and a programme of work is drawn up by the school.

The measures of control taken are relaxed or increased according to the child's progress during the period in the unit which can vary from 24 hours to a few days.

Apparently the success rate of the unit is high and plans to modify behaviour and return the child to school have largely been successful. I am however concerned that a number of these practices appear to contravene the Community Homes regulations on control and/or give rise for concern. The fact that generally a child's liberty is restricted during his stay by the almost constant presence of a member of staff is difficult to reconcile with the regulations.

The withdrawal of privileges, early bed times, loss of recreation as outlined to me appear to come within the regulations on control.

continued ..
The holding back of pocket money as a punishment seems to fall outside the regulations and the domestic duties undertaken by the children go some way beyond the imposition of a minor but unwelcome chore.

The practice of the removal of a child's clothing to discourage further misbehaviour is used occasionally in other establishments but where this is defined as a punishment it appears to fall outside the regulations.

All the punishments apart from the withholding of clothes are entered openly in the measures of control book. Mr. Latham accepts that procedures must comply with the regulations and that the practices regarding pocket money, household chores and additional recreation to say the least are questionable in this respect and will be modified accordingly.

I have also asked Mr. Latham to enter the measures taken more specifically on a day to day basis rather than the present blanket measures which appear to cover the total stay of a child. I feel that clear direction and advice is required in this case to protect both the interests of children and staff and I would recommend that further discussions take place with the area so that the activities of the unit can carry on but that they are brought into line with the Community Homes regulations on control.

Date: 17th February 1984
THE BIRCHES, NEWCASTLE

NOTES OF MEETING HELD ON 11TH OCTOBER 1984

PRESENT: Mr. Crockett, Mr. Pierpoint, Mrs. Brennan,
Mr. Latham & Mr. Hill

The meeting was convened in response to a letter from the Principal Area Officer
detailing the use of residential establishments in the Newcastle Area and proposals
for future development. The following items were discussed:-

1. Extension to the Birches at an estimated cost of £40,000. Mr. Crockett
explained that due to the present financial situation, no money is
available at the moment to finance this project.

2. Through route to Gower Street. It was agreed that this scheme would ease
the traffic problems at the Birches, although it was made clear by
Mr. Latham that heavy vehicles would not use the Gower Street entrance.
Mr. Hill to follow up with the County Architect's and Planning Department
as appropriate and consideration to be given to the £2000 required in next
year's Minor Works Programme.

3. Lack of domestic hours at Wood Lane, Hartshall Road and the Birches. It
was pointed out that no additional hours can be provided at present.
Although it is accepted that domestic staff levels are inadequate.

4. 245 Hartshall Road - extension to car park. It was agreed that this is
a much needed facility that would cost in the region of £1100, there is a
delay due to a query over the boundary of County Council land. This to
be pursued further by Mr. Hill and the project to be considered in the
1985/86 Minor Works Programme. It was agreed that before any plans are
finalised, neighbours should be consulted regarding the proposals.

5. Steps at the side of Hartshall Road. This project has been cut out of
this year's Minor Works scheme due to lack of finance but will be put
forward again for consideration next year.

6. Intensive Unit - Hartshall Road. It was agreed that Mr. Hill should
re-examine the practices within the Unit to ensure that they fall within
the Community Homes Regulations on control.

7. Use of rooms. It was confirmed that the Principal Area Officer has the
authority to change the use of a room within residential establishments.
It was agreed, however, that where no cost is involved, the Homes Adviser
should be informed for information and where finance is involved, prior
consultation should take place with the Homes Adviser, who will also
ensure that the Fire Officer is kept informed of any developments or change
of use.

8. Residential I.T. Mr. Crockett confirmed that the only authorised Residential
I.T. provision at the moment, is at Riverside and further Residential I.T.
should not take place at Wood Lane. (A letter containing this instruction has
recently been sent to the Area.)

It was agreed, however, that the Area would put their proposals in writing
concerning Residential I.T. in the Newcastle Area for further consideration. It
was further confirmed that the Area have been given a flexible brief regarding the use
of the 10 beds at 245 Hartshall Road and that they can continue to be used for
short stay preventative work as appropriate in addition to semi-staffed use.

4/FH/JW
12.10.84.

261
245, HARTSHILL ROAD. SEMI-STAFFED UNIT

As requested, I have examined the practices within the so-called Intensive Unit at 245, Hartshill Road.

As previously reported, the accommodation consists of a bedroom, sitting room, bathroom and toilet and is used to accommodate a maximum of four children although the average number of occupants at any one time is two. The Fire Officer has been consulted regarding the use of the Unit which is situated on the first floor of the semi-staffed accommodation at 245, Hartshill Road.

Most of the children accommodated in the Unit have previously been resident at The Birches, although there are occasional exceptions to this rule. The children's group mainly comprise of individuals who need to be removed from the main group at the Family Centre so that more individual care can be offered. A number of these children are transferred to the Unit if their treatment programme at The Birches breaks down. A further group are made up of children who present abscending problems that cannot be contained within the main group, although it is stressed by the Area that not all the children who abscond are transferred to the Unit. The accommodation is also used as a crash pad facility for children requiring short-term care and a number of children who encounter problems with non-school attendance are also accommodated from time to time.

A treatment programme is drawn up and a Keyworker appointed for each child admitted to the accommodation.

The Unit is staffed by Social Workers from The Birches or semi-staffed staff, although on occasions Social Services Aides provide the staff cover. At all times overall responsibility for the Unit is provided by the senior member of staff on duty at the Family Centre. The usual practice is that one member of staff is rostered outside school hours although additional staff are drafted in as required. Sleeping-in cover is also provided and on occasions the member of staff in question has slept in the same room as the children or on the landing outside. Occasionally the sleeping-in duties are covered by the semi-staffed staff but if the needs of a child are such, additional sleeping-in cover is provided for the unit and an extra allowance claimed.

Unless there is a specific decision to the contrary, most children accommodated go out to school in the normal way. When a decision is made (after consultation with the school) as part of a treatment programme, that the child should not attend school, alternative arrangements are made regarding education at Hartshill Road. Any children in the Family Centre in addition to the Unit children who do not attend school at any particular time are taught in a separate area of the building at Hartshill Road. School work is supplied by the Education Department from individual schools and as appropriate the children are taught by Home Tutors from the Education Department. Additional tuition is provided by a Teacher Trained Community Services Worker and I am advised that the Newcastle Area have applied through the Department for ongoing Urban Aid to finance this individual on a permanent basis.

When a child is transferred to the Unit he is initially required to wash his clothes and these are not returned for periods of up to 36 hours during which time the child is clothed in pyjamas or p.e. kit.

continued ... ...
If appropriate, as part of a plan to modify behaviour a number of further measures are taken, including the loss of privileges, loss of recreation, the imposition of household chores and additional recreation. The additional recreation takes the form of organised tasks outside the establishment, usually such things as gardening or sports under the supervision of staff. These activities mainly take place during the weekend.

The measures of control are relaxed or increased according to the child's progress during the period in the unit which can vary from 24 hours to a few days. All the punishments are entered daily in the measures of control book and all staff have been made aware of the Community Homes Regulations on control.

The Unit is a valuable facility in the area and due to the commitment of the Area Officer, Team Leader and Area Staff, provides a positive approach to the problems of non-school attendance and absconding.

The obvious problem concerning the Unit surrounds the question of the extent of the restriction of a child's liberty, although at no time is a child locked in a room, even if accompanied by an adult. However, in view of the high staff to child ratio (1 to 2), it seems less likely that a child will abscond from the Unit than he would from the Family Centre where staffing ratios are often as low as 1 to 10.

The D.H.S.S. Circular covering the secure accommodation (No. 2) Regulations 1983 state that control imposed or implied by staff or other responsible adults will not be considered to constitute restriction of liberty, although control should always be imposed or implied in a manner consistent with good child care practice.

We are obviously sailing close to the wind with some of these arrangements unless it is abundantly clear that the continued staff presence in the Unit does not have the effect in practice of restricting the liberty of a child any more than it would do in a normal small staff, children's group situation in a residential setting.

With reference to the need for good practice I would not consider that the removal of a child's clothes and the substitution or pyjamas or p.e. kit for varying periods of time can possibly constitute good practice. I feel that this measure, which is not confined to 245, Hartshill Road, should be discontinued in all our establishments. Quite clearly it was introduced as an attempt to deter absconding.

In addition, measures such as physically containing a child within a room by requiring a member of staff to sleep in the same room or on the landing outside should be discontinued.

With reference to the further measures of control within the Unit, I would not consider that the practice of additional recreation when defined as a punishment as it appears to be at Hartshill Road, comes within the Regulations.

On the information supplied to me, it would appear that the other measures taken do fall within the Regulations, although I feel it is essential to reiterate to the Area formally that no measure must be taken other than those listed in the Community Homes Regulations 10, control.

continued ...
I also feel that Social Services Aides are occasionally undertaking responsibilities beyond the level envisaged for this post. I would, therefore, recommend that the minimum Senior cover in the Unit should be Residential Care Officer, 2 or Social Work Assistant, 2. This can be achieved by linking the activities of the Unit more closely with the general semi-staffed use.

I would also recommend that we should discourage the use of terms such as special and intensive when referring to the Unit. In practice the accommodation is used to provide short stay facilities at Hartshill Road in line with the Family Centre concept of flexible use of resources. It was decided at our recent meeting with the Area on the 11th October, 1984, that the beds at Hartshill Road can be used for short stay preventative work in addition to semi-staffed use.

I would also recommend that the arrangements for the education of non-school attenders in consultation with the Education Department, is recognised officially.

It is also important that statutory visitors should have access and, in fact, be shown around the Unit during their visit to the semi-staffed accommodation.

Summary of Recommendations

As outlined in this report I recommend that the activities of the Unit should be allowed to continue on the following conditions:

1. There should be no more loss of liberty in the Unit than that caused by the control imposed or implied by staff through a manner consistent with good child care practice.

2. The practice of the removal of a child’s clothes and the substitution of pyjamas, p.e. kit, etc., should be discontinued.

3. The practice of staff sleeping-in the same room as children or on the landing outside the room should be discontinued.

4. The use of additional recreation when defined as a punishment should be discontinued.

5. All measures of control taken must comply with the Community Homes Regulations 10, control and should be recorded in the appropriate book.

6. The use of the terms special or intensive in reference to the Unit should be discontinued.

7. Statutory visitors should be given access as required to the Unit and all parts of the building.

8. The minimum level of staff cover at Hartshill Road should be Residential Care Officer 2 or Social Work Assistant 2. If semi-staffed staff are used in this respect, they should be made fully aware that their responsibilities include supervision of the Unit from time to time.

continued ... ...
9. Arrangements for the education of non-school attenders should be recognised officially by the Department.

10. The use of a second sleeping-in member of staff at Hartshill Road should be accepted and should take place when determined by the needs of the children within the Unit.

I recommend that a letter is drafted to the Area to include the conditions I have outlined. I would also suggest that we should inform all the Principal Area Officers that the practice of the removal of a child's clothes to deter absconding should be discontinued.
Since the completion of my report the Area have transferred the Unit to the integral ex-staff masionette at 245 Hartshill Road. The move was made to provide more space for this facility although it is still envisaged that a maximum of 4 children will be accommodated at any one time. The accommodation consists of 2 bedrooms, kitchen, sitting/dining room and bathroom/toilet.

There is Committee approval for the masionette to be used to extend the facilities of the Family Centre. The Area are aware that this does not include permission to create additional children's beds but as agreed in our meeting with the Area on the 11th October 1984 the ten beds at Hartshill Road can be used flexibly for short stay purposes in addition to semi-staffed use. For some time we have had permission from the Fire Officer to lock one of the 2 doors between the masionette and the main establishment to separate the activities of the 2 areas.

The DHSS Circular (copy attached) covering the secure accommodation regulations outlines quite clearly that the locking of internal doors to confine a child or children to a certain section of a home even when accompanied by adults is not permitted. In practice anyone in the masionette could get out through one of the three external doors (2 of which are fire exits) by unlocking these from the inside or by breaking the glass on the fire door separating the first floor of the masionette from the bedroom accommodation in the semi-staffed unit. However, the fact remains that the locking of the internal door in question could be seen to have an effect of confining children to a particular area. I would like to consult on this particular point.

I would also wish to add to my list of recommendations the requirement that no more than 10 children's beds are used at any one time in total at Hartshill Road with a maximum of 4 of the 10 in the unit.

I will of course notify the Fire Officer of these latest developments if the arrangements are agreed at our meeting on Wednesday.

Date: 20th November 1984
RESTRICTION OF LIBERTY OF CHILDREN IN CARE

1. The Secure Accommodation (No. 2) Regulations 1983 define secure accommodation as "accommodation provided for the purpose of restricting the liberty of children." Under regulation 3 the Secretary of State's approval is required before accommodation in a community home may be used for the restriction of a child's liberty. Local authorities may find it helpful to have the following guidance on how the Secretary of State will define restriction of liberty for this purpose.

2. The following forms of the restriction of the liberty of children in care will not be permitted except in accommodation approved for use as secure accommodation by the Secretary of State:
   a. The locking of a child or children in a single room at any time, even when accompanied by a responsible adult or adults;
   b. The locking of internal doors to confine a child or children in a certain section of a home, even when accompanied by a responsible adult or adults.

3. The following procedures will not be considered as constituting the restriction of the liberty of children though they should be adopted only where they are acceptable to the Fire Prevention Officer, and consistent with building regulations, and conducive to a domestic atmosphere within the home:
   a. The locking of external doors and gates at night, consistent with normal domestic security;
   b. The locking of external doors and gates during the day time where the purpose is to prevent intruders from gaining access to the home, provided that children are not prevented from going out;
   c. The securing of windows.

4. Control imposed or implied by staff or other responsible adults will not be considered to constitute the restriction of liberty, though control should always be imposed or implied in a manner consistent with good child care practice.

5. Procedures designed to ensure the safety of children which also have the effect of restricting their liberty may not be adopted unless they have been drawn to the attention of the Secretary of State, who will decide whether such procedures are acceptable.

6. Where a home or a part of a home is surrounded, or it is intended to surround a home or part of a home, with walls or fencing continuously more than 6 feet in height, this must be drawn to the attention of the Secretary of State so that he may decide whether such restriction of liberty is acceptable.
Staffordshire County Council

Mrs. E. Brennan,
Principal Area Officer,
Newcastle.

My ref 4/NFC/FH/MF

Dear Mrs. Brennan,

245 HARTSHILL ROAD, STOKE-ON-TRENT

I write with reference to the short stay facilities currently operating in the maisonette at 245 Hartshill Road.

Whilst I fully appreciate the positive work in progress, I have decided after lengthy discussion on the matter, to lay down a number of safeguards for children and staff which must be adhered to at all times.

The instructions are as follows:-

1. Control implied or imposed by staff should at all times be implied or imposed in a manner consistent with good child care practice.

2. No more than 10 children's beds are to be utilised at any one time at Hartshill Road, this number to include a maximum of 4 in the staff maisonette.

3. The use of the terms special or intensive should be discontinued.

4. Statutory Visitors must be given access as required, to the maisonette and all parts of the building.

5. The minimum level of staff cover at Hartshill Road, should be Residential Care Officer Grade 2 or Social Work Assistant Level 2. If semi-staffed staff are used in connection with the activities in the maisonette they should be made fully aware of their responsibilities in this respect.

6. In normal circumstances, only one sleeping-in allowance per night will be paid at Hartshill Road. If circumstances arise that warrant a second person sleeping-in, clearance must be obtained on each occasion from Central Office.

Date 22nd November, 1984

C. H. W. 
Director of Social Services

69 Foregate Street, Stafford-ST16 2PY
Telephone 3121 Extension 7030
7. All measures of control taken must comply with the Community Homes Regulation 10, Control, and should be recorded in the appropriate book.

8. The practice of staff sleeping in the same room as children or on the landing outside the room must be discontinued.

9. The use of additional recreation when defined as a punishment must be discontinued.

10. No internal doors in the unit must be locked at any time, including the door leading from the maisonette to the main establishment.

The practice of the removal of a child's clothes and the substitution of pyjamas or P.E. kit, etc., to deter absconding, falls outside the Community Homes Regulations. However, I wish to give this matter more general consideration before I issue a final instruction. I would ask you, therefore, to attempt in the intervening period not to use this practice, pending further guidance.

Will you please formally acknowledge the receipt of these instructions and ensure that all staff connected with the unit are made fully aware of them.

Yours sincerely,

[Signature]

Director of Social Services
Mrs. E. J. P. Brennan,
Principal Area Officer
Newcastle.

4/NPC/FH/KD               11th February, 1961

Dear Mrs. Brennan,

295, HARTSHILL ROAD

I write following my letter to you of the 22nd November, 1961, concerning the short stay facilities currently operating in the maisonette at 295, Hartshill Road.

Whilst I appreciate the need to discuss the contents of my letter with relevant staff in your area, I would ask you to acknowledge receipt and to confirm that all staff concerned with the Unit have now been made fully aware of the instructions I have laid down.

Yours sincerely,

Director of Social Services

[Signature]
Staffordshire County Council

Mr. B.J. O'Neill, C.S.W.,
Director of Social Services,
Social Services Department,
69, Foregate Street,
Stafford.

Copy to Mr. A.R. Latham, Area Officer, (Children).

By ref EJPB/NW

Your ref 4/MPC/FH/KD

Date 25th March, 1985.

Dear Mr. O'Neill,

245, Hartshill Road,

I apologise for the delay in replying to your letter. Certainly the matter has been discussed with all the relevant staff concerned with the unit, and they are fully aware of the points you have raised.

Since you wrote your letter, there have been one or two developments.

Point 6 Mr. Spurr has agreed that I approve the sleeping-in allowance for the unit as it is impossible to obtain clearance on each occasion from Central Office. This I will watch carefully.

The only point I find difficult to accept is Point No.10. The purpose of locking this door is not to secure the children within the unit. This is not possible as in the corridor from that door to the unit, there is a fire door to the yard at the back. The purpose of locking this door is that the big general room is used by I.T., we have a lot of children who have no other connections other than I.T. in that building, and it stops them from wandering in areas which does not concern them. This, therefore, helps security and as you are already aware, security is a matter of great concern to us. I would be grateful if this instruction could be reviewed.

Yours sincerely,

E.J.P. Brennan

[Signature]

E.J.P. Brennan (Mrs.)

Principal Area Social Services Officer.

P.S.

1. I am inclined to agree about the locked door.

2. The whole setup is being considered closely and may well be brought to an end very soon.
Mrs. E. Brennan,
Principal Area Officer,
Newcastle.

4/4/61

Dear Mrs. Brennan,

245 HARTSHILL ROAD

Thank you for your letter of the 25th March acknowledging the instructions in respect of the unit at 245 Hartshill Road.

I note that the only point that you find difficult to accept is the instruction (point 10) to leave unlocked the door separating the unit from the main establishment.

After further consideration I would inform you that I am agreeable to the locking of this door by the use of the existing yale lock which will enable the door to be opened from the unit side as required but not from the establishment side. I would further ask you to make arrangements to remove the key to the mortice lock on this door. This arrangement should get round the problem of security but will continue to enable children to leave the unit by this door when necessary.

Yours sincerely,

[Signature]

Director of Social Services
I haven't had a chance to discuss with you the issues raised by Mr. Sullivan following his statutory visit, but my observations on the points in question are as follows:-

1. Time Out Area - I am not aware that the Newcastle Area have any plans to phase out this facility, and on the contrary, they appear to regard it as an essential part of their resource. As you are aware we have laid down guidelines in respect of the operation of this facility.

2. Use of Social Services Aides - we have instructed the Area that the minimum staff cover in the building at 245 Hartshill Road should be Social Work Assistant, Level 2 (R.C.O. 2) and Social Services Aides should not be left in charge of the establishment at any time. I am assured by the Area Officer that this instruction is complied with all times.

3. Semi-staffed Facilities - As you are aware, it is hoped eventually to phase out the semi-staffed usage at Hartshill Road, but I will arrange to visit the premises once again with the Building Inspector to see what improvements, if any, can be effected on the top floor of the building.

5th June, 1985
Appendix I: Letter Elizabeth Brennan 7 November 1986

Staffordshire County Council

Mr. B.J. O'Neill, C.S.W.,
Director of Social Services,
Social Services Department,
69, Foregate Street,
Stafford.

Strictly Confidential

For the attention of Mr. Crockett, Deputy Director.

My ref. EJPB/MW

Dear Mr. O'Neill,

Mr. Tony Latham, Area Officer.

I feel that I must put in writing my concern over the situation with Mr. Latham.

Following Mr. Crockett's discussion with myself and Mr. Latham in relation to Mr. Latham's role in this office, I can confirm that Mr. Latham has mainly done the work of his various projects in his own time. However, because of the very close relationship between the Projects and the work of the Family Centre, Mr. Latham still gets directly concerned with things involved with the Family Centre. Some of these things I would not normally expect an Area Officer to get involved with.

This means that though there has been an improvement in the amount of time he spends managing the child care team in the area office, it is still far from satisfactory and I get anxious, particularly where child abuse is concerned that far too much responsibility is being left to Senior Social Workers.

I am aware that Mr. Latham works many more hours than he should do for the department, but a lot of this is of his own making. Because of the hours he works he gets extremely tired and it is having a serious effect on his health. He is also asking to take more time off in lieu so that he has more time during the day to do his project work.

In addition to these problems in relation to his Area Officer work, I am aware that he is doing a great deal of work with the Project and of course he is never able to get away from that work because so much of it is based at his own home.

Another difficulty has been that I have never been certain whether Mr. Latham has actually been off sick, working time off in lieu or what. He is inclined when off sick or doing his project work from home, to be available for telephone calls etc. which makes it difficult...
to collate the extent of the problem.

Certainly I was concerned in January when Mr. Latham was having pains in his chest and he was having to go up to the hospital for physiotherapy because he was having pains in his right arm and it appeared almost paralysed.

On return from my leave on 30th June, I found that Mr. Latham went off sick on the day I went on leave on 13th June and has not been back at work since. At present, he has a sick note until 21st July, although he was due to have leave from 17th - 25th July. The sick notes have stated "depression"; "heart and chest pains" and the third was undescipherable.

I have not had the opportunity to discuss the situation further with Mr. Latham, nor have I told him that I am writing this letter, but I am concerned that because he is trying to do his project work in his own time, it is having a serious affect both on his work as an Area Officer and on his own health.

Yours sincerely,

[Signature]

E.J.P. Brennan.
Principal Area Social Services Officer.
Appendix J

245 Hartshill Road,
Stoke-on-Trent

Heron Cross House,
Stoke-on-Trent
The Alders, Tamworth

The Birches, Newcastle-under-Lyme

The Little House (The Birches)
Appendix K: Statutory Visitors' forms

STRICTLY CONFIDENTIAL

STAFFORDSHIRE COUNTY COUNCIL
SOCIAL SERVICES COMMITTEE
COMMUNITY HOMES REGULATIONS, 1972 - REG 3(2)
REPORT ON A STATUTORY VISIT TO

Date of Inspection ......................

A. GENERAL CONDITION OF ESTABLISHMENT (Structural state, hygiene etc.)

(i) Dining Room(s)

(ii) Day Room(s)

(iii) Bedrooms

(iv) Kitchen (including vegetable preparation facilities, larders etc.)
      Satisfactory

(v) Laundry

(vi) Toilets

(vii) Corridors

(viii) Staff Day Rooms

(ix) Store Rooms

SW. 197

Seen ....................................

Dir. ....................................

A.D. (R) ...................................

A.D. (C.W.)* ..................................

Officer-in-Charge at time of Inspection

Name ....................................

Designation .............................
B. PRECAUTIONS AGAINST FIRE AND ACCIDENTS

(1) Frequency and adequacy of fire drills

(ii) Frequency of inspection of fire fighting equipment

(iii) Additional measures required as precautions against accidents.

C. CONTROL

(1) Number of absconders since previous official visit

(ii) Additional measures of control recorded since previous official visit

D. GENERAL COMMENTS

NOTE:
On completion of this report and Form SW.199 (which should accompany it), both reports should be passed to the Director's Secretary.

-------------------------------
Inspecting Officer

-------------------------------
Date

280
STAFFORDSHIRE COUNTY COUNCIL
SOCIAL SERVICES COMMITTEE

DISTRICT ADVISORY SUB-COMMITTEE

COMMUNITY HOMES REGULATIONS 1972 - REG.3 (2)

Establishment........................................

Date of Inspection...................................

A. General Condition of Establishment

B. Precautions Against Fire and Accidents

C. Control

D. Comments

Inspecting Officer.........................

Designation.................................

Date...........................................

281
Appendix I:

Community Homes Regulations 1972

STATUTORY INSTRUMENTS

1972 No. 319

CHILDREN AND YOUNG PERSONS

The Community Homes Regulations 1972

Made - 2nd March 1972
Laid before Parliament 10th March 1972
Coming into Operation 1st April 1972

The Secretary of State for Social Services (as respects England, except Monmouthshire) and the Secretary of State for Wales (as respects Wales and Monmouthshire) in exercise of their powers under section 43 of the Children and Young Persons Act 1969(a) and of all other powers enabling them in that behalf hereby make the following regulations:

Citation and commencement

1. These regulations may be cited as the Community Homes Regulations 1972, and shall come into operation on 1st April 1972.

Interpretation

2.—(1) In these regulations, unless the context otherwise requires—

“the Act” means the Children and Young Persons Act 1969;

“the Act of 1948” means the Children Act 1948(b);

“community home” means a home provided under section 36 of the Act, and unless the context otherwise implies includes a controlled community home and an assisted community home;

“child” means a person under the age of 18, and a person who has attained the age of 18 and is subject to a care order;

“responsible organisation” means the voluntary organisation responsible for the management, equipment and maintenance of an assisted community home;

“responsible body” means a local authority providing a community home under section 36(2)(a) of the Act, a local authority specified in the instrument of management for a controlled home under section 41 of the Act, and a voluntary organisation providing an assisted home under section 42 of the Act;

“local authority home” means a community home provided by the local authority under section 36(2)(a) of the Act;

“controlled community home” means a controlled community home designated as such in the regional plan in accordance with section 36(3) of the Act;

(a) 1969 c. 54. (b) 1948 c. 43.

[H.197]
“assisted community home” means an assisted community home designated as such in the regional plan in accordance with section 36(3) of the Act;

“regional plan” has the meaning assigned to it in section 36(1) of the Act;

“managers” means a body of managers provided for in an instrument of management in accordance with section 39(1) of the Act, exercising the functions of the responsible authority as provided by section 41(2) of the Act as respects a controlled community home, or as the case may be, those of the responsible organisation as provided by section 42(2) of the Act as respects an assisted community home;

“secure accommodation” means accommodation in a community home for the purpose of restricting the liberty of children resident therein in accordance with sections 24(2) and 43(2)(c) of the Act;

“care authority” means a local authority into whose care a person is committed by means of a care order under section 20 of the Act, or who have received a child into care under section 1 of the Act of 1948 or to whose care a child is committed under section 23 of the Act;

“approved school” means a school approved by the Secretary of State under section 79 of the Children and Young Persons Act 1933(a);

“approved probation hostel and approved probation home” means premises approved under section 46(1) of the Criminal Justice Act 1948(b).

(2) The Interpretation Act 1889(c) shall apply to the interpretation of these regulations as it applies to the interpretation of an Act of Parliament.

General provisions governing the conduct of community homes

3.—(1) The responsible body, and in the case of a controlled or assisted community home the managers, shall arrange for the community home under their charge to be conducted so as to make proper provision for the care, treatment and control of the children who are accommodated therein.

(2) In the case of a controlled or assisted community home the managers shall arrange for one or more of their number to visit the home at least once in every month and to report in writing to them on the conduct of the home; and in the case of a local authority home the authority shall arrange for the home to be visited at least once a month and a report made to them in writing upon the home by such persons as they consider appropriate.

Appointment of person in charge

4. The person in charge of a controlled or assisted community home shall be appointed in accordance with the provisions of the instrument of management, and the person in charge of a local authority home shall be appointed by the local authority.

Medical care and hygiene

5. The responsible body shall ensure that arrangements are made—

(a) for providing all children resident in a community home with adequate medical (including where appropriate psychiatric) and dental care;

(b) for maintaining satisfactory conditions of hygiene in the home;

and may for these purposes appoint one or more medical officers.

(a) 1933 c. 12. (b) 1948 c. 58.
(o) 1889 c. 63.
Notification of death, illness or accident

6. The person in charge of a community home shall as soon as possible notify—

(a) the responsible body and the managers of the death of any child accommodated in the home and the circumstances of the death,

(b) the responsible body and the managers of the outbreak in the home of any infectious disease which in the opinion of the medical officer or other medical practitioner attending the children in the home is sufficiently serious to be so notified, or of any serious injury to or serious illness of any child accommodated in the home,

(c) the child's parent or guardian, the care authority (not being the responsible body), any visitor appointed for the child under section 24(5) of the Act, and any person or organisation having accepted responsibility wholly or partly for the cost of the child's maintenance in the home, of the death of, or of any serious injury to or serious illness of, any child accommodated in the home.

Precautions against fire and accident

7.—(1) The responsible body shall ensure that adequate precautions are taken in a community home against fire and accidents, and in regard to fire if the responsible body are not themselves the local fire authority they shall consult that authority as to the precautions to be taken.

(2) The managers of the community home, or if there are no managers, the local authority providing the home, shall make arrangements to ensure that by means of drills and practices the staff and as far as practicable the children are well versed in procedures in case of fire, and that they know the precautions to be taken for the prevention of accidents.

Religious observance

8. The managers, or if there are no managers, the local authority providing the home, shall ensure that every child resident in the home has so far as practicable in the circumstances the opportunity to attend such religious services and to receive such instruction as are appropriate to the religious persuasion to which the child may belong.

Visits by parents, guardians, relatives and friends.

9. The responsible body shall provide suitable facilities for visits to a community home by parents, guardians, relatives and friends of the children accommodated therein, but the use of such facilities, times of visiting and other arrangements connected with the visits shall be as the managers, or where there are no managers, the local authority, may decide.

Control.

10.—(1) The control of a community home shall be maintained on the basis of good personal and professional relationships between the staff and the children resident therein.

(2) The responsible body in respect of a local authority home or controlled community home and the local authority specified in the instrument of management for an assisted community home may approve in respect of such home such additional measures as they consider necessary for the maintenance of control in the home, and the conditions under which such measures may be taken, and in approving such measures and conditions they shall have regard to the purpose and character of the home and the categories of children for which it is provided.
(3) Any approval mentioned in the preceding paragraph shall be given in writing to the person in charge of the home, save that in the case of an assisted community home the approval shall be given to the responsible organisation, and shall be reviewed every twelve months.

(4) Full particulars of any of the measures mentioned in paragraph (2) of this regulation which are used and of the circumstances in which they are used shall be recorded in permanent form by the person in charge of the home and the record shall be kept in the home.

Secure accommodation

11.—(1) The responsible body may make application to the Secretary of State for approval to provide and use in a community home secure accommodation, and if such approval is given the Secretary of State may attach to it such terms and conditions as he thinks fit.

(2) Where secure accommodation has been provided in a home in accordance with approval from the Secretary of State the person in charge of the home may, if he considers it to be necessary in the interests of a child residing in the home or for the protection of other persons, admit a child to such accommodation for one continuous period not exceeding 24 hours or for more than one such continuous period provided that the total time spent in secure accommodation shall not exceed 48 hours in any consecutive period of seven days.

(3) If an extension of the period in secure accommodation is thought necessary by the person in charge of the home, he may apply to the managers, or if there are no managers, to the local authority providing the home, and permission to extend the period to a maximum of 14 continuous days may be given.

(4) If a further period in secure accommodation is thought necessary by the person in charge of the home he may make further application before the expiration of the period of 14 days, and permission may be given to extend the time to a total of 28 continuous days.

(5) Immediately on the managers or the local authority providing the home giving the permission mentioned in the foregoing paragraph they shall inform the care authority (or voluntary organisation having care of the child) that they have given such permission, and the care authority or voluntary organisation may before the expiry of the period of extension—

(a) grant their permission for the period in secure accommodation to continue or to be extended for a specified or an indefinite period,

(b) refuse such permission, in which case the period in secure accommodation shall come to an end not later than 48 hours after notification of the refusal,

and if such grant or refusal has not been notified by the end of the 28th day the period in secure accommodation shall cease forthwith.

(6) If the care authority or voluntary organisation grant permission under paragraph (5) of this regulation they shall review it at intervals not exceeding three months with a view to considering whether to terminate it.

(7) The care authority or the voluntary organisation having care of the child may terminate any permission mentioned in this regulation at any time by notifying the person in charge of the home, and they may communicate their permission, their refusal of permission or their termination of permission to the person in charge of the home in writing or orally and any such oral communication shall take effect immediately but shall be confirmed in writing.
(8) If such permission expires or is refused or terminated the care authority or the voluntary organisation having care of the child shall notify the person in charge of any future arrangements which they are making for the child's accommodation.

(9) For the purpose of giving or withholding permission for extension of time one of the managers or an officer of the local authority, as the case may be, shall be available at all times (including week-ends and public holidays) and the date and times when such manager or officer is available shall be ascertainable from a duty register to be kept in the home.

(10) The care authority or voluntary organisation having care of the child if they consider it necessary in the interests of the child or for the protection of other persons may decide that a child shall be admitted to secure accommodation and may accordingly arrange for the child to be so accommodated and in such case paragraphs (2) to (9) of this regulation shall not apply but the care authority or voluntary organisation having care of the child shall review their decision at intervals not exceeding three months.

(11) All admissions to, discharges from and permissions in respect of the use of secure accommodation shall be recorded showing the date, and as regards admissions and discharges, the time thereof. The records shall be made by the person in charge of the home and shall be preserved in permanent form and retained in the home.

Obligation to receive children into secure accommodation

12. If a child in care is accommodated elsewhere than in a community home, or in the community home where a child is has no secure accommodation, and if the responsible body, care authority or voluntary organisation having care of the child or person in charge of the home considers it to be necessary in the interests of the child or for the protection of other persons that the child be admitted to secure accommodation, they may apply to the person in charge of a community home having suitable secure accommodation for the child's admission thereto, and the person in charge may if room is available accommodate the child therein, for a consecutive period not exceeding 14 days, provided that:

(a) where a child has been taken into secure accommodation on the application of a person or body other than the care authority or the voluntary organisation having care of the child such person or body shall within 24 hours inform the care authority or the voluntary organisation that the child has been taken into secure accommodation, and the care authority or voluntary organisation before the expiration of the period of 14 days may,

(i) grant permission for the period in secure accommodation to continue or to be extended for a specified or an indefinite period,

(ii) refuse to allow the child to be further accommodated in secure accommodation, in which case the child shall not be accommodated for longer than 48 hours after notification of the refusal, and if such grant or refusal has not been notified within 14 days from the time the child is first accommodated in secure accommodation he shall not be further so accommodated; and the provisions of paragraphs (6) to (8) of regulation 11 shall apply to the foregoing part of this regulation and any reference to permission in those paragraphs shall be construed as permission given under this regulation.
(b) a person in charge of a home having secure accommodation shall not
refuse an application to accommodate a child in secure accommodation
if room is available and arrangements to receive into secure accommo-
dation children from outside the home are sanctioned by the regional plan;
but if the person in charge is instructed by the responsible body or the
managers to accept the child he shall do so notwithstanding that such
arrangements have not been sanctioned.

Review of permission to extend period of time in secure accommodation

13.—(1) Each care authority and each voluntary organisation responsible
for the care of children shall appoint a committee, and two or more local autho-
rities and two or more voluntary organisations may combine for the purpose of
appointing a joint committee to represent them, for the purpose of reviewing
permission given for admission to secure accommodation; and such committees
may be appointed in connection with one or more homes.

(2) A committee mentioned in the foregoing paragraph shall have among its
members an independent person, and for the purposes of this regulation “an
independent person” shall be any person fulfilling the requirements of regulation 3
of the Children and Young Persons (Definition of Independent Persons) Regulations 1971(a).

Care during an interim order or on remand

14. Save for paragraphs (10) and (11) the provisions in regulation 11 of these
regulations shall not apply to persons—

(a) committed to care during the currency of an interim order as defined
in section 20(1) of the Act;

(b) committed to care on remand under section 23 of the Act;

(c) taken into care and detained under section 29 of the Act.

Directions regarding accommodation of children

15. The Secretary of State may give and revoke directions requiring the
responsible body to accommodate in a community home a child in the care of a
local authority for whom no places are made available in that home under the
regional plan or to take such action in relation to a child accommodated in
the home as may be specified in the directions.

Information and records

16. The person in charge of a community home shall give to a person autho-
rised under section 58 of the Act to inspect the home, such information as he may
require and as may be relevant to his inspection of the home, its state and man-
agement, and of the children and their treatment, and shall further give to such
authorised person access to records concerning the home kept therein, and
the responsible body shall give to the person access to any records they may
keep elsewhere in relation to the home.

Approval of Secretary of State to diminution etc. of buildings, grounds or facilities

17. Where the premises comprising a controlled or assisted community home
were formerly used for an approved school, approved probation hostel or
approved probation home, the voluntary organisation providing the community
home or the trustees in whom the property of the voluntary organisation is

vested shall not, without the approval of the Secretary of State, do anything by way of diminution or alteration which materially affects the buildings or grounds or other facilities or amenities available for children in such home.


Keith Joseph,
Secretary of State for Social Services.

1st March 1972.

Peter Thomas,
Secretary of State for Wales.

2nd March 1972.

EXPLANATORY NOTE
(This Note is not part of the Regulations.)

These Regulations make provision for the conduct of community homes and for securing the welfare of the children in them.
Appendix M:
Annex B, LAC (83) 18

ANNEX B
(LAC(83)18)

RESTRICTION OF LIBERTY OF CHILDREN IN CARE

1. The Secure Accommodation (No. 2) Regulations 1983 define secure accommodation as “accommodation provided for the purpose of restricting the liberty of children.” Under regulation 3 the Secretary of State’s approval is required before accommodation in a community home may be used for the restriction of a child’s liberty. Local authorities may find it helpful to have the following guidance on how the Secretary of State will define restriction of liberty for this purpose.

2. The following forms of the restriction of the liberty of children in care will not be permitted except in accommodation approved for use as secure accommodation by the Secretary of State:
   a. The locking of a child or children in a single room at any time, even when accompanied by a responsible adult or adults;
   b. The locking of internal doors to confine a child or children in a certain section of a home, even when accompanied by a responsible adult or adults.

3. The following procedures will not be considered as constituting the restriction of the liberty of children though they should be adopted only where they are acceptable to the Fire Prevention Officer, and consistent with building regulations, and conducive to a domestic atmosphere within the home:
   a. The locking of external doors and gates at night, consistent with normal domestic security;
   b. The locking of external doors and gates during the day time where the purpose is to prevent intruders from gaining access to the home, provided that children are not prevented from going out;
   c. The securing of windows.

4. Control imposed or implied by staff or other responsible adults will not be considered to constitute the restriction of liberty, though control should always be imposed or implied in a manner consistent with good child care practice.

5. Procedures designed to ensure the safety of children which also have the effect of restricting their liberty may not be adopted unless they have been drawn to the attention of the Secretary of State, who will decide whether such procedures are acceptable.

6. Where a home or a part of a home is surrounded, or it is intended to surround a home or part of a home, with walls or fencing continuously more than 6 feet in height, this must be drawn to the attention of the Secretary of State so that he may decide whether such restriction of liberty is acceptable.
Appendix N:

Staffordshire County Council Education Committee Bye-Laws

STAFFORDSHIRE COUNTY COUNCIL EDUCATION COMMITTEE

BYE LAWS

made under

Section 18, Sub-Section 2, of the Children and Young Persons Act, 1933, by the Staffordshire County Council at a meeting held on 24th February, 1977, and applicable to the whole of the area of the said County Council as the Local Education Authority under Section 1 of the Local Government Act, 1972.

OPERATION OF BYELAWS

These byelaws shall come into operation on and from the first day of November One thousand nine hundred and seventy seven.

Interpretation of Terms

1. For the purpose of these byelaws—
   (a) The expression "child" means a person who is not over compulsory school age.
   (b) The expression "guardian" in relation to a child includes any person who, in the opinion of the court having cognizance of any case in relation to the child or in which the child is concerned, has for the time being the charge of or control over the child.
   (c) A person who assists in a trade or occupation carried on for profit shall be deemed to be employed notwithstanding that he receives no reward for his labour.
   (d) The expression "local authority" means the local education authority.

   NOTE:
   (1) A child is of compulsory school age until he has attained the age of 16.
   (2) A child whose 16th birthday occurs between 1st September and 31st January (both dates inclusive) ceases to be of compulsory school age at the end of the spring term which includes such month of January.
   (3) A child whose 16th birthday occurs between 1st February and 31st August (both dates inclusive) ceases to be of compulsory school age on the Friday before the last Monday in May.

Prohibited Employments

2. No child shall be employed in any of the following occupations—
   (1) In the sale or delivery of intoxicating liquor not in sealed containers.
   (2) In the collection or sorting of refuse.
   (3) In the delivery of fuel oils.
   (4) Employment at any machine preservative as dangerous in an order made under Section 19 of the Offices, Shops and Railway Premises Act, 1963, excluding agricultural machines which are covered by other legislation.
   (5) In cinemas, dance halls, discos, cabarets and theatres except when performances entirely by children.
   (6) Employment in commercial (but not domestic) kitchens.
   (7) Outside window cleaning more than 10 ft. above ground level.
   (8) In any other occupation which may from time to time be prohibited by other legislation.

Regulations of Employment

3. No child under the age of thirteen shall be employed provided that subject to the provisions of these byelaws a child who has attained the age of 10 may be employed by his parents or guardian in light agricultural or horticultural work.

4. No child shall be employed on school days except for a maximum of two hours per day which shall consist of a maximum of one hour between 7 a.m. and 8.30 a.m. and one hour between end of school and 7 p.m. or of a maximum of two hours between end of school and 9 p.m., with the proviso that if a child works both morning and evening, it must be for the same em.

5. No child shall be employed on any Saturday or school holiday, or on any other weekday on which the school is not open for any reason whatsoever except as hereafter provided.
(i) A child under 15 years may be employed between the hours of 7 a.m. and 7 p.m. for a maximum of 5 hours a day subject to a maximum of 25 hours per week.

(ii) A child of 15 years and over may be employed between the hours of 7 a.m. and 7 p.m. for a maximum of 8 hours a day subject to a maximum of 35 hours a week.

(iii) A child may be employed in harvesting during school holidays only between the hours of 7 a.m. and 7 p.m. for a maximum of 8 hours a day subject to a maximum of 35 hours a week.

(iv) Where a child is employed by virtue of the provisions of (i), (ii) and (iii) above, no child shall be employed for more than 4 hours continuously without a period of 1 hour or more for rest and recreation.

6. No child shall be employed on Sundays except for a maximum of 2 hours between 7 a.m. and 11 a.m.

7. No child shall be employed except subject to the following conditions:

(a) Written notification shall be sent by the prospective employer to the local authority stating his name, address and occupation, together with the name, address and date of birth of the child, the occupation in which and the place at which it is proposed the child shall be employed and at the times at which it is proposed the employment shall begin and end.

(b) The child shall serve with him during the time of employment, and produce for inspection when required to any authorized officer of the local authority, a card headlined called the "employing card" which shall be issued by the local authority to each child in respect of whom a written notification has been received.

(c) Before issuing an employment card the local authority shall obtain from the District Community Physician a certificate that such employment will not be prejudicial to the health or physical development of the child and will not render him unfit to obtain proper benefit from his education.

(d) The local authority shall enter on the employment card the name, address and date of birth of the child, the occupation in which, and the times at which the employment of the child is permitted. The times so entered shall be such as the employer may choose, provided they are such as are allowed by these byelaws and they may be altered by the local authority from time to time on the application of the employer.

(e) A child to whom an employment card has been issued in accordance with the provisions of these byelaws shall be employed only within the times entered thereon by the local authority.

(f) The employer shall keep affixed in a conspicuous position in the place, or in connection with which the child is employed, a notice showing the name, address and date of birth of the child, the occupation in which and the times within which, the child may be employed on school days, on Sundays and on weekdays when the school is not open.

(g) The employer shall send to the local authority on the first day of January and the first day of July in each year a written notification in respect of each child employed by him on that date naming his name, address and occupation, the name and address and date of birth of the child, the occupation in which, and the place at which he is employed and times at which the employment begins and ends.

(h) At any time after an employment card has been issued the local authority may require the child to undergo a further medical examination and in the light of a report thereon may revoke or amend the employment card.

8. No child shall be employed in any work out of doors unless he is suitably clad and is suitably clad for protection against the weather.

The Byelaws made by the Staffordshire County Council, the former Burton upon Trent County Borough Council and the former Stoke-on-Trent City Council and confirmed by the Secretary of State on the 30th June, 1971, 16th February, 1955, and 17th August, 1955 respectively are hereby revoked.
The Common Seal of THE STAFFORDSHIRE
COUNTY COUNCIL was hereunto affixed
in the presence of:

M. E. JONES
A Member of the
County Council

W. J. SIMPSON
Director of
Administration

Date of Sealing 13th July, 1977.

The foregoing by-laws are hereby confirmed
by the Secretary of State for Social Services
on 31st October, 1977, and shall come into
operation on 1st November, 1977.

P. C. CLARKE
Assistant Secretary,
Department of Health and Social Security

Seal
of the
Secretary of State
for
Social Services

我心里想，如果我有超能力，我一定会用它们来帮助需要帮助的人。
Appendix O:

Extract from: Family Centres, A Change of Name or A Change of Practice, SSI, DH, 1988, (6.7.8 to 6.7.11)

6.7.4 Another important factor in this equation was the availability of other local resources. Some Areas clearly found it easier than others to recruit suitable foster parents. Those that could not do so found that their Family Centres were sometimes having to accommodate children who should have been Boarded Out. Similar problems arose in areas which had no long stay children's homes, for although Principal Area Officers were free to approach those areas in which long stay units were situated, it appears that most areas made a disproportionate use of those homes which, theoretically, they managed on behalf of the entire County. Some Areas without their own local resources had found themselves keeping children in their Family Centres for much longer periods than they would have wished.

6.7.5 In order to keep abreast of such discrepancies an effective mechanism would have been necessary to allow senior management to monitor developments and to deploy additional resources as required. Such a mechanism had not yet been devised, although the County had recently appointed an Assistant Director (Children and Families), part of whose brief was to review the functioning of the Family Centres.

6.7.6 Two further consequences of the manner in which Family Centres developed were the isolation of Family Centre Team Leaders, and their ignorance of how the different centres functioned; and the apparent absence of any standardised procedures and practice guidelines within the Department. Although regular meetings are said to occur between Principal Area Officers, these do not include Team Leaders, and it may be that as Team Leaders have assumed more direct responsibility for the management of their Centres there has developed a corresponding need to improve their knowledge of how other centres are operating.

6.7.7 Finally there was the question of staffing. Staffordshire wanted to overcome the difficulties which have traditionally existed between fieldworker and residential staff and made the forward-thinking decision to pay centre managers on the same scale as their counterparts in the field. Some centre staff were also paid on this basis as level 1 or 2 social worker, though almost invariably unqualified, and while this created problems associated with the elimination of overtime and required more flexible patterns of working, it was a significant step towards parity between the two staff groups. In conjunction with its policy on training the Department is understood to be developing a strategy which will lead to the upgrading of all centres staff in line with fieldworkers.

6.7.8 A number of professional developments were worthy of comment. In The Birches Family Centre a series of clear, simple statements of current procedure had been written by the Team Leader covering issues such as the admission process and daily routines, and notes to the parents and residents about the philosophy and practice of the centre. These were admirably clear and succinct and were undoubtedly of great value in ensuring a coherent and consistent approach by centre workers to their various responsibilities.

6.7.9 In the same centre an Area Officer had been extremely active and innovative in developing IT and YTS schemes to ensure that youngsters did not become 'stuck' in the centre but could move on, eventually, if appropriate, into independent housing and employment. One member of the centre team was effectively seconded for much of his time onto a scheme which generated supportive accommodation for youngsters. Houses were managed for private landlords as hostels and the DHSS payments for which youngsters then qualified were used to maintain the houses, pay rent to the landlord and pay an allowance to the youngster on top of his YTS earnings. The scheme appeared to work extremely well in an area where private tenancies were still readily obtainable and reflected an unusually energetic and imaginative entrepreneurial spirit within the Area.

6.7.10 The Birches Family Centre was fortunate in having old staff accommodation which could be used to house whole families, and also an annexe in which a range of services, including residential
accommodation for adolescents, could be provided. One particular approach was built around ‘Family Meetings’ which were an interesting mixture of planning meeting, family therapy and confrontational therapy. Adolescents who were experiencing problems which were likely to bring them before the Court or into care were invited to attend. All other significant individuals were also invited, including family members, teachers, Education Welfare Officers, and Probation Officers. The nature of the problem was discussed and agreed and options explored. A written contract was produced and sanctions for non-compliance worked out. This could entail the youngster spending time away from home in the centre but without reception into care. In cases of non-school attendance school work was obtained and supervised at the centre. Weekly review meetings were held and great flexibility was shown in devising suitable plans.

6.7.11 Not only did this general approach appear to work very successfully, but it also demonstrated the ability of centre staff to work professionally with complex cases in a preventive mode, which undoubtedly enhanced their status and credibility in the eyes of fieldwork staff.

6.8 General Evaluation of Service

6.8.1 Staffordshire is a diverse authority with a population of 1,016,000. During 1984/85 total gross expenditure of Social Services was £39,189,000. This represented an expenditure on field social work of £5 per head of population in 1984/85, as compared to £6 per head in the comparison group and cluster and £7 per head as the average throughout England. It was therefore not a well resourced authority and had not previously enjoyed a reputation for progressive developments in the field of social work.

6.8.2 In 1983 family Centres were introduced as a means of cutting expenditure on residential child care, providing a more local service, and diverting resources away from long term residential care into community based preventive services.

6.8.3 The haste with which this was achieved meant that each Area Office was thrown back on its own resources and in these circumstances some managed much better than others. The benefit of such a policy was that individuals who chose to do so were able to exercise considerable imagination and initiative and to develop new services. The disadvantage was that those areas with less flexible personnel in key positions floundered for want of guidance and direction.
The St Albans Child Care Inquiry sat for 78 days between July and November 1990 and heard from 155 witnesses. It considered many matters of local, regional, and social importance, particularly relating to the care and protection of children.
The Most Reverend Anthony Farquhar
Chairman
St Patrick's Training School
73A Somerton Road
BELFAST
BT15 4DE

12 March 1990

Dear Bishop Farquhar,

ST PATRICK'S TRAINING SCHOOL

I have recently assumed responsibility for the NIO division which encompasses Training Schools Branch and I have been looking forward to meeting you and your St Patrick's management team at an early date. I regret that before doing so, I am obliged to write to you in the following terms.

You will recall that an inspection of the School was carried out by the Social Services Inspectorate of DHSS on behalf of the Secretary of State in January 1988. The report contained 52 recommendations and was issued in February 1988. On 24 January this year, SSIS carried out a follow-up inspection. I enclose a copy of their report. You will note that the Inspectorate is far from satisfied with progress in implementing its earlier recommendations and is deeply concerned about a number of problems. In forwarding the report to me the Chief Social Services Inspector has commented:

"In general terms the follow-up report presents a picture of a facility which is in serious physical decay, in poorly managed, suffers from low staff morale but most importantly provides a standard of care for children which has little or no regard for human dignity and which is unacceptable by modern standards".
He has told me that unless action is taken on some of the key points within a matter of days, he will have no alternative but to advise the Health and Social Services Boards not to send any children to St Patrick’s.

Clearly this is a most serious situation and, whatever the long-term future may hold, both the management of St Patrick’s and the Northern Ireland Office must consider what we can do now to address the problems.

On the question of improving the physical state of the property, there are, as you know, difficulties in committing major sums of public money until the long-term future of the School has been decided. However certain measures can, and must, be taken right away. For our part we have put in hand an urgent study of what remedial action of a “first-aid” nature can be taken quickly and I hope to have details of this within a few days. Some other problems are of a “housekeeping” nature and no doubt you will take these on board.

Fire safety is obviously of the utmost importance and you have written to us about this following Mr McKeag’s survey which I understand took place just after the DHSS inspection. As Mr Ireland has informed you, we have asked Brother O’Riordan for copies of previous fire inspection reports but as yet none has been received. However, Fire Authority advice has been sought and while we have not yet received a written report, I am advised that:

a. the list of defects prepared by Mr McKeag is not accurate; and

b. the defects which do exist do not constitute an immediate threat to health and safety. Accordingly, the Fire Authority is prepared to accept the continued use of the chalets on the understanding that refurbishment and modernisation is not long delayed.
I understand that while there is no automatic fire alarm system in chalets 1 and 2, there is a manual one, and that although there is no immediate access to emergency lighting, there is a site emergency generator which becomes operational within 60 seconds. Similarly the existing electrical wiring was installed to the standard of the 14th edition of the IEE regulations and is in a satisfactory condition. All these systems are considered adequate for the moment, but should be modernised at an early opportunity. We are advised, however, that many of the existing light fittings, especially in the bedroom areas, present a potential safety hazard and that a number of socket and power outlets have become broken, dislodged or scorched. Appropriate remedial action for these will form part of our first-aid plan.

The other major area of concern, arises from continuing inadequacies in childcare practice and the Inspectorate advise that immediate attention must be given to the areas of staff supervision, night supervision of children, institutional practices, poor management, fire drills and security arrangements. The Chief Inspector has placed on record his willingness to provide professional help and guidance on an on-going basis to facilitate the dramatic improvements considered necessary in this field.

Such is the seriousness, and urgency, of the situation that I think we ought to meet at an early date to consider the report, and agree a programme of action. I would be happy to come to St Patrick's for that purpose, and the Chief Inspector of Social Services, Dr Kevin McCoy, would be happy to accompany me. Perhaps when you have had a chance to digest the findings, and discuss them with your colleagues, you would get in touch.
We have sent a copy of the report to Brother Leopold in his capacity as School Director.

Yours sincerely

[Signature]

A D SHANNON

ENC

ID/ADS1
COMMENTS FROM THE BOARD OF MANAGEMENT OF ST. PATRICK'S TRAINING SCHOOL SUBSEQUENT TO THE FOLLOW-UP INSPECTION REPORT FORWARDED TO THE CHAIRMAN BY MR. SHANNON ON 12TH MARCH 1990
A special meeting of the Board of St. Patrick's Training School took place on Friday, 33rd March. The planned meeting for 2nd April was also held.

The special meeting was called to discuss Mr. Shannon's letter to the Chairman and the follow-up Inspection Report. These were further discussed at the meeting of 2nd April. Both documents were fully discussed in an attempt to ascertain areas:

1. Where the recommendations of the General Report had been satisfactorily implemented
2. Where the Board had shown undue delay in implementing recommendations for whatever reason
3. Where the Board and Management had no control over what had not happened
4. Where the Board considers that true progress made since the General Inspection had not been clearly acknowledged
5. Which had only arisen since the time of the General Inspection.

Various members were asked to investigate different areas.

It was thought that some areas e.g. references to the long-term strategy for St. Patrick's Training School, should best be left to the forthcoming meeting of Mr. Shannon with representatives of the Board.

The long discussion of the two documents took place against a background of dismay at the difference between the tone of the original report and the follow-up report accompanied by Mr. Shannon's letter.

The original report, Section 17.1 said: "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".

In contrast with this the Chief Social Services Inspector now comments: "In general terms the follow-up report presents a picture of a facility which is in serious physical decay, is poorly managed, suffers from low staff morale but most importantly provides a standard of care for children which has little or no regard for human dignity and which is unacceptable by modern standards".

The Board also found surprising the contrast between the reference to the 'full assistance' offered throughout the original inspection and the recurrent use in the follow-up Inspection Report of 'apparently', 'seemingly', 'It was told', 'I do not know but if' etc. which might be taken to indicate that answers were not given to questions asked about such areas rather than, as was the case, such questions were not asked.

Indeed, on re-studying the documentation, members of the Board were worried lest information had been less readily made available to the Inspector than at the time of the original inspection. Members were reassured that this was not the case, and that every co-operation was indeed given.
18.3  Implemented.

18.4

**Staff Training:** The Board understands that the Inspector accepts that the steps taken so far should ensure that suitable training for staff will take place in the near future.

18.6

It remains the policy of St. Patrick’s Training School to appoint female staff when suitable candidates apply. It had not been deemed suitable to shortlist the two candidates referred to in Mr. Donnell’s report. To include these two applicants in the short list would have been inconsistent with the principles of Equal Opportunities legislation to which we in St. Patrick’s are fully committed.

18.8

**Staff Supervision:** As stated to SSL, this recommendation is ‘in hand’. Considerable progress has been made in recent months and management are confident that it will be fully implemented within six months. Management will gladly avail of any assistance the Lisnevin model of staff supervision can provide and approaches have already been made to Mr. McCloskey for assistance.

18.9

Implemented.

18.10

"At least one residential social worker should sleep in each unit during the night".

While we do not have a sleeping-in arrangement in each unit as suggested, we have the following arrangements:-

1. RSW sleeps in Slemish House
2. RSW sleeps in Chalet 2, also covering Chalet 1.
3. Brother Ailbe, Assistant Director, who has overall responsibility for the Justice area, sleeps in Slemish House - adjacent to his unit
4. Mr. Murphy, Sen. RSW, who is responsible for the Reception area, lives on the school campus.
5. The Director, Senior Deputy Director, Bro. John Sen. RSW and Bro. Finian, RSW, also live on the campus.

These are all connected to all units in the school by an internal telephone system. (Appendix 1)

The record of the school in answering emergencies, day or night, over the past 70 years speaks for itself.

The Board was disappointed that the high level of on-campus presence on the part of the Brothers was not acknowledged. However, if the NGO thinks that the present arrangements are unsatisfactory and would wish to provide a more comprehensive service, management would be happy to comply.

18.11 & 18.12 Implemented.
Renovation of toilets etc.: The Board is pleased that the NIO accepts its responsibility in this area. If the situation is such that the Environmental Health officer "might have been forced to have taken drastic action", then the Board does not feel that this problem can be left to the long-drawn-out process of a feasibility study. The delay in dealing with this problem can be documented to 1986 and, even in the revised plan of work, this was to have been carried out in 1988/89. The Board is confident that all that can be done at school level to provide cleanliness is being done. (Appendices 2A and 3A)

Implemented.

The recently established Licensing Review Committee has, management believes, provided the Key Worker with a higher degree of accountability for the care programme of each boy. The Key Worker is obliged to provide a written report to this Committee and, when possible, appear in person before the Committee to explain his/her plan and answer questions about his/her role. The chain of professional responsibility is assured by having the Team Leader comment on the care programme, as described by the Key Worker, to the Committee. This heightening of the profile of the Key Worker will obviously encourage a more direct role in the review process.

It will be possible to advance further along the road of implementation when proper facilities are provided other than in the Assessment Unit.

Pocket Money/Special Allowances: Training Schools are not yet in a position to implement this. All boys do now receive some remuneration. Within our financial constraints we have taken on board a system whereby birthdays, bonus systems, etc., can merit additional pocket money.

Information to hand would indicate that, in this respect, allocations to Training Schools fall far short of that recommended by EH&SSS. This also applies to allocations for clothing.

Recommendations regarding clothing are being addressed along the lines suggested by the Inspectorate and will be operational early in the new financial year.

An attempt has been made to balance value with individualism. The use of second-hand or rather used laundered clothing is now confined to rough work as was suggested in the original recommendations.

The Board agreed that it is very difficult to ascertain the dividing line between debutism and a realistic awareness of the problem of pilfering where access to rooms is recommended for the boys. While it is not nearly as widespread as the Report suggests, it is hoped that the long-awaited provision of single rooms will further reduce the incidence of pilfering. (Appendix 4).
18.20 & 18.21 Implemented.

18.22 Much good work had already been done by APRU (Mr. C. Cunningham and Mr. Swainston) and it is envisaged that this work will be ongoing.

18.23 The Board agrees that the area of case files was of great importance. The Director reported that considerable improvement has been made. The Board was surprised to hear that the Inspector was 'told' that little change had taken place. Members found it difficult to understand why a request was not made to see the files once such a claim had been made.

In view of their experience and expertise in this area, Fr. McCann and Mr. D. McKillop were asked to look at a random selection of case files and report back to the Board. In their report they state that: 'The files we examined in Reception and Assessment were, in our opinion, of the highest standard'. (Appendix 5)

18.24 (Par. 23-25 of the Follow-up Report). It was accepted that the deterioration in fabric and furnishing has progressively worsened in recent months. Management accepts its share of the blame for allowing the deterioration. It also accepted in good faith that the priority work programme of 88/89 would have been implemented. Our experience of working with the NIO over the years could have justified this faith and trust. Now, at last, it is happy to report that an emergency face-lifting programme is presently in progress pending implementation of an agreed renovation schedule.

Some of the furniture referred to in the Follow-up Report has been stored awaiting the carrying out of this face-lift and will be in position as soon as that face-lift is completed. (Appendix 2C)

The members of the Board were assured that at no time has any member of management alleged religious discrimination in the allocation of funds. No one at Board level has done so. Certain questions have been asked as to why work on the chalets and similar work has been repeatedly postponed while other similar schools have had such work done. A request for parity of treatment for schools of similar nature cannot be interchanged with allegations of religious discrimination. The Board would resent any attempt to do so.

Reference to maintenance is incomprehensible given the physical state of the school. In the opinion of the Board, the inference that a major part of the decline of the condition of Chalets 1 and 2 is due to poor management is manifestly untrue.

The Board noted the comments on financial arrangements for the school, particularly how the report treated questions of underfunding capital and revenue monies for upkeep. These are dealt with at the common level of maintenance. (Appendices 2B, 2D & 2E)

18.25 Not applicable

18.26 18.27 Implemented

18.28-18.29 Management is conscious of the necessity to reduce the incidence of smoking and would welcome further assistance in this area.
Given the background of the client group, it has been management's tradition to approach this sensitive issue on an individual basis. Staff from ground level to the Director are involved in what is in some cases intensive counselling.

There is very close liaison between teaching staff, social work staff, school chaplain and medical staff where cases of high risk have been identified. All staff are acutely aware of the many risks incurred through promiscuous behaviour but management can confidently state that the issues raised by the Inspector are being professionally addressed. Moreover, the advice and support of the Down and Connor Marriage Advisory Service has been sought to structure this ongoing programme.

The Inspector's Follow-up Report gives little recognition to the work that is done in this field on an individual basis with our residents, i.e. the work that has been done other than in a structured educational way. As regards the latter, it was agreed that consideration should be given to programmes in use in schools elsewhere in the Diocese. The Down and Connor Diocesan Religious Advisors have agreed to assist in this.

18.32–18.35 Role of Assessment and responsibility for reviews, etc.: Progress to date has been slow in the implementation of these recommendations. However, steps are being taken to ensure their full implementation and new structures will be in place in the near future. This will entail some training for Senior RSWs in the management of meetings. The Licensing Review Committee will also be monitoring reviews/progress reports.

Mr. McKenna welcomed the recent arrangements made for reviews in the Units and the role of his department in same. This will enable him to "become more fully involved in the reception and initial assessment of all young people coming into the school" (SSI Report 7.9).

18.36, 18.37, 18.38, 18.39, and 18.40 Implemented.

18.41 Role of Field Social Work Department: Management are awaiting a response from NIO to a submission from the Training Schools Community Care Teams regarding future funding arrangements before implementing this recommendation. Meanwhile the Senior Social Worker is aware of the annual budget for his department. The Board would be interested to know if the Senior Social Worker was in agreement with the comments that "little has been done regarding this recommendation".

18.42 & 18.43 Implemented.

18.44 Facilities are there for the storage of food but are under-used. This will be discussed further in conjunction with the MMRD recommendations.

18.45 This statement is inaccurate. Documentary evidence could have been provided to show that Matron had been given this on 1st December, 1989.
The food committee has been expanded to include representatives from each unit. Boys will also be consulted and their wishes will be catered for, as far as possible. In future Board members will examine the Menu book as part of their area of inspection.
(Appendices 2D, 2E, 3A and 3B)

The Board acknowledged that there has been undue delay in establishing a regular and documented system of visiting. With the widening of the Board's membership this is now being implemented.

The Chairman of the Board has personally examined and signed the Record of Major Incidents at each Board meeting. For that reason the Board found it difficult to understand why the implementation of this recommendation should be deemed 'apparent'.

The Board acknowledged that undue delay had taken place in carrying out fire drills. A series of fire drills recently carried out have clarified certain areas of difficulty and enabled us to rectify these.

The Board acknowledges its responsibility to ascertain that the fire safety situation is carefully monitored. The Board would have wished to receive copies of the Fire Authority's written report on its investigation, particularly in the light of Mr. McKeag's report.

Discussion then took place on one area not mentioned in the original report, namely the key situation.

This is a new issue and was not included in previous recommendations. Traditionally staff have been considered sufficiently responsible for the safe keeping of their keys and we see no reason to change a system which has stood the test of time.

However, in Slemish House, keys are not removed from the premises. The Board felt that the areas of the school, other than Slemish House, should be regarded as a school much more than as a high security unit.

Slemish House itself is of a different nature. Keys required by staff on duty are signed for on arrival. Staff also 'sign-in' their keys on completion of duty. Only the Director has a key to that unit on his person.

This fact could easily have been ascertained by the Inspector. Thus could have been avoided the outlining of the hypothetical flaw and the horrific hypothetical scenario which followed it.

The Board is worried that this paragraph, combined with the previous one, might leave an impression of a highly irresponsible management, unconcerned about the security of premises and of staff.
In conclusion, the Board has tried to acknowledge and rectify as a matter of urgency those areas where undue delay in the implementation of the recommendations had taken place.

At the same time it is hoped that this approach will be matched with a similar sense of urgency by others sharing responsibility for the well-being of the children and young people entrusted to our care.

It does not feel that these areas of urgency can be shelved in the name of a prolonged Feasibility Study.
The chart shows the "on-campus contact" for each unit, to be used in the case of an emergency. The Night Supervisor visits each bedroom at least twice each night. On these visits he must always...
A. On 5 February 1988 St. Patrick’s wrote to the Northern Ireland Office to express their concern about these toilets. They had raised similar concern on numerous occasions before and have done so many times since.

In paragraph 18.13 of the Inspector’s report dated 23 February 1990 he said regarding the ablution area in the main building: "I have no immediate or quick solutions to these problems" even though in paragraph 5, 20 of the February 1988 Report the Social Services Inspectorate said that there was a short term need to improve the showers and toilets.

The Northern Ireland Office’s whole attitude in this matter appears to be guided by their total obsession with costs savings in contrast to health and sanitation standards. Indicative of this is the comment contained in the Chief Engineer of the DirSN’s letter to the Northern Ireland Office dated 22 May 1989 regarding Mechanical Services Installation (Showers) namely: that the Northern Ireland Office’s suggestion indicating that St. Patrick’s should just replace the mixer valve on a like for like does not comply with present day (1989) standards or acceptable codes of practice for installation. Even though the Chief Engineer went on to recommend to the Northern Ireland Office on or about 22 May 1989 that "depending on the number of boys currently in residence", 3 or 4 shower positions should be completely renovated and the remainder removed from service, the Northern Ireland Office have still not allocated funds for either such renovation or such removal from service.

Even though St. Patrick’s wrote to the Northern Ireland Office as recently as the 20 March 1990 the Northern Ireland Office does not appear to have made any helpful short term or long term decision regarding either the toilets or the shower units in the main building.

B. The Inspector was assured by the Northern Ireland Office that at no time were St. Patrick’s ever denied money for maintenance and pointed out that the financial statistics referred to seemed to substantiate this claim. He did not state what the financial statistics were. He did not define "maintenance". He did not point out that the Northern Ireland Office had not produced funds for problems which should have been dealt with in the short term though it is a moot point if such problems come under the term "maintenance". Unfortunately maintenance statistics do not give a clear picture. They do not show, inter alia:

(i) That even though the Director sent the Northern Ireland Office on or about 9 June 1989 a report by the Deputy Director dated 23 May 1989 regarding emergency and preventative maintenance and asked the Northern Ireland Office to treat this as a matter of extreme urgency, the Northern Ireland Office have not yet responded thereto.

(ii) That even though the Director sent the Northern Ireland Office on or about 26 October 1989 a report by the Deputy Director dated 26 October 1989 regarding "the need for an urgent review of the present system of supervising and co-ordinating the work of the school’s Term Maintenance Contractors", and the Director asked the Northern Ireland Office in a letter dated 26 October 1989 to give this matter their immediate and sympathetic consideration and the Northern Ireland Office in a letter to the Director dated 31 October 1989 said that this matter was receiving attention, the Director has received no further response from the Northern Ireland Office to his letter.
THE DEPARTMENT OF JUSTICE

STATEMENT TO THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 7

TRAINING SCHOOLS AND YOUTH JUSTICE INSTITUTIONS

28 August 2015
Introduction

This is a supplementary statement by the Department of Justice (DOJ) further to paragraph 15 of the joint DOJ and DHSSPS Overarching Statement provided to the Historical Institutional Abuse Inquiry dated 21 August 2015, (Anything else the Department considers it should bring to the HIA Inquiry’s attention in respect of these matters).

I, Gary Wardrop, will say as follows:

Throughout the period that the Inquiry has been running, the Department has reviewed its records to identify information relevant to the HIAI and to provide such documents to the Inquiry.

In the course of this work the Department has identified records which show that a number of investigations into allegations were undertaken prior to 1995. These records have been provided to the Inquiry. This statement addresses the Department’s role in relation to those investigations and the action taken to address the issues, and policies and procedures affecting the training schools.

The joint DOJ and DHSSPS statement of 21 August 2015 sets out the relationship between MOHA/NIO and the Board of Management for each school. The Department provided the policy framework, legislation and financial resources to deliver policy objectives. The Schools’ Board of Management were responsible for the day to day running of the schools, and involved the MOHA/NIO when something of significance arose and the Board considered it necessary to involve the MOHA/NIO.

NIO File W14/87: Information and Allegations of Misconduct

The DOJ holds a number of papers relating to allegations of misconduct relating to Rathgael and Lisnevin training schools during the period December 1986 to December 1989. The papers provide records of events and actions brought to the NIO’s notice. In each instance the records indicate that the NIO has acted promptly, sought investigations into events, and considered steps taken to address the issues and outcomes of the investigations. The papers indicate the protocols and procedures operated by the NIO and the training schools.

To illustrate those processes I have highlight a number of examples below:

Allegation of member of staff acting inappropriately January 1987

In response to a journalist approaching the NIO (dated 15 January 1987) regarding alleged “free living parties” on the Rathgael campus, a senior NIO official wrote to
the Chairman of the Rathgael school on the 20 January 1987. The official asked the Chairman to thoroughly investigate the allegations and provide the Department with a report on the matter\(^1\). Following these investigations the Director of Rathgael wrote to a member of staff, whom the Director had interviewed as part of the in-depth investigation. In his letter, the Director set out his conclusions that the officer had not acted with propriety and good sense, and had not shown good example and precept to the young people in their charge. The individual had, in the Director’s words, misused the centre’s accommodation. The Director’s letter\(^2\) terminated his employment with one month’s notice.

In addition, the Director wrote to all staff to remind them of their responsibilities, particularly to ensure that they behaved professionally and complied with the Centre’s policy on campus accommodation\(^3\).

The Chairman of the Rathgael management board wrote to the NIO on 4 February 1987, providing a report on the investigation undertaken, explaining how the disciplinary procedures were used, and the outcomes of the investigation.

**Incident at Runkerry May 1989**

In an incident which occurred on 9 May 1989 at Runkerry (outwards bound location used by training schools), a child alleged she was the victim of bullying and sexual abuse amongst peers. A thorough investigation was held by Mr T Cromey, Head of Education, and information was provided by a teacher and residential social worker. The investigation’s report detailed the events that happened, found that bullying had occurred, and set out the events resulting in embarrassing sexual exposure of the victim. The Investigation identified the culprit(s) involved and made recommendation on the actions which should be taken in respect of the person responsible for the bullying. A detailed memorandum\(^4\), dated 19 May 1989, was provided to the Chairman and Director of Rathgael, those involved in the investigation and the pupil responsible for the bullying, received a number of sanctions, was closely monitored, and received an official police caution at Bangor RUC Station on 12 October 1989\(^5\).

The investigation also considered the effectiveness of the school’s practice of “Walking Supervision.” The conclusion indicated that although the supervisory system was in operation, the alleged victim did not take the opportunity to inform the supervisors of what was going. Reports on the outcomes were provided to the NIO.

**Incident regarding sexual activity between boys and girls October 1989**

---

\(^1\) Senior official letter to Chairman of Rathgael dated 20 January 1987.  
\(^2\) Director’s letter dated 3 February 1987  
\(^3\) Director’s letter to staff dated 2 February 1987.  
\(^4\) Memorandum from Head of Education to Chairman of the Management Board and others, 19 May 1989.  
\(^5\) Ibid, (page 2) manuscript notation of police caution on memorandum dated 19 May 1989.
Papers provided to the NIO on 8 December 1989, show that an incident took place at the Rathgael School on the evening of 13 October 1989, calling into question the protocols and procedures operated by Rathgael supervisory staff. A night supervisory report\(^6\) indicated that night checks were undertaken, and that there was some suspicion regarding a number of boys. Following further night checks there was nothing unusual to report. However, a further check at 7:40 am indicated that two girls had spent some time with two boys. This was reported immediately to reception staff and a senior member of staff.

The Incident report\(^7\) of 14 October sets out the actions subsequently taken by staff. A manuscript Incident report\(^8\) shows that the Staff immediately reported the matter to the Police in Bangor, who conducted an investigation. The papers indicate that staff took prompt action and appropriate action, with a female officer accompanying the girls during their time with the Police.

**Allegation of inappropriate behaviour between a member of staff and boys December 1989**

A further allegation of impropriety by a member of staff was investigated in December 1989. The allegation was brought to the NIO’s attention by way of an anonymous letter via Health Boards and enquiries by the press. The NIO wrote to the Chairman of Rathgael Whiteabbey Schools Management Board setting out actions to be taken, and requested that investigation to be undertaken urgently\(^9\).

A senior NIO Official wrote to the Minister to inform him of the circumstances and actions being taken\(^10\). This included precautionary suspension of the Deputy Director of the school, in line with standard procedures. The Ministerial briefing confirmed advice from the Social Services Inspectorate that involving the Police was not necessary in the first instance. The briefing also outlined how the investigation should be handled. The instructions made clear that if the investigation found anything to substantiate the allegations, then the investigation should be referred to the Police immediately.

The Investigation report was produced on 11 December 1989\(^11\), addressing each allegation and the steps taken to secure appropriate information. Its conclusions indicated that the allegations were untrue.

The Chairman wrote to the NIO setting out how they intended to conduct the investigation, and seeking agreement to the proposed way forward and the findings

---

\(^6\) Night Supervisors Incident Report dated 13/14 October 1989, reported by Harry Dobbin.

\(^7\) Incident Report dated 14 October 1989, reported by Mrs Aspinall

\(^8\) Incident Report completed on 14 October 1989 by Mr Raymond Rea.

\(^9\) NIO letter to Chairman of Rathgael Whiteabbey Schools Management Board dated 8 December 1989.

\(^10\) NIO letter to Minister dated 8 December 1989

\(^11\) Director of Rathgael letter to NIO dated 11 December 1989

15\320056
to date. This approach was agreed by the NIO. The Chairman’s letter of 13 December 1989 to the NIO set out details of the investigation and its findings, and sought the NIO’s agreement to its proposed actions, to be further agreed by the Management Board in a special meeting. The NIO submission to the Minister of State dated 15 December 1989, confirms that the NIO agreed with the conclusions of the investigation and that the Deputy Director was reinstated.

It would appear that the NIO worked at pace with the School in respect of this incident and gave direction and advice on the nature of the investigations, calling upon the professional advice of the SSI. It also indicates the effective use of procedures to ensure that investigations were objectively and effectively carried out.

**NIO File W277/92: SSI Investigation - Martin Huston**

Within this file there is no actual definitive date of when the NIO became aware of allegations by Mr Huston regarding St Patricks. The File was opened in 1992 and there are no former file references. The file also contains a medical report from 1986 which references that he and a group of four boys being regularly forced to have sex in a Training school.

The file contains copies of court transcripts of proceedings for the 26 August 1992, and the 29 and 30 October 1992. It is thought this information was secured in light of a newspaper article dated 1 November 1992.

On 2 November 1992 the Chief Probation Officer wrote to Board members informing them amongst other things that the NIO would make an announcement that an independent investigation would be carried out by the SSI.

On 2 November Mr Lyon set out a press release on an investigation into the Huston case. On 17 November 1992 the Chief Inspector of the SSI wrote to Minister with draft Terms of Reference for the SSI investigation. This was subsequently approved on 20 November 1992.

Mary Madden informed senior NIO officials of assistance to the Inquiry team, providing the Inquiry team with information and papers relating to the police investigations.

During the period of the SSI investigation, the NIO looked into the nature of its pre-employment check process, and the availability of other checking mechanisms in

---

12 Minute from Chairman of Rathgael to NIO dated 11 December 1989
13 Letter to Chairman of Rathgael from NIO dated 12 December 1989
14 Chairman of Rathgael letter to NIO dated 13 December 1989
15 NIO submission to Minister of State dated 15 December 1989.
16 Medical Report by M Kee Senior Registrar, Department of Mental Health, EHSSB, 19 November 1986
17 Submission from Chief Inspector SSI to Minister dated 17 November 1992, including reply dated 20 November 1992
15\320056
DHSS and Department of Education. NIO wrote to DHSSPS requesting that pre-
employment checks are extended to include staff within Training Schools.

On 13 September 1993, the Chief Inspector of the SSI provided Minister with a
submission on the outcome of the Investigation, and seeking approval to publish the
report¹⁸.

The Information held within the file would indicate that the NIO took immediate action
to put in place a thorough and independent investigation into the case.

NIO File W58/89: St Patrick’s Brother

In November 1993 the NIO were alerted to allegations that had sexually abused pupils in St Patrick’s Training School through a Police
investigation regarding allegations made by and other past pupils during their in St Patrick’s Training School¹⁹. At that time Brother ¹⁹

On receipt of this information the NIO gave consideration to how an investigation
could best be instigated. As part of its deliberations the NIO took into account the
Police’s desire to delay NIO contacting the Chairman of the St Patrick’s Management
Board, in order for the Police to complete the gathering of evidence. However, given
the responsibility for the children currently in the school, the NIO sought advice from
the Chief Inspector of the SSI, who provided the NIO with professional and policy
advice.

Advice from the Chief Inspector of the SSI set out policy and procedures on the
handling of complaints, used for children in residential care, indicating these were
appropriate. The Chief Inspector of the SSI agreed with NIO’s preference to advise
the Chairman of the Board of Management of the allegations and the Chairman
should assess the risk and appropriate action taken²⁰.

The NIO decided to meet the Chairman of the Board of Management and advise him
of the serious allegations concerning Brother ²⁰.

In responding to this incident, the NIO acted promptly on receipt of the allegation. It
followed procedure and best practice and sought the professional advice of the SSI.

---

¹⁸ Submission from Chief Inspector SSI to Minister dated 13 September 1993
¹⁹ Submission to Mr Lyons, NIO from NIO dated 23 November 1993
²⁰ Submission to Mr Lyon dated 25 November 1993

15\320056
Background

1. I am currently Head of Personnel and Office Services Division (POSD) in the Department of Justice. My main areas of responsibility include:
   - To continue the programme of work to achieve Human Resources (HR) Shared Services across the DOJ;
   - Ensure smooth transition of HR Services from Northern Ireland Prison Service to POSD;
   - Provide high quality HR services to customers and stakeholders, guiding businesses through changes that will occur in staffing arising from the Voluntary Exit Scheme (VES);
   - Ensure business areas are appropriately staffed after VES;
   - Deliver and provide high quality service on Procurement, Estate Management, Learning and Development, Health and Safety and Security across DOJ.
   - To deliver improved levels of performance and tackle under performance.

2. I joined the Northern Ireland Office (NIO) on 27 January 1992. Prior to that date I was a Solicitor in the Crown Solicitor’s Office. The NIO had planned to carry out a fundamental review of Criminal Justice and I was invited to join the NIO to assist in that review. Although I would be working in a general grade, my legal skills were viewed as being advantageous to the project.

3. When I arrived the NIO was restructuring to create a new Directorate – Criminal Justice – headed by a newly appointed Home Office Official, John Lyon. The Directorate would consist of three Divisions – Criminal Justice Policy; Criminal Justice Services; and Police Division. I arrived as this restructuring was being finalised and was assigned to the newly established Criminal Justice Services Division. Within this Division three major areas of work were brought together (each headed by a Principal/Grade 7) – Probation; Training Schools; and Emergency Planning (the handling of major incidents
whether as a result of terrorist or non-terrorist action). In addition to heading this Division a major part of my job would be working on the project team, under the direction of John Lyon, carrying out the fundamental review of all aspects of the Criminal Justice system.

4. Prior to my arrival, Alan Shannon had responsibility for two of the three areas – Probation and Training Schools – handing over responsibility to me on 27 January 1992. As I had never worked in the NIO before that date, nor in my professional life dealt with any matters concerning or arising from Training Schools, I cannot provide any information as to what may or may not have happened before I joined the Department.

5. When I took up post there was a well-established working relationship between the Schools and the Department supported by experts in the area of child protection and social work and also in the area of finance. I understand that Alan Shannon, who held the post previously to me and who worked in the NIO for a longer number of years within the remit of the Inquiry, will set out in detail the nature of the relationships between the Department, the Social Services Inspectorate and the relationship between the Department and the Schools. There was no change to these arrangements during my time as head of Criminal Services Division except that I had to develop my own personal relationship with each of the schools and those colleagues who provided expertise and advice to the department.

6. During the period I was in post, the day to day working contact and oversight with the Training Schools was handled by the head of the branch. Allan Johnston initially held that post during my time, and latterly it was John McCartney. They dealt with all financial matters, ensuring good governance and the proper application of departmental policy, rules and guidance. They would deal with one-off individual matters or issues that arose working with the staff at the schools to resolve them. The head of branch would have brought matters to my attention if they were grave or of high significance. For example, I received a phone-call one evening from Allan Johnston advising me of a serious disturbance at Lisnevin when a number of boys had overpowered staff in the dining hall, proceeded to lock themselves in, and
where they wrecked the place and set the furniture alight. The staff had managed to regain control when the Fire brigade had arrived to put out the fire by breaking into the room. That same evening Allan Johnston and I travelled to Lisnevin to see for ourselves the extent of the damage, to ensure the staff and the boys were uninjured, to hear from the staff what had occurred and to satisfy ourselves that the situation was resolved. While Ministers and senior staff were kept informed of these matters, a full report was put into the system the following day¹ (paragraph 1.5 of Exhibit 1 refers).

7. As a general rule the head of branch would keep me informed of what was happening and I, in turn, would keep John Lyon, my line manager informed of developments. I would become directly involved in issues when it was necessary to reinforce messages – for example in financial management and good governance - or when major decisions had to be conveyed – for example, when we had taken the decision to invest capital in either new builds or refurbishment in existing buildings. I remained in this post until 26 October 1995 when I moved to become head of Financial Services Division in the department.

8. Most of our engagement with the Training Schools, whether with the individual institution or all four schools together, was through formal meetings. Where issues crossed all four schools those meetings invariably would have been chaired by either John Ledlie or John Lyon. For example, John Lyon regularly held meetings to discuss with the practitioners the review of the Criminal Justice system and some of the emerging findings. In addition, the Head of Branch and his staff held regular formal meetings to discuss and resolve matters of mutual interest. On occasions I would chair some of these regular monthly meetings sometimes to reinforce the government’s policy or position or as a means to maintain my own working relationship with the schools. Outside the formal meetings the head of branch, and his staff, would have been in (virtually) daily contact either by phone, by letter, or, where the business need dictated it, by holding informal impromptu meetings.

¹ Appendix 2: Incidents which occurred during April 1994; para. 1.5
9. In addition senior staff of the department, John Ledlie, Deputy Under Secretary, John Lyon, Head of Criminal Justice Directorate and his successor, Jim Daniell, would have had their own separate contact with the Schools, chairing meetings when the matter was of serious concern, (for example, John Lyon led on the meeting with the Chair and Deputy Chair of St. Patrick’s Management Board in relation to the matter of brother... – (see further below), and on important and/or on cross cutting policy issues affecting all or individual schools. The Secretary of State, Ministers and Senior staff would have carried out visits to each of the schools periodically, meeting both the senior staff and representatives of the Management Board. Rathgael’s Management Board was appointed by the Secretary of State who would occasionally hold meetings with the Management Board, accompanied by the senior staff of that institution.

10. While I held the post the Chair of Rathgael changed from Lady Moira Quigley to Tom McGrath but the Chairs and Deputy Chairs of all the other Schools remained unchanged.

Allegations of sexual abuse against the De la Salle Brothers and particularly

11. During the time I held this position, I was made aware of serious allegations of sexual abuse by two ex-pupils against Brothers of the De la Salle Order at St Patrick’s and specifically of an allegation against... From reading the files I can now say this occurred in November 1993\(^2\) (Exhibit 2). I cannot recall how it was brought to my attention but my recollection is that the police advised either Allan Johnston (Head of Training Schools Branch) or his deputy, Bill Gallagher, of these complaints and the stage of their investigation into them. It was of immediate concern that one of the Brothers against whom allegations were made, was now the Principal of the Training School.

---

\(^2\) Allegations of sexual abuse at St Patrick’s – Note of a meeting between NIO and SSI – 18 November 1993
SPT-12924 – SPT-12925
12. As seen from documents (Exhibits 3 - 7) at the time, this matter was immediately brought to the attention of the most senior members of staff within the department – Sir John Chilcot, (Permanent Under Secretary), John Ledlie, (Deputy Under Secretary) and John Lyon all were made aware, as were Ministers. The urgency of the issue was immediately recognised at all levels and meetings to discuss these matters and the implications were held as early as possible internally; with the SSI (for expert advice) (Exhibit 8); and the police to determine the best way forward. The police raised concerns in two respects: the impact on the individual, their reputation and that of the school should those allegations prove false; however should the allegations prove to be true, alerting the school authorities at such an early stage of their investigation could not only hamper it but could stop it altogether. Their fear was that the De la Salle Order could move out of the jurisdiction and beyond their reach. From the start, the SSI took the view that the safety of children at the school was the priority and should be removed from his position pending the outcome of the police investigation as is the recommended and adopted practice under such circumstances. We fully accepted the SSI’s recommendation while acknowledging the police concerns. Ministers were formally advised and their approval sought to allow officials to inform the Chair of the Training Schools, Bishop Farquhar and ask that be removed pending the outcome of the police investigation.

13. Having secured Ministerial approval, John Lyon considered it appropriate to invite the police to join the meeting with the Bishop but after internal consideration the police declined (Exhibit 9). John Lyon and I arranged and met Bishop Anthony Farquhar and Canon Peter McCann. That meeting took place in Canon McCann’s parochial house at St Malachy’s Church. John

---

3 Note of a meeting at CJSB between NIO and the RUC to discuss alleged sexual misconduct at St Patrick’s Training School – 18 November 1993 SPT-12926
4 St Patrick’s: Allegation of sexual abuse – memo from to J Lyons dated 23 November 1993 SPT-12927 – SPT-12933
5 St Patrick’s: Allegation of sexual abuse – memo from J Lyons dated 23 November 1993 SPT-12934 – SPT-12935
6 St Patricks: Allegations of abuse. Note from PS/PUS to dated 25 November 1993 SPT-12936
7 St Patrick’s: Allegations of Abuse – Note from J Lyon to dated 25 November 1993 SPT-12937 – SPT-12938
8 St Patrick’s: Allegations of abuse – note from K McCoy to dated 25 November 1993 SPT-12939 - 12940
9 Note for Record regarding police attendance at the meeting with the Bishop and Conor McCann SPT-12941
Lyon, who took the lead at that meeting, appraised them of the serious allegations made against **LN(BR)26** by ex-pupils of the school and the advice of SSI that **LN(BR)26** should be suspended during the police investigation, advice which the department fully supported. They were also advised that the police would at an appropriate stage of their investigation want to interview **LN(BR)26** under caution, and we shared with them the police concerns that **LN(BR)26** might leave the jurisdiction and that De la Salle Order and school might frustrate the investigation. We suggested that this would not be in anyone’s interest and hoped that would be a view shared, which it was.

14. Both men understood the gravity of the allegations but emphasised that knowing the individual as they did, could not believe nor did they believe the allegations made against him. They undertook to consider the matter urgently and come back to us with their decision, which they subsequently did. We were advised that the allegations were put to **LN(BR)26** who had denied them vehemently. **LN(BR)26** had confirmed he would submit to a police interview under caution at any time and he would not leave the jurisdiction pending the outcome of investigation as he was determined to clear his name. The Management Board had discussed the matter and decided, as these were unproven allegations and given **LN(BR)26** strong denial of wrong doing, they would not remove him from his position as Principal at this point. However, we were advised that should more information come to light, the Board would review their decision. We registered our surprise and disappointment with the decision. This outcome was relayed back to Ministers and senior officials.

15. Although **LN(BR)26** remained as Principal of the School until he retired, his retirement occurred before I left the Division in 1995 and probably not long after the outcome of the police investigation was known.

16. I have no recollection of having any further dealings with this matter.
17. In preparation for making this statement my attention has been drawn to documents speaking to my involvement in addressing a number of issues arising out of the death of

18. Previous to reviewing the relevant documents (Exhibits 10-12), I had no recall of the matter either the circumstances of the death of or the reports that flowed from his death nor have I any recollection of the discussion or action taken before or subsequent to it. I have now had the opportunity to read all the papers provided by my colleagues in DOJ and have no independent recollection of the matter. I am, therefore, not able to add to the information contained in those papers, except what I can opine from reading the material.

19. There was an issue of absconding from two of the training schools - Rathgael and St Patrick’s. Residents in Bangor had made complaints about boys leaving the school and heading into Bangor Town Centre where many became involved in anti-social behaviour. In West Belfast, joy-riding and car theft was prevalent and a security headache for the police and the army. It was a cause of concern that some children from St Patrick’s became involved in this type of behaviour.

20. reports had been commissioned (and received) - one from the Western Board and the other from St Patrick’s Training School. It is evident from the papers which I have read that each of the reports were unsatisfactory and had raised concerns: see the comments of Jim Daniell (Exhibits 13-15). SSI was

---

11 Meeting re: case from PS/Mr Hunter 13 January 1995 SPT-12918
12 Death of agenda for meeting 19 January 1995 SPT-12916 – SPT-12917
13 Meeting with NIO: Note from J Hunter to Dr McCoy 19 January 1995 SPT-12610 – SPT-12611
14 Note of meeting between officials of the Management Executive and officials to the NIO on 19 January 1995 to discuss matters relating to the death SPT-12909 – SPT-12911
15 File note of meeting in respect of (deceased) held on 19 January 1995 SPT-12912 – SPT-12915
commissioned to carry out an independent and thorough review\textsuperscript{16} (Exhibit 16) covering the areas in the Western Board’s review and the St. Patrick’s report. The SSI report\textsuperscript{17} (Exhibit 17) contained the terms of reference for the review at page 33\textsuperscript{18}.

21. Paragraph 5.21\textsuperscript{19}, page 22 of the SSI report sets out the unacceptably high level of absconding from the school – 353 incidents in the first six months of 1994 –commenting that it was part of the culture and made recommendations. The report made no comment on the response of the senior staff and the Management Board to this growing problem within the school. It is clear from reading the papers that Ministers were concerned that previous SSI inspections had failed to bring to light deficiencies identified by the Inspectorate in this review before and were also exercised on the question of the frequency of inspections at the Schools and whether it gave them the assurances they needed. I can only surmise that as I would have been aware of these concerns following receipt of the St Patrick’s report followed by the SSI review, I must have been conveying Ministerial and the departmental concerns to Mr. McElfatrick. On reading the papers there is a suggestion that a further wider review focussing on the Management Board may have resolved the matter.

21. The record made by Mr. McElfatrick suggests that this meeting involved a frank exchange of views. I must stress again that I have no actual recollection of the LN(SPT) 81 case nor of any meetings that took place on that issue, including the meeting with Mr. McElfatrick. I did not take a note at that meeting and if NIO recorded the meeting it would have been done by a member of the branch. When I left the division in October 1995 all papers and files remained with the division. I am no longer a member of the NIO and do not hold any papers belonging to that period. From my recollection and perspective I do not believe that the meeting with Mr. McElfatrick adversely

\textsuperscript{16} Investigation at St Patrick’s Training School in respect of – note from K
\textsuperscript{17} SSI Review of the circumstances surrounding the death of – SPT-12652
\textsuperscript{18} Ibid, page 33 SPT-12652
\textsuperscript{19} Ibid, page 22, para 5.21 SPT-12641
effected the overall working relationship between the department and the Social Services Inspectorate.

Mary Madden

9th September 2015
APPENDIX 2

1. INCIDENTS WHICH OCCURRED DURING APRIL 1994

1.1 At about 9:30 p.m. on Saturday 2 April, 4 boys (J. Carlisle, E. Gibson, B. Martin and A. Morrow) barricaded themselves in B. Martin’s bedroom. At 10:20 p.m. E. Gibson responded to staff advice to leave the barricade and go to his own room. The remaining boys attempted to barter for extra cigarettes in return for coming out. When this ploy did not succeed they caused considerable damage to the room and its contents. It was made clear to them that they could leave the barricaded room at any time on request. They elected to remain where they were and remained there until 10:30 the following morning.

1.2 On Sunday 3 April at 9:30 p.m., 3 boys (S. Fullerton, P. McHugh and A. Stanfield) barricaded themselves in a bedroom but responded to staff persuasion and left quietly 20 minutes later.

1.3 At 7:30 p.m. on Monday 4 April, Darren Leckey was challenged by a member of staff for throwing milk about. When asked to go to his room and calm down his response was to remove a fire extinguisher from its wall mounting which he used to smash several panels of reinforced glass in the upstairs modular office and the stairhead glass screens. Darren was removed to his bedroom, shortly after which William Ireland smashed more sections of reinforced glass with a croquet mallet.

1.4 At 9:30 p.m. the same evening, 4 boys (B. Martin, T. McDowell, S. Phoenix and A. Rice) broke away from staff on the way to bed and barricaded themselves in the TV room in Woburn corridor. At the same time 2 other boys barricaded themselves in a bedroom. Both groups attempted to gain extra cigarettes in return for their cooperation. Again staff resisted attempts to barter and the 2 groups of boys asked to come out of their own accord and return to their own rooms at 1:00 a.m. and 2:00 a.m. respectively.

1.5 The afternoon shift on Tuesday 5 April commenced with a severely understaffed situation. At 7:30 p.m. the general alarm sounded and several boys barricaded themselves in the Remand Servery. They were belligerent and resisted encouragement to come out.
Other groups of boys were unsettled and agitated. Some were attempting to retrieve packets of cigarettes thrown from the barricaded area where the shop had been broken into. Soon afterward a fire was started by boys barricaded in the Servery. The fire was both inside and outside of the room. Smoke from the fire set off smoke alarms and there was a sizeable blaze at the seat of the fire. Mr Fitzpatrick had already alerted the Director and evacuated staff and all boys within their control to the dining room. As the last of the boys entered the dining room the phone was ripped out and staff had chairs thrown at them. Mr Fitzpatrick secured the dining room with the boys inside it and mustered staff in the Remand area. He then used a fire hose to extinguish the fire in and outside the Servery. Mr Fitzpatrick led staff with one boy who had extricated himself to the front of the gate. The Fire Service had arrived but the fire was out.

Boys in the dining room were smashing furnishings and fittings and some broke out of the kitchen into the grounds causing damage to the kitchen equipment and storerooms en route.

At this stage the police had arrived and were standing by. Mr Fitzpatrick accompanied by the Director reentered the building and escorted 8 boys who had remained in the wrecked dining room to their bedrooms. Staff, with the assistance of R.U.C. officers, recovered several boys from the grounds and the roof and escorted them to their rooms.

Several other boys had scaled the perimeter fence and made off into the surrounding countryside. Meanwhile, Mr Fitzpatrick and the Director made successive but unsuccessful attempts to talk the barricaded boys out. Reluctantly the Director took the decision to make use of the R.U.C. Mobile Support Unit (M.S.U.) to break down the barricade and effect the removal of the boys so that staff could take them to their rooms. In the event when the barricade went down the boys put up no resistance and were led past the M.S.U. by Mr Fitzpatrick to waiting staff. By 10:15 p.m. R.U.C. officers had recaptured all but 2 of the missing boys who returned of their own accord.

It should be noted that the R.U.C. provided staff with excellent support and co-operation and acted at all times with discipline and restraint.
An ambulance conveyed 2 boys to hospital. Stephen Quigley who had broken his leg was returned to Lisnevin in plaster before midnight. Thomas McDonnell was detained at Newtowmards hospital overnight for observation as a precaution because he took a blow to the head in the melee in the dining room.
ALLEGATIONS OF SEXUAL ABUSE AT ST PATRICK'S

NOTE OF A MEETING BETWEEN NIO AND SSI HELD ON 18 NOVEMBER 1993 AT DR McCoy's OFFICE, DUNDONALD HOUSE

Background Leading to Meeting

In the interests of expediency Mrs Madden asked Mr Gallagher to appraise SSI, at the earliest opportunity, of new information which had come to light in relation to allegations of sexual abuse at St Patrick's. A Mr Stitt who is an ex-pupil of St Patrick’s (early 1960s) has made a statement in which he names Brother David as one of the perpetrators.

Mr Gallagher had the opportunity of passing on this information on 15 November 1993 when he spoke to Mr Donnell after a meeting both were attending at Lisnevin. Dr McCoy was subsequently informed of this new information on 16 November 1993. Up to then correspondence on the Robshaw investigation into similar allegations had been side copied to Dr McCoy appraising him of any new developments as they became known to this Division.

Meeting on 18 November 1993

It was mutually agreed that representatives from the Division (namely Mrs Madden, Mr Johnston and Mr Gallagher) should meet urgently with SSI (namely Dr McCoy, Mr McElfatrick and Mr Donnell) to discuss fully the implications of the latest statement, in particular the allegations against Brother David.

At the meeting Dr McCoy expressed the view 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.
The Division's view was that if it was to ask the Bishop to suspend Brother David there is a chance that he might leave the jurisdiction and thus jeopardise further police action. The point was also made by this Division that the allegations referred to incidents which happened in the 1960's and that others named by Stitt had not yet been approached to provide corroborative evidence.

It was agreed that there was an urgent need for Dr McCoy and Mrs Madden to seek a meeting with ACC Monahan, the senior RUC officer in charge of the investigation, to discuss with him the various views and concerns expressed by the Division and by SSI.
NOTE OF A MEETING AT CJSD BETWEEN NIO AND THE RUC TO DISCUSS
ALLEGED SEXUAL MISCONDUCT AT ST PATRICK’S TRAINING SCHOOL
HELD ON THURSDAY 18 NOVEMBER 1993 AT 15.00 HOURS

THOSE PRESENT:

Mr Mike McArdle RUC
Mr Bob Lusty RUC
Mrs Mar. Madden NIO
Mr Allan Johnston NIO
Mr Bill Gallagher NIO
Mr John Steen NIO

1. Mrs Madden informed the meeting that the NIO had been
advised by the DHSS (Social Services Inspectorate) that
DHSS had some concerns about the allegations of gross
sexual misconduct at St Patrick’s Training School. In
particular, since allegations had been made against the
current Director of the School, DHSS felt that it would
be appropriate to suspend the Director as a
precautionary measure.

2. It was the police view that the Directors suspension
would severely inhibit police investigations and may
cause the Director to flee the jurisdiction.

3. It was accepted by all present that the NIO is in an
invidious position. If the Director is suspended then
police enquiries may well be irreparably damaged and if
he is not suspended there is a slight risk of further
offending.

4. It was agreed that an urgent meeting should be arranged
between the NIO and Senior RUC officers to air fully all
respects of this case.
OFFICIAL-SENSITIVE-PERSONAL

SPT-12927

CONFIDENTIAL

FROM: MRS M E MADDEN
CJSD
25th NOVEMBER 1993

CC: PS/PUR (L&A)
Mr Legge
Dr McCoy, DHSS

MR J M LYON
AUS (CRIMINAL JUSTICE)

ST PATRICK’S: ALLEGATIONS OF SEXUAL ABUSE

The purpose of this submission is to inform you of:

- the recent development in the RUC inquiry into allegations of sexual abuse made by a former pupil, LN(SPT)134, who was resident at St Patrick’s Training School between 1981-1983.

- the new, and more serious allegations of abuse by the present director, LN(BR), made by another pupil, LN(SPT)196, who was resident at the School in the 1960's.

- the possible links with DHSS’s recent investigation into the case of Martin Huston, who, as a known sex offender, was still able to work with children in a voluntary capacity with NIACRO. Huston is currently serving a prison sentence for homosexual offences against boys.

and to recommend that we seek Ministerial approval to advise the Chairman of the Management Board, Bishop Farquhar, of the allegations made against the current director and invite him to consider the position of the director while the investigation is ongoing.

CONFIDENTIAL

OFFICIAL-SENSITIVE-PERSONAL
LN(SPT)’s Allegations

2. In his statement LN(SPT) alleges abuse by staff and pupils. He does not identify any of his alleged abusers by name but provides descriptions. The RUC has advised that of the 300 boys resident at the school during the period in question, 100 have, for various reasons, declined to be interviewed, 160 have submitted to an interview and a further 40 are still to be approached.

3. As a result of the 160 interviews the RUC has gathered sufficient evidence to bring charges against a former pupil who was later employed as a chef at the school. The RUC are presently trying to trace the current whereabouts of this person. Only one inmate (Kelly), considered an unreliable witness due to a previous conviction for perjury, has named an alleged abuser as [REDACTED] not fit that of the Brother.

LN(SPT) Allegations

4. During the course of the RUC investigation into Robshaw’s allegations the Sunday World published an article on 22 August (a copy is attached). This newspaper report caused LN(SPT) to write to the RUC wherein he made specific allegations against Brother BR 20.

5. The RUC has interviewed LN(SPT) who has made a full statement of complaint to the police officers conducting the inquiry. In his statement LN(SPT) has named, in addition to [REDACTED] five other members of the De La Salle Order (one of whom is deceased) as having seriously sexually abused him. He has also named persons whom he alleges, witnessed some of the acts. The RUC has traced seven of these witnesses who are all residing in England. They have plans to approach all these individuals this week and invite them to make statements.
6. The RUC have advised us that they intend to interview 

LN(BR)26 under caution, when they have completed all their interviews arising out of both LN(SPT)1 and LN(SPT)1 allegations. They would hope, at that stage to have sufficient evidence to make an arrest and formally charge LN(BR)26 after the interview. They stress that so far they have one statement of complaint against LN(BR)26 which is not corroborated. Kelly, who mentions LN(BR)26 did not attend the school at the same time as LN(SPT)1.

Huston

7. DHSS colleagues will soon publish the report of their investigation into how Huston, a known sex offender, was able to obtain work in a voluntary capacity with NIACRO.

8. During the course of the DHSS investigation St Patrick's Board of Management were asked to conduct an internal investigation into allegations of sexual abuse made by Huston against unspecified persons. Bishop Farquhar, Chairman, commissioned LN(BR)26 who subsequently reported verbally to the NIO that nothing was found which would substantiate Huston's allegations.

9. The RUC team investigating LN(SPT)1 and LN(SPT)1 allegations recently interviewed Huston. He has now made a statement describing, but not naming, a person who abused him. The RUC believe that the description matches one of the Brothers named by LN(SPT). This Brother is now deceased. Huston does not implicate LN(BR)26. As a result of this fresh information Bishop Farquhar has been asked to confirm the result of the internal investigation in writing.
The Dilemma

10. I shared this information with our professional advisers, SSI, last week. Dr Kevin McCoy, Chief Inspector SSI, and I met with Superintendent Nesbitt, RUC, on Friday, 19 November to discuss this matter more fully.

11. The dilemma, facing the department, is whether to advise the Chairman of the Management Board, Bishop Farquhar, of the specific allegation made by Stitt against [LN(BR)26] The Bishop is already aware of allegations against unspecified individuals made by [LN(SPT)] and Huston. He is presently ignorant of [LN(SPT)] allegations.

RUC Position

12. The RUC are anxious that their investigation is not compromised by allowing a potential suspect to be forewarned of allegations, thereby giving him an opportunity to, at worst, leave the jurisdiction, and at best, prepare "his story". Naturally they wish to complete their inquiries and obtain corroborative evidence so that at the termination of any interview they could arrest and charge. At present they do not have sufficient evidence to cause them to want to interview [LN(BR)26] at this stage. Notwithstanding the outcome of further interviews the RUC have stated that they will be interviewing [LN(BR)26] under caution.

DHSS/SSI Advice

13. SSI, as our professional advisers, consider that, in the interests of the children presently at the school, the NIC should share this information with the Bishop. This would allow the Bishop to decide what the present risk is, and to take appropriate action. Although sensitive to the RUC concerns

CONFIDENTIAL
(that an approach to the Bishop would be counter-productive to their inquiries) SSI consider that the NIO must act to inform management of the school and advise them of the possible course of action.

NIO's Options

14. The NIO could elect to do nothing until the RUC have completed their inquiries. This could be some months away. If, on completion, [LN(BR)26] is arrested the NIO could be subject to criticism for allowing Brother [LN(BR)26] to remain in a position of power and authority despite having the benefit of the [LN(S)] information. The department could also be criticised by the Management Board for not giving them the opportunity of suspending the director pending investigation and thereby leaving them vulnerable to criticism.

15. Informing Bishop Farquhar, on the advice of SSI is not without its difficulties. The Bishop could:

- decide to allow [LN(BR)26] to continue in his present post on the basis that the allegations are some 30 years old and unsubstantiated.
- retire [LN(BR)26] early and remove him from the school. This is defensible as [LN(BR)26] is within 2 years of retirement.
- suspend [LN(BR)26] pending completion of the RUC investigation.
16. Each course of action open to the Bishop presents NIO with relationship difficulties. Alerting the Bishop to one man's allegations, some 10 years old and presently unsubstantiated, could damage relationships between the NIO and representatives of the Catholic Church and the School not only at the working level but also possibly at Ministerial level. The Bishop could write to the Secretary of State to protest at NIO officials acting, in his perception, on rather flimsy information.

17. If the Bishop suspended it is likely that the media would, on hearing this news, draw comparisons with Kincora, link the Huston allegations in the DHSS report to departure and possibly criticise Government's lack of supervision and monitoring of training schools.

18. A further difficulty in the relationships could be caused between the department and the Order if Brother were to be moved out of the jurisdiction. This is exactly what the police fear as important questions would remain unanswered and a problem could possibly remain elsewhere. It could leave the department in the position of dealing with members of the same Order who collectively have moved a fellow Brother out of the jurisdiction. It must also be remembered that did name some seven Brothers in all.

Conclusion and Recommendation

19. Despite these concerns SSI take the view that a serious allegation has been made. By a man (whom the RUC have judged to be reliable) against the current director, of the school. They consider the allegations to be believable despite their age - because of their experience from the Kincora Enquiry. In SSI's view
the children presently in the school are entitled to protection and the department must put their welfare first. NIO must be seen to act on a written statement of complaint to the RUC which makes very serious allegations against [LN(BR)26].

20. There are two options open to the department:

- to ignore SSI advice and do nothing until the RUC has completed its investigation, or

- to advise the Bishop now of the allegations made by [LN(S)] and invite him to consider Brother [LN(BR)] position.

There are advantages and difficulties with the two options. Either will require Ministerial approval in my view. Recognising the sensitivities of this issue and before going to Ministers, I would be obliged if you could advise whether you are content with the recommendation I propose to offer which is to accept our professional advisers recommendation to approach the Bishop now.

Mary E Madden
ST PATRICK'S: ALLEGATIONS OF ABUSE

This is to respond to your note of 23 November reporting the current position in respect of allegations of sexual abuse against staff in St Patrick's School.

2. Allegations like these are serious and deserve to be fully investigated. I am glad to see that that is what the RUC is doing.

3. We know - and I am sure SSI will confirm - that such allegations are not uncommon in institutions dealing with children. It is part of work in this area. Not all are substantiated. Some are. It would not be right to make a presumption either way on the basis of an allegation. In such instances, while having regard to the position of the investigating authorities, it must be right that we follow the best practice as advised by SSI.

4. I think it would be helpful at this stage if SSI were to let us have his advice on the basis of the information in your submission.

5. Subject to Dr McCoy's considered advice on what is the accepted procedure in cases at this stage in their development, I believe it would be right and appropriate to inform the Bishop of the allegations and to invite him to consider what action might appropriately be taken. I would hope we could offer him the advice of SSI. We might also, I hope, be able to offer him a consultation with the RUC, if the RUC would agree to that.
My inclination would be to initiate this at a meeting with the Bishop - which I would be happy to chair if that would help - followed up by a letter. I assume that the meeting would provide information about the allegations against all the staff identified and not just the Director. Any meeting would, I suggest, best be arranged after this week so as to take account of any immediate outcome from the RUC's approach to potential witnesses in England.

7. I agree that it would be helpful to brief Ministers. My own view, however, is that a decision about approaching the Bishop is one for us appropriately to take - but that we should inform Ministers in advance what we have decided.

8. Subject to colleagues' views, therefore, I suggest we await Dr McCoy's guidance and, subject to that, you prepare a submission to Ministers informing them of our intention to brief the Bishop.
PUS has seen your minute of 23 November to Mr Lyon, and Mr Lyon's response of the same date. PUS has commented that he agrees very much with Mr Lyon's advice, and especially with paragraph 7, which records Mr Lyon's view that a decision about approaching the Bishop is one for us to take, but that we should inform Ministers in advance what we have decided.

David McCoy
D T McILROY
PRIVATE SECRETARY
25 NOVEMBER 1993
MRS MADDEN

ST PATRICK'S: ALLEGATIONS OF ABUSE

I discussed with Dr McCoy his helpful note to you of 25 November about the policy on handling complaints about children in residential care.

2. In the course of our discussion, we considered the particular position of the current allegations against some St Patrick's staff which alleged the commission of serious criminal offences. While this was not the same as the commission of disciplinary breaches - which appeared to be the focus of the DHSS circular and additional board guidance attached to Dr McCoy's note - Dr McCoy confirmed that, in such cases, the appropriate procedure was for the board of management to be informed. This was fully in accord with established precedents which related specifically to allegations about offences occurring some years before the date of the allegation. It was not unusual for the police investigating an allegation to be concerned that any action taken by the board might compromise the conduct of those investigations. The normal practice was for the police to appoint a liaison officer who would liaise with the board of management about the conduct of the investigation.

3. Dr McCoy confirmed also that, on the basis of precedents and best practice, it was for the board of management to decide what action to take in respect of the staff who were subject to the allegations. The Department would only wish to consider intervening if the decision was thought to be unreasonable on the basis of the circumstances of the particular case.

CONFIDENTIAL
4. I understand from Dr McCoy that he believes the RUC would be amenable to attending a meeting with the Bishop.

5. If I have inaccurately reflected Dr McCoy’s further guidance, I am sure he will let us know. Otherwise, I suggest that you confirm with the RUC that we propose to see the Bishop, and would like to invite a representative of the RUC to attend. I think it would be helpful if Dr McCoy were also to be present and I am grateful for his willingness to do this.

6. I doubt if it would be helpful for our first contact with the Bishop on this matter to be through a deputation of the size which will be required. I suggest, therefore, that, once you have recontacted the RUC about their attendance at the meeting, and followed up their contact with the alleged witnesses in England, you call on the Bishop to let him know what has surfaced and invite him to agree to a fuller discussion – perhaps involving also Father McCann – a day or two later.
FROM: K F McCoy
Chief Inspector
Social Services Inspectorate

DATE: 25 November 1993

Mrs Madden
Northern Ireland Office

ST PATRICK'S: ALLEGATIONS OF ABUSE

In his minute of 23 November to you Mr Lyon asked me to let you have my advice on action to take in the light of the information in your submission.

The policy on handling of complaints about children in residential care in Health and Social Services Boards and voluntary organisation homes is set out in the DHSS Circular HSS(CC) 2/85 entitled "Provision of Information to and a Complaints Procedure for Children in Residential Care and their Parents". Paragraphs 40-44 of this Circular deals with the investigation of complaints. A copy of the Circular is attached.

The Circular has been implemented by Health and Social Services Boards and a copy of the Eastern Board's Complaints Procedure is also attached. Section D of this document sets out detailed procedures regarding complaints against a member of staff.

I am not sure if similar guidance was issued to training schools and if such detailed procedures were developed. However a report of the Inspection of Shamrock House Close Supervision Unit at St Patrick's conducted in January 1992 contained the following paragraph under the heading "Complaints".

"Staff procedural guidelines cover the policy on complaints procedure. However, although the guidelines set out, in general terms, the arrangements for dealing with the complaint the instructions need to be expanded and developed further. A document should be prepared for the information of boys and their families. The Inspectors discussed this with Senior Management and recommended that a document, similar to that currently being introduced in Health and Social Services Boards Children's Homes, should be produced and made available to the young people in Slemish."

CONFIDENTIAL
I understand that Mr Dumigan was asked by St Patrick's to head up a small committee to consider the extent to which the school could make use of the Board's system but we don't know what has happened as a result of the work of that group.

The Eastern Board procedure represents best practice in this area at present and I would confirm my earlier advice which is that the Bishop should be informed of the allegations which have been made and that he be advised about possible courses of action.

In the event of a meeting being held with the Bishop I would be willing to participate if you and colleagues thought this was useful and appropriate.

K F McCoy
Note for the record.

I spoke to Sgt. Neddrell about the suggestion that a member of the RUC should attend the proposed meeting with the fishing and tourism industry. Sgt. Neddrell advised me that he has discussed this with his superiors and they have decided that it would not be appropriate for the RUC to attend.

I shared this information with the PSO on Friday 24 November and expressed surprise and indicated he would undertake a further search into the advisability of the RUC attending.

He began work on Monday - leave as route to London.

2nd of Sept.
11.30 am
And the current investigation involves an establishment run by Catholic De La Salle Brothers this time. Last time, the Kincora 'boy-buggers' saga turned the spotlight on children, workers at the home, on Protestant paramilitaries and some politicians.

This time, the intensive RUC investigation centres on the St. Patrick’s juvenile offenders’ centre run by the De La Salle Brothers on Belfast’s Glen Road.

Both the police and the Northern Ireland Office at Stormont have confirmed that RUC officers are investigating claims that young inmates at the Training Centre were subjected to homosexual sex attacks.

Now, SUNDAY WORLD has learned that RUC officers are interviewing young inmates at the St. Patrick’s juvenile offenders’ centre on Belfast’s Glen Road.
From N J Chambers

To Mr P Simpson
   Mr J Hamilton
   Miss M Reynolds
   Mr J McCartney (NIO)
   Mr McGilPatrick
   Mr Walker
   Mr Fitzpatrick

16 August 1994

Mr Burke telephoned to-day to confirm the report which appeared in the Belfast Telegraph on 15 August that the above young person, who had absconded from St Patrick’s Training School along with a group of others boys, died as a result of a road traffic accident.

He was transferred from Harberton Children’s Home to St Patrick’s Training School on a Place of Safety Order on 22 July 1994 and was due to appear in the juvenile court to-day, 16 August.

Board social work staff have visited the boy’s mother and offered her support. [REDACTED] has offered no criticism of the Board’s handling of her son.

Father of the deceased has to-day been interviewed by the Belfast Telegraph. A reporter, Tanya Atkinson, has asked the Board to respond to a number of questions regarding of [REDACTED]:

Will there be an inquiry, if so to whom will it report and when?

Was the boy’s transfer to St Patrick’s because of the lack appropriate psychological services in the WHSSB?

What procedures exist to prevent young people from walking out of Training Schools?

Is it true that legal proceedings will be brought against the Board, DHSS and the Minister?
The Board and the Training School have agreed to make no comment on these matters, beyond what was contained in a press release issued by the latter on 15th. A copy of this will be sent to the Department.

Another boy, who had been in the care of the Board at Fort James Children’s Home was also involved in the above incident. He is named Durose dob 28 December 1981. This boy is the subject of an interim Training School order. He was not injured.

I understand that the Press has been approached by the Belfast Telegraph for comment and that the inquiry has been referred to the Board.

Mr McCartney has confirmed that a report of the incident has been requested from the Training School.

N. J. Chambers
FROM: PS/Mr Hunter

DATE: 13 January 1995

Dr McCoy
Mr Conway
Mr Chambers
Mr McElfatrick
Miss Reynolds
Mr Downey

MEETING RE: [SP 81]

I confirm that a meeting with Mr Jim Daniel, Mr John McNeel and Mrs Mary Madden of the Northern Ireland Office, to discuss the [SP 81] case, will take place at 9.15 am on Thursday, 19th January in Room 414.

G Lawrenson (Miss)
PS/Mr Hunter
Management Executive
Office of the Chief Executive

From: Maureen Olver
Purchasing and Performance Review Directorate

Date: 16 January 1995

Mr Hunter
Mr McCoy
Mr McElfatrick
Mr Chambers
Miss Reynolds
Mr Downey
Mr Conway

Mr Daniell
Mrs Madden
Mr McMeel

DEATH OF SPITBI

I attach the agenda for the meeting of Thursday, 19 January, about the death of SPITBI.

The meeting will be held in the Chief Executive’s office, room 424, Dundonald House at 9.30am.

M OLVER
PFRD3
Tel No: (5) 24803

Health and Personal Social Services Northern Ireland
Dundonald House, Upper Newtownards Road, Belfast BT4 3BF. Tel: 580500 Fax: 584973
MEETING NIC - AGENDA

1. Views on adequacy of reports from St Patrick's and Western HSS Board.
2. Publication/Sharing of reports.
3. Possibility of legal action by parents.
4. Line to take with Ministers at this time.
5. Advisability of public statement at this time.
6. Further action to be taken.
FROM: J G HUNTER  
DATE: 19 January 1995  

cc: Mr Chambers  
Mr McElfatrick  
Miss Reynolds  
Mr Downey  
Mr Conway  

Dr McCoy  

MEETING WITH NIO: SPT 81 CASE  

We had a useful meeting this morning with colleagues from the NIO to discuss the way forward on the two reports received into the investigation of the circumstances surrounding SPT 81's death.

The meeting began by examining the reports and exploring their deficiencies. Jim Danieli expressed concern about the quality of the report from St Patrick’s Training School, not least over its failure to address properly the arrangements for supervision of children, and its policy in respect of children who abscond. Norman Chambers noted that while the report commissioned by the Western Board contained an honest and critical scrutiny of the Board’s handling of this case, it was deficient in respect of the arrangements for the transfer of SPT 81 to St Patrick’s. Jim Danieli pointed out that the report contained criticisms of the RUC for their failure to follow up allegations of abuse made against SPT 81 and against his parents. He felt that the RUC should have an opportunity to respond to those criticisms.

It was agreed that the Department would go back to the Western Board and invite it to approach the RUC for comment before it formally accepted the report of the Review Team. It was also agreed that the Western Board should endeavour to keep the report confidential given that it contained material which was critical of the SPT 81 and which contained reference to other children. It was recognised that in the event of court action on the part of the SPT 81, both reports would be discoverable - in which case the Board should seek to limit the material given to the court to that which directly impacted on the matter before it. It was also agreed that they should not make further comments without consultation with the Department.

Turning to the deficiencies in the two reports, it was agreed that the SSI should be commissioned to undertake an independent review of the care given to William in St Patrick’s with particular reference to the arrangements for his transfer from the Western Board, his supervision in St Patrick’s and its policy for dealing with children who absconded. The team should include an “independent” member and should aim to complete its report by the end of February. NIO undertook to consider the provision of secretarial support services. Messrs McElfatrick and Chambers undertook to draft terms of reference for the investigation which could then be put to Ministers (next week) in a joint submission from the two Departments reporting progress. This submission is to be drafted by Michael Downey.

Subsequently, I put Tom Frawley in the picture. He accepted that the Board should seek the comments of the RUC and collate them with the comments of the Foyle Unit for discussion at the Social Care Committee on 1 February. He was under pressure to issue
a public statement and had undertaken to make a non-committal factual statement reporting that the Board's considerable of the report was continuing. It was likely that this statement would issue around the time of the Social Care Committee meeting.

Mr Frawley welcomed the proposed investigation by SSI and promised his Board's support. He also welcomed my suggestion of a meeting between officials to discuss the Department's views on the Bunting Report. I indicated that the meeting should be held before 1 February and he agreed. Given my diary commitments, would you and Norman Chambers wish to liaise with Dominic Burke over the arrangements for the meeting?

I am copying this minute to colleagues in case I have missed anything of significance. Michael Downey has a full record of our discussion.

JG Hunter
NOTE OF MEETING BETWEEN OFFICIALS OF THE MANAGEMENT EXECUTIVE AND OFFICIALS OF THE NORTHERN IRELAND OFFICE ON 19 JANUARY 1995 TO DISCUSS MATTERS RELATING TO THE DEATH OF ST PATRICK’S TRAINING SCHOOL. 

Present:

Mr J Hunter ME
Dr K McCoy SSI
Mr N Chambers SSI
Mr V McElfatrick SSI
Mr M Downey ME
Mr J Daniell NIO
Ms M Madden NIO
Mr J McMeal NIO
Mr J McCartney NIO

1. Mr Hunter welcomed the Northern Ireland Office representatives and explained that the purpose of the meeting was to discuss the way forward in the light of two reports received on the circumstances of the death.

ADEQUACY OF REPORTS FROM ST PATRICK’S TRAINING SCHOOL AND FROM THE WESTERN HEALTH AND SOCIAL SERVICES BOARD.

2. Mr Daniell expressed dissatisfaction over the adequacy of the report from St Patrick’s Training School. In particular he was concerned about its failure to address the question of arrangements for the general supervision of children and the School’s policy for dealing with children who abscond. As to the circumstances surrounding the death of Mr [SP1], he was concerned about the impression gained that boys might come and go at will from the School; that the assessment centre was the most open part of the premises in that respect; that a member of staff had left the boys concerned alone for some time;
and that the fact that they were missing had not been reported to the RUC for approximately one hour.

3. Turning to the Western Board’s report, Mr Chambers said that whilst the report was considerably more thorough and open than the report from St Patrick’s it nevertheless was deficient in addressing the arrangements for the transfer of [SP 81] to the School. Mr Daniell pointed out that the report contained unsubstantiated criticisms of the RUC for alleged failure to take action on accusations of sexual abuse made against [SP 81] and against his parents. Mr Chambers agreed that the Review Team needed to be in a position to stand over its comments, and that clarification was needed as to what discussions there had been between the Team and the RUC. In any event, the Department should go back to the Board and invite it to approach the RUC before it formally accepted the report of the Review Team.

4. As to action in respect of the deficiencies in the two reports, it was agreed that the SSI would undertake an urgent and independent review of the care and supervision of [SP 81] in St Patrick’s with particular reference to the arrangements for, and the reasons for, his transfer from the Western Board, and also for the policy pursued by the School in respect of children who abscond. It was agreed the Mr Chambers and Mr McElfatrick should draft terms of reference: that an independent member should be involved in the exercise; that NIO should consider providing secretarial services; that the report should be completed by the end of February; and that, in the meantime, Mr Downey and Ms Madden should jointly prepare a submission to Ministers, before the end of January, reporting progress.
SHARING OF REPORTS / POSSIBILITY OF LEGAL ACTION BY PARENTS

5. It was agreed that it was important that the Western Board's report should be kept confidential at this time, not least in view of its criticisms of the Campbell family and its references to allegations relating to the abuse of other children. However, in the possible event of court proceedings it was likely that both reports would be deemed discoverable, in which case the Board should seek to limit the material made available to the court to that which was directly relevant to the circumstances surrounding death.

LINE TO TAKE WITH MINISTERS

6. A submission would be prepared as indicated at paragraph 4 above.

ADVISABILITY OF PUBLIC STATEMENT AT THIS TIME

7. No public statement should be made at this time.

FURTHER ACTION

8. As above.

PFRD 3
January 1995
FILE NOTE OF MEETING IN RESPECT OF SPT 81 (DECEASED)
HELD ON 19 JANUARY 1995

PRESENT:

Mr J Hunter
Mr J McDaniel, NIO
Mr N J Chambers
Mr H V McElhatrick
Ms M Madden, NIO
Mr J McCartney, NIO, Training School Branch
Mr M Downey
Mr John McNeill, Legal Adviser, NIO
Mr J Conway, Legal Adviser, DHSS
Miss M Reynolds

APOLOGIES:

Dr K F McCoy

AGENDA

• to discuss the reports received from St Patrick's and WHSSB;
• to discuss proposed follow-up action;
• to agree a way forward in terms of handling reports, publicity and possible legal action.

SUMMARY OF DISCUSSION

1. St Patrick's Report

NIO accepted that as it stands this report is not sufficient. Concerns expressed related to:

• absconding levels, no information is available on rate and background;
• the openness of the assessment unit given that the children placed within this unit are less well known to staff;
• adequacy of supervision;
• delay in reporting absconding to the RUC given that 5 boys were involved, some of whom were known to be disturbed at the time of leaving the facility.

2. WHSSB’s Report

Accepted as a thorough analysis in general which did highlight professional and
procedural shortcomings. Weaknesses identified were:

• the reason for SPT transfers to St Patrick's and the liaison arrangements between social services and the training school;

• the NIO felt a central issue was the justification of the move to St Patrick's;

• references to police action regarding the alleged assault SPT and his alleged sexual assault of another resident, on the face of it was quite damming criticism of the police. There is the need to assess how the review team arrived at these conclusions and how they were substantiated. NIO would feel if grounds emerged that the matter would require to be pursued by the Independent Commissioner for Complaints. Agreed that DHSS needed to raise this issue with the Board and ensure that the comments are substantiated.

3. Proposed Action of WHSSB

• Board are currently drawing up an implementation plan to present to its Social Care Committee on 1 February 1995;

• an audit of case files has been commissioned. The adequacy of this response was raised;

• the Board had intended to raise the report at this month's meeting of the Board. Mr Hunter has requested that discussion with the Board should be deferred. The outside time limit which WHSSB feel would be possible for them is March 1995 given the level of public concern and the pressure coming from William's parents and their legal representatives.

4. Disclosure of reports

• the commitment of the WHSSB Chairman to openness with the family was raised. NIO questioned that the report in its entirety could ever be made public;

• the possibility of disclosure through legal action was raised. is known to be a volatile, aggressive man who is an alcoholic and an experienced litigant. The potential for legal redress is, therefore, strong;

• the fact that the contents of the WHSSB report extends beyond the and contains details about this family not for public disclosure was acknowledged. It was noted that relevant information should be made available without prejudice to other clients;

• the deficits in the St Patrick's report were acknowledged. NIO felt that there was a need for an independent inquiry to redress these deficits. Agreement in principle that SSI should be commissioned to undertake an independent inquiry and that an independent person should be seconded to that team. The timescale for completion of the report would be the end of February 1995.
NIO and DHSS to clear with Ministers the commissioning of SSI to undertake this work.

5. The Way Forward

- Terms of reference are to be drafted by SSI and agreed by NIO;
- Ministers are to be briefed on the reports at this stage and asked to agree an independent inquiry by SSI;
- A composite submission to Ministers is to be drafted by Michael Downey and John McCartney.

6. Legal Advice:

- The Place of Safety Order transferred responsibility for day to day care to the training school who, therefore, were responsible for his safety and well-being;
- The family will be advised to sue with a "broad brush", likely parties to any action are: St Patrick's, WHSSB, the Department and the Motor Insurer's Bureau. The training school will, however, be in the front line as the courts will take the view they had a duty to care. The question will centre on whether the degree of care and control exercised was sufficient;
- The WHSSB, even if disclosed in total would not be of significant help to the family's solicitor. Legally a link would have to be made between the criticisms in the report and the absconding. This would be difficult as it was concluded that the decision to transfer to training school was appropriate and he had been assessed as at a low risk in terms of absconding;
- View is that the Place of Safety Order was valid;
- In terms of damages the amount would not be significant given SSI's inquiry report will be highly pertinent to any legal action. Solicitors can obtain all reports on discovery. Parts of a report can be withheld on the grounds of privilege;
- The issue of an out of court settlement was raised.

7. Agreed Course of Action

1. DHSS to go back to WHSSB to ask that the review team revisit the following outstanding issues:

- Comments relating to the police management of 2 incidents;
- SSI transfer to St Patrick's Training School and the liaison
between the two agencies.

ii. The WHSSB are not to make their report public at this stage given the confidential material which extends beyond the [REDACTED] family. Some disclosure, at least of recommendations, may, however, be required.

iii. SSI are to be commissioned to undertake an inquiry at St Patrick’s which should be completed, if possible, by the end of February 1995. An independent person should form part of the membership of the team. Terms of reference to be drafted by SSI and agreed by NIO and Ministers.

iv. NIO to consider providing secretarial support to the SSI inquiry.

v. Mr J Daniel to appraise the RUC of developments in relation to issues raised in the WHSSB’s report.

vi. Interim report to be prepared for Ministers.

vii. No public statement will be issued by the Departments at this time.

viii. The WHSSB are to be asked to discuss possible public statements with DHSS prior to them being issued.

MARION REYNOLDS
FROM: K F McCoy
Chief Inspector
Social Services Inspectorate

DATE: 20 January 1995

CC: Mr Hunter
Mrs Madden
Mr McCartney
Mr McMeel
Mr Conway
Mr Downey
Mr Chambers
Mr McElfatrick
Miss Reynolds

INVESTIGATION AT ST PATRICK'S TRAINING SCHOOL IN RESPECT OF
(SPT 81)
(DECEASED)

I have now had an opportunity to discuss with Mr Chambers and
Mr McElfatrick the outcome of yesterday's meeting regarding the
case of SPT 81. I understand the meeting concluded that
the Social Services Inspectorate should be asked to undertake an
independent investigation into the circumstances of the case from
admission to St Patrick's Training School on 22 July
until his death on 30 July 1994. I am content that SSI should
assist in this way but there are a number of points I would wish to
make at this stage so that we can be clear on the way ahead.

- The need for the investigation is based on the shortcomings of
the report submitted by St Patrick's in response to requests
from the Northern Ireland Office. I think it would be
important to discuss the shortcomings of these reports with
St Patrick's and to indicate why an independent investigation
and report is necessary.

- The terms of reference for the investigation should be
formally established by the Northern Ireland Office and should
be discussed with St Patrick's before being finalised and
issued to SSI. Suggested terms of reference are attached to
this minute for your consideration.

- It is important to clarify the basis on which the
investigation is to be conducted; this could avoid
difficulties later on. Section 167 of the Children and Young
Persons Act (Northern Ireland) 1968, as amended by Schedule
16, paragraph 11 of the Health and Personal Social Services
(Northern Ireland) Order 1972 would seem to be appropriate in
this case.

- I think it is important that this is seen as a Ministerial
initiative and I would undertake the investigation on the
basis of a minute of appointment by the Minister under
appropriate legislative cover and report directly to him when
the investigation and report are complete. St Patrick's
should receive a copy of this minute.
Consideration needs to be given to the publication, availability and access to the final report. It is important that we are clear about this early on in the process as it would help shape the content and the format of the report.

Finally, I have considered the views expressed about the inclusion of an independent representative on the investigation team. I would not regard this as necessary. The Social Services Inspectorate has independent status and I do not think there is a need to involve anyone from outside in this investigation. In any event, to do so could cause delay and might prejudice the meeting of a deadline of 28 February which is already a tight timescale.

It might be easier to clear a number of these points through discussion rather than extended correspondence and I would be happy to facilitate an early meeting to do so.
Suggested Terms of Reference

To review the circumstances of the case of \[\text{SP181}\] from his admission to St Patrick's Training School on 22 July 1994 till his \[\text{***}\] and to consider:

- the information about his background and behaviour provided to the Training School by the Board;
- the arrangements for his care and supervision in St Patrick's Training School;
- the circumstances surrounding his absconding on 14 August 1994;
- policy relating to staffing and absconding at St Patrick's Training School and the extent to which these were being implemented;
- lessons to be learnt from the case regarding the care and supervision of young people with challenging behaviours.
Thank you for your letter regarding the Social Services Report on the tragic death of SPT 81.

You asked for copies of the reports produced by the Western Health and Social Services Board and by St Patrick's and for there to be an inquest into SPT 81.

First of all, I would like to say that I sympathise with the great distress caused to the LN(SPT) 81. With regard to the disclosure of reports, you have received that produced by the Social Services Inspectorate. In relation to the report produced by the WHSSB, I understand that the Board is of the opinion that it should remain confidential. The Board considers that it has a duty of confidentiality to the children and others mentioned in the report and that it is under an obligation to those individuals who had contributed to its report on the assumption that it was to remain confidential. I note from your letter that the Board has nevertheless provided briefings on the report and I can confirm that the Director of Social Care remains willing to speak to you or other WHSSC members.
You mentioned the report produced by St Patrick’s Training School. The Care Unit of the former Training School now operates as Glenmona Resource Centre, a voluntary children’s home. Disclosure of this report is a matter for Glenmona and any approach should be made to the management of the home.

Finally, you mentioned the possibility of an inquest. As you are aware, the Coroner considered that the facts of this case were clear and decided against an inquest. Once again, I would stress that I have the deepest sympathy for the [redacted] but I feel that, in view of the Coroner’s decision, the case has effectively been closed.

JOHN McFALL
Minister for Health and Social Services
REVIEW OF THE CIRCUMSTANCES SURROUNDING

THE DEATH OF

SPT-12618
## CONTENTS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Introduction</td>
<td>1</td>
</tr>
<tr>
<td>2. The history of the case of SPT 81 and the events leading to and the circumstances surrounding his absconding</td>
<td>2</td>
</tr>
<tr>
<td>3. The reasons for SPT 81 transfer from Harberton House to St Patrick’s Training School</td>
<td>13</td>
</tr>
<tr>
<td>4. The adequacy of information about SPT 81’s background and behaviour provided to the training school by the Board</td>
<td>16</td>
</tr>
<tr>
<td>5. The arrangements for SPT 81’s care and supervision in St Patrick’s Training School</td>
<td>18</td>
</tr>
<tr>
<td>6. Lessons to be learnt from the case particularly in areas such as the transfer of children to training schools, the supervision with challenging behaviours and absconding</td>
<td>28</td>
</tr>
<tr>
<td>7. Recommendations</td>
<td>31</td>
</tr>
<tr>
<td>8. Appendix A - Terms of Reference</td>
<td></td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1 SPT 81 was an eleven year old boy who had been in the care of the Western Health and Social Services Board but had been transferred to St Patrick’s Training School under the provisions of a Place of Safety Order. After being at Aisling House, the St Patrick’s assessment unit, for approximately three weeks, he absconded from the school on the 8th March 1995.

1.2 Subsequently, the Western Health and Social Services Board commissioned a review of its care for SPT 81 and the Board of Management of St Patrick’s prepared a report for the Northern Ireland Office on the incident. There were, however, a number of matters not fully covered by these two reports and in March 1995 the Ministers responsible for the Criminal Justice Services Division of the Northern Ireland Office and the Department of the Health and Social Services jointly commissioned the Social Services Inspectorate to undertake a review of the reasons for the transfer of SPT 81 to St Patrick’s, the care and supervision he received while there and the events leading to his absconding from the training school. A copy of the full terms of reference is reproduced at Appendix A.

1.3 The review was undertaken by Mr Victor McElhatrick and Mr Chris Walker of SSI who were assisted by Mr Robert Mitchell of the NIO. They interviewed the Western Board staff who were involved with the case, the senior management of St Patrick’s and the staff of Aisling House. Assistance was given by the PUC in clarifying the events that occurred immediately before and after his death as well as Police procedures for dealing with reported absconding. The inspectors also read the two reports already prepared as well as case and other records relevant to the care that he received.

1.4 The inspectors are aware that many of the staff were closely involved in his care and that his death had shocked them deeply. Furthermore the staff had already provided information for the two earlier inquiries. In this light the inspectors wish to record their appreciation of the open and honest way their questions were answered and other information readily and willingly provided.
2. THE HISTORY OF THE CASE OF S.P.T. 
AND THE 
EVENTS LEADING TO AND THE CIRCUMSTANCES SURROUNDING 
HIS ABSCONDING ON 14 AUGUST 1994.

2.1 Four children were born to L. and J. who was born on 7th June 1990. L. was the maternal grandmother of the children and J. was the maternal grandfather. In November 1991 the parties separated and the children were placed in the care of the Social Work Board and J. continued to look after them. In February 1992 it was alleged to have assaulted one of the children after which he was placed in his father’s care. This arrangement broke down after a few days and he was admitted to the care of the Western Health and Social Services Board and placed in Nazareth House Children’s Home in Londonderry.

2.2 In Nazareth House S.P.T. improved difficult for staff to manage and required close supervision because of his aggressive behaviour. It was, however, recorded that he interacted well on a one to one level. In September 1992 S.P.T. absconded with another boy. Both of them were found at the grandmother’s home the following morning and returned to the children’s home.

2.3 During the Autumn the relationship between S.P.T. and his mother is reported to have improved and it was decided that he should return home to her care on 27th November 1992. Because of sick leave and other staff shortages there was no fieldwork input from the Board during this period either to help prepare S.P.T. for his return home or to support Mrs Campbell in the early stages of her attempt to take on his care.

2.4 In February 1993 S.P.T. refused to return home from school, alleging that his mother had beaten him. He requested to be received into care but the social worker arranged for him to be looked after by an aunt. After two nights he agreed to return home.

2.5 In April and May 1992 S.P.T. was reported to have problems coping with his aggressive behaviour. On 12th May she contacted the out of hours emergency social work service to request that he be received into care again. Admission was deferred and a referral was made to the Child and Adolescent Psychiatric Team who agreed to provide a consultation service. A few days later S.P.T. again requested that he be received into care because of the difficulties that he was experiencing in controlling his behaviour. S.P.T. was subsequently received into care under the provisions of Section 103 of the Children and Young Persons Act (Northern Ireland) 1968 on 24th May.

2.6 S.P.T. was admitted to Harberton House Children’s Home. Initially he appeared to settle quickly in the unit but within a few days he began to demonstrate behaviour problems including lying, bullying and aggression to staff when they challenged him. Separation from the rest of the group, on
"time out", as it was called, in his bedroom was the normal response to this behaviour but it appears to have been largely ineffective in that he was sent there on forty six occasions in a four month period. The reports on the case file indicate that he had difficulty functioning in a group but, as in Nazareth House, he thrived on individual attention and related much better on a one to one basis.

2.7 Over the Summer work with continued. On the one hand it was reported to be difficult for the residential social workers since he only responded to comments on the positive aspects of his behaviour and "switched off" when the negatives were raised. He also found it difficult to maintain relationships with other children. He sought their company but soon ended up fighting with them.

2.8 On the other hand it was reported that he would seek out staff for their attention and could be very pleasant to have about. He enjoyed various activities appropriate to his age group such as model making and painting and it was again noted that he enjoyed one to one contact with staff.

2.9 During this period he became more settled in the home and less challenging to the staff. They attributed this improvement in behaviour to increased contacts, including overnight stays, with his home and mother which he saw as a reward for good behaviour.

2.10 In September returned to school and his teacher subsequently reported that his behaviour in class was much better. She said that he settled in easily with his class-mates and with her. Again she commented that he worked well on a one to one basis and responded well to encouragement and praise. His negative behaviour was also mentioned. It included a dislike for correction, flaunting the school rules as well as a degree of aggression towards other children but she saw many commendable qualities in him whom she described as "a very manly little boy".

2.11 On 21st September 1993 the Senior Social Worker from the Child and Adolescent Psychiatry Team contacted the Social Worker to advise her that was on their waiting list. However, she was told that he would not be seen by the team before October at the earliest and even then they would not be able to undertake any direct work with him. The social worker indicated that she was considering to provide family therapy, counselling and a psychological assessment of the report also contained the comment that "appears to have a very 'disturbed' attitude towards women, particularly women who are in authority...". The meeting between the social worker and the psychiatric team was, in fact, not held until 12th November 1993.
2.12 As mentioned above the team indicated that it would only be in a position
to provide consultation and this was undertaken by the Senior Social
Worker, Nurse Therapist and Trainee Psychologist. It was decided that
there was no need for a psychological assessment as one had been carried
out previously by an Educational Psychologist. It was also considered
unnecessary for SPT to have a psychiatric assessment and that his
emotional and behavioural problems should be susceptible to the work
being undertaken by his field and residential social workers. Nevertheless,
it was also recorded that residential care did not appear to be the best
placement option for him.

2.13 On 5th January 1994 he returned to Harberton House after a visit to
his mother’s home and alleged that he had been physically abused by her
and her cohabitee. A child protection case conference was already
scheduled to be held on 12th January and this took place as planned.
SPT attended part of the meeting and expressed his view that he was
happy at Harberton House, he did not wish to see either his father or
mother and that his return to his mother’s care would not work if her
partner was present in the house. At this case conference it was agreed
that SPT would remain in care on a long term basis and that he would
be referred to the fostering unit. However, it was not until the end of
April that the referral report was forwarded to the unit.

2.14 By March 1994 he was reported to be more settled in the home. He
had re-established contact with his mother and had visits from her and his
brother and sisters every Sunday. However, on 4th March he
superficially scratched one of his wrists and on 21st March he and
another boy went missing from the home. They were returned about three
hours later by a member of staff who found them walking along a road.
Staff considered this latter incident to be a prank.

2.15 During April it was reported that while challenging he had begun to respond to the one to one work being carried out with him by his primary worker. However towards the end of the month staff had cause to talk to him and another boy who had exposed themselves to each other in one of the bedrooms. During an interview about this incident it emerged that three boys, including SPT, had earlier been involved in sexual assaults against a girl resident on three occasions.

2.16 These incidents were reported to the Police on 25th April and in
accordance with the child protection procedures a strategy discussion was
held two days later when it was agreed that they would be jointly
investigated by social workers and the RUC. On 5th May he was jointly
interviewed by his social worker and a police officer. A child protection
case conference was held on 6th May and it was decided also to involve a
police officer from the team investigating allegations of organised abuse in
the Creggan area. Following this investigation the Police forwarded a
report to the Director of Public Prosecutions. He decided that no action would be taken against any of the children.

2.17 Subsequently the behaviour deteriorated. After returning from two days at Extern’s Killadoss Centre on 6th May he lost some privileges for misbehaving and was hostile towards staff. He damaged his room and became upset. Apparently, more seriously, he cut his wrist for a second time, albeit very superficially, with a piece of glass and made statements including one that “he wanted to be in his box” and “if this doesn’t work the Foyle will”.

2.18 During the next few weeks Senior Social Worker (Residential Team Leader) discussed behaviour with him and the possibility of a transfer to training school was raised. Other residential staff also expressed concern about the suitability of his placement in Harberton House to the field worker on more than one occasion.

2.19 Before the residential review that was held on 27th May the field social worker and the primary worker jointly prepared a report that made 17 points. The most relevant ones are:

i. The fostering unit have not yet identified a suitable long term foster home for.

ii. He wished to remain in care.

vii. He related well on a one to one basis with staff but still had problems in a group setting because of his attention seeking behaviour.

viii. His bullying had increased and become more subtle. Due to his behaviour he is no longer allowed to go swimming with the other children.

x. He did not want to stay at Harberton but did not want to go to training school.

xi. Because of the risk to other children from his behaviour, staff felt unable to offer other children a safe environment and they had to refer the matter. It was reported that Harberton might no longer be a suitable placement for him.

xiii. Attempts should continue to obtain a specialist long stay foster care placement.

xiv. In the short term, St Patrick’s Training School should be considered for time out.
"xvii. The Social Worker had concerns about going to training school due to his age but accepts the fact that due to the lack of anything suitable it is an option."

2.20 The review took place on 27th May and the following decisions were made:

1. Given continued risk to other children, and his inability or unwillingness to take on his responsibility for this, it was agreed that a place in St. Patrick's Training School would be sought for a limited time as part of an agreed programme of work with

2. Ongoing work will continue to address issues relating to his behaviour and his relationship with his family and other adults and children.

3. Recognition that he is an abuser, requires to be involved in a programme which will address this, including where this abusive behaviour came from.

4. Social Work staff to liaise with St Patrick's with a view to seeking a place for

5. Review will be held at Harberron House on 23rd September 1994."

2.21 Given that my was in the Western Board's care on a voluntary basis it was particularly appropriate that was present at this review. It was recorded that she was fully involved in the discussion but it was not recorded whether she was in agreement with the decisions made, in particular the one to refer him to a training school.

2.22 On 31st May the Senior Social Worker (Residential Team Leader) telephoned St. Patrick's and spoke to the Intake Social Worker. There were no vacancies in Aisling House (the STP's assessment unit) at that time but he agreed to place him on the waiting list. He also recorded the conversation on the Initial Referral Form. The presenting problems were recorded as being as:

"Sexual assault on 10 year old female
Sexualised language and behaviour
Threatening behaviour to 10 year old and others."

Although the Inspectors were told by ST Patrick's management that expectations for the placement were discussed during this and subsequent telephone conversations, they were not recorded on the initial referral form and no written information was sent to ST Patrick's by the Western Board until after admission more than seven weeks later.
2.23 A case discussion was held at Harberton House on 27th June 1994 when, among other things, it was confirmed that attempts to secure a place for William at St Patrick’s would continue. In the middle of the following month the Western Board’s staff were informed that he could be admitted there on 22nd July as a place had become available.

2.24 The Western Board were granted a Place of Safety Order on 22nd July and William was transported to St Patrick’s by his own social worker. When he was admitted to Aisling no written information about his behaviour was provided for the training school staff. However, it was arranged that an initial case review would be held four days later on 26th July.

2.25 Following the admission a woman member of the Aisling House staff was appointed as his key worker and she helped to settle him into the unit. He was reported as being “quite cocky and attempted to have the last word”. At bedtime time he was found sticking a compass spike into his door lock and the senior residential social worker removed it from him and warned him about his behaviour.

2.26 The behaviour caused problems the following evening as well. The night supervisor recorded that both SPT 81 and another boy were very badly behaved and that he had to contact the Senior Residential Social Worker at 11.20 pm. SPT 81 had demanded that his bedroom light be left on and called the night supervisor “a variety of choice names” including “queer” and others that were “more spicy”. As a result the Senior Residential Social Worker removed him to Slemish House which is St Patrick’s close supervision unit. It provides secure accommodation for “care” boys on the campus.

2.27 SPT 81 as returned to Aisling at about 8.45pm on the evening of 24th July, but the night supervisor again recorded that SPT 81 and the other boy were “very cheeky and high”. After lights out they continued to disturb the other boys, one of whom complained about their behaviour and asked the supervisor to keep them quiet. However, he noted that this was “an impossible feat” for him.

2.28 After that the number of references to SPT 81 in the night book decline rapidly. On 27th July it was noted that “LJ and SPT 81 in bed by 9.10pm after attempting to abscond at 9pm” (there is no further information about this attempted absconding in any of the other records) and on 31st July SPT 81 had his radio on at 7.45am. A little cheeky when asked to turn it off.”

2.29 The case file also suggests that William was beginning to settle quite rapidly after his first week at Aisling. There are fewer comments about bad behaviour and more about him playing with his toys (apparently a rare activity for boys in St Patrick’s), his interest in helicopters, being “competitive in a positive way” and responding co-operatively to a request
that would, according to a residential social worker from Harberton House who was visiting at the time, have created a serious adverse reaction if it had occurred during his stay there. However, he was placed in one of Aisling House's "quiet rooms", which are actually locked secure rooms, for 8 minutes on 3rd August after he threatened to hit another boy with a pool cue and had been verbally abusive to staff and boys.

2.30 Reverting to the earlier stages of his stay in Aisling, the initial case review was held at St. Patrick's on 26th July. It was chaired by the Intake Senior Social Worker and attended by a key worker, three staff from the Western Board and the Inspector. It was the first occasion that any significant amount of information was shared about his history and the reasons for his referral to St. Patrick's or the expectations of what the placement was intended to achieve were discussed. It appears that the Western Board staff were talking in terms of "time out" for him and that they did not give a clear indication of what they expected St. Patrick's to be able to do to help him that would not have been possible in Harberton House. The inspectors' discussions later with the Western Board staff indicated that the phrase "time out" only meant that it was intended to be a temporary placement and that it was envisaged that he would return to Harberton House at a later date.

2.31 The chairman of the meeting tried to clarify the expectations of the placement. The social worker requested that he should be referred to the Adolescent Psychology and Research Unit (APRU) for a full psychological assessment. It was indicated that such an assessment could not be completed within the time available in a Place of Safety Order and that it would be necessary to seek an Interim Order for detention, possibly followed by another one, making it likely that he would spend up to fifteen weeks in the training school. The Basic Information Form, which was completed after the meeting, indicates that in addition to the psychological assessment the placement was expected to provide:

"Time out; behaviour modification, target areas - looking at taking responsibility and consequences of his actions".

2.32 Following the meeting the Western Board staff returned an Initial Information Form to St. Patrick's. It indicates the reasons for the admission to training school were:

"Bullying and aggressive behaviour towards residents in Harberton.

"Involvement in sexual assault of a female resident in the unit."

It also mentioned that he had caused superficial injuries to himself in the past and threatened to have a plan which would mean that no one would have to bother with him anymore.
2.33 As a result of the decisions made at the initial case review an application was made to Londonderry Juvenile Court for an Interim Order of Detention. It was due to be heard on 16th August 1994. The key worker also passed on the referral for assessment to APRU.

2.34 The psychologist subsequently saw him twice, on 4th and 9th August. She envisaged seeing him once a week during his placement. Ideally she would have liked to have seen him twice a week which would have speeded up the whole process but her workload precluded this. The first session was largely devoted to building up a relationship with him but she also began exploring some of the issues. They included his superficial self injuries and his threats to kill himself. She told him that he threatened to harm himself as a way of "winding up" the staff at Harberton and annoying them. The psychologist did not consider these threats to be serious. She also talked to him about his bullying which he saw in a similar light of annoying people.

2.35 During the second session the psychologist administered a Family Relations Test which he was very resistant and tried hard to deny his negative feelings towards almost all the members of his family. Subsequently the discussion was taken up with his key worker at Harberton House. She told the Inspector that this conversation led her to feel that the social workers had been concentrating too much on his bullying and anger which were the symptoms of his problems rather than tackling the underlying causes of them which probably lay in his past experiences in his family.

2.36 During the second week of August he was reported to be quiet and settled. One member of staff described him to the Inspectors as being "totally controllable - almost polite" during this period and questioned why he needed to be placed in a training school. The key worker was on duty almost continuously from Thursday 11th August until the afternoon of Sunday 14th. She reported on his case file in detail over this period and almost without exception the comments were positive.

2.37 On Sunday 14th August the day that he absconded with four other boys - Asling House was due to be staffed by the keyworker during the morning and early afternoon and another Aisling House residential social worker during the afternoon and evening. In addition a residential social worker from Saul House (one of the long term care units) was expected to be on duty in Aisling all day. In practice events did not work out quite like that. The Saul House RSW had been on duty in his own house from 9am to 9pm on Saturday 13th August in sole charge of four or five boys. At 9pm he had gone off duty leaving the night supervisor in charge.

2.38 On the following day Saul should have been staffed by two people but one of them had reported sick and the other one had gone to Galway to retrieve
an absconder and did not return to Belfast until after midnight. The RSW told the inspectors that he had told one of the school’s senior management team on Saturday morning and again after Mass on Saturday evening that there did not appear to be anyone available to cover Saul House on the Sunday. As far as he was aware no plans were made to cover this. Consequently when he awoke on the Sunday morning he telephoned the night supervisor in Saul and found that no one had reported for duty. He came to St. Patrick’s and telephoned the key worker who was on duty in Aisling and advised her of the problem. She told him that all the boys were still asleep and that she could manage without his help. As a result he decided to let the night supervisor go home and showed the staff member who had gone to Galway. He agreed to shower and come in to work. The RSW decided that he would cover Saul until he was relieved.

2.39 When the RSW was relieved by his colleague he went to Aisling. By that time it had been reported that the weekend leave arrangements of two Aisling boys had broken down and their parents had requested that they be returned to the school. As a result the key worker left to collect them accompanied by another RSW who worked in Chalet 1. This arrangement left Aisling, Saul and Chalet 1 with only one member of staff on duty in each.

2.40 The RSW was left in Aisling supervising four boys (PD, GL and PO’R). PD and PO’R were playing with a football, GL was playing with a frisbee on the other side of the building and the RSW was talking to PD.

2.41 The key worker and the RSW from Chalet 1 returned with the first boy (SO’N) at about 12.45pm and he went into the house. They then left again to collect the other (SN), returning at about 1.30pm after which the key worker went off duty having been relieved by another residential social worker who had come on duty at 2.30. For the first time that day there were two members of staff in Aisling House. They both felt that the group was becoming increasingly unsettled and was beginning to run out of the minibus. At that stage four of the boys (PO’R, PD, SO’N) were outside playing football and GL was still playing with his frisbee. The Saul House RSW arranged to get the keys for the minibus from the brothers’ house. He suggested that the four boys who were playing football should accompany him but they did not want to. He then left his colleague with the six boys. This RSW entered the house apparently wanting to check on the whereabouts of the boy GL, although in fact he was still outside playing with his frisbee where he had been for some time. While they were thus unsupervised the five boys absconded. This was at 1.30pm.

2.42 When the Saul RSW returned his colleague told him that “all” the boys had gone although one of them, GL, turned out to be there. When asked, he said that he did not know where the others had gone. The two RSWs
then searched the school grounds and, having found no sign of them, one of them took the minibus standing to tour the area to see if they could be found. He returned at about 4.30pm whereupon their absence was reported to the police, the boys' parents and the children's homes from whence they had come. One of the RSWs also phoned acquaintances in the community to ask them look out for the boys.

2.43 According to the statements that the four surviving boys subsequently made to the staff of the school the abducting was, to at least some extent, planned in advance in that they had hidden a bag of clothes and food in the bushes alongside Hookers Lane, which leads from Ailing to the Mona by-pass and is a route favoured by boys leaving the school illegally, between the times that SO'N and SN were returned to the school. After the boys left they made their way right across the city to the Antrim Road area. During the evening they passed some time in Dunville Park and the Waterworks before returning to the Falls Road area in the early hours of the following morning.

2.44 In the early hours of the morning the boys broke into one car but were unable to drive it because of a chain attached to the steering wheel. At about 3.30am they did succeed in "bump-starting" another car. On the first attempt two boys (SO'N & SN) got into the car but it stalled and had to be push started again. On this occasion a third boy (PO'K) also got in, leaving PD in the road. According to PD, one boy was in the road crying because he could not get into the car. The Police confirmed that a lady in the street had heard a boy crying at this time.

2.45 The three boys in the car drove around a block and were seen from an army observation post in Divis Street. Initially the soldiers did not pay much attention to it because it was only being driven slowly. However, their attention was drawn by the rear lights which were flashing on and off. They radioed their suspicions that it might have been stolen to Grosvenor Road RUC Station where it was arranged that a patrol would be sent to investigate.

2.46 PD moved to the corner of Albert Street and Ross Street where the soldiers view of them was obscured by buildings. However, according to the boys' statements each time the car was driven around the block the soldier stood in front of it in an attempt to get the driver to stop but managed to jump aside to avoid being hit. On the first two occasions he jumped out of its path in one direction and the driver swerved the other way avoiding him. On the third occasion he has said to have jumped the other way, was hit by the car, run over and killed.

2.47 The car stopped a short distance down the road where it was again seen from the army observation post. It was abandoned by the boys who made their way through an alley way into the Falls Road. Their movements were reported to the Police by the Army until they lost sight of them but a
short time later they were picked up by security cameras in the Springfield Road. Within a few minutes the Police arrived and all the boys were arrested.
3. THE REASONS FOR TRANSFER FROM HARBERTON HOUSE TO ST. PATRICK’S TRAINING SCHOOL.

3.1 The above history of the case indicates that he was a boy with a very troubled history which resulted in him displaying marked behavioural problems to his parents and other carers. He had been rejected by both his parents who had either deserted him or abused him and he had been received into care twice in circumstances that must have caused him great distress.

3.2 Reports from Nazareth House, the first children’s home in which he was placed, his primary school and Harberton House all comment on the difficulties that he experienced functioning in groups in which he felt the need to be competitive, aggressive and demanding. In contrast he was reported to relate well within one to one contacts with teachers and children’s home staff. In this light the Western Board staff’s view that residential care was not a suitable placement for him and the decision to seek a foster home for him appears to have been the correct course of action. It is then disappointing to note that although this decision was reached at a case conference held on 12th January 1994 the referral to the fostering unit was not made until the end of April. The delay was explained to theInspectors by a senior manager as having been caused by the staff’s lack of confidence in the fostering unit’s ability to find a placement for him since it had not proved possible in the past to find homes for other children who were either younger or displaying less disturbed behaviour. Although the recruitment of foster parents is not a matter specifically within the terms of reference of this review the Inspectors consider that reference should be made to it. If a suitable foster home had been available it is suggested that a place in a training school would have been sought for him.

It is recommended that the Western Board should commission a review of its fostering services with a view to achieving an improved level of availability.

3.3 The reports suggest that early in 1994 he was making some progress in Harberton House, particularly since the appointment of a new keyworker. There was no mention of a move to training school until after the allegation that he had been involved, together with other boys, in a sexual assault on a girl in the home. Within a short time the residential team leader told the Inspectors that admission to training school was an option and other staff were casting doubts, in their reports, on the suitability of the current placement. Possibly as a result of the stress created by the investigation of these matters and the suggestion that he might be moved to training school his behaviour rapidly deteriorated. He scratched his wrist and made threats about his own life. Other residents complained of his bullying.

3.4 The earlier decision on the unsuitability of residential care for him appears to have become overlooked and the fostering option was not
mentioned in the decisions made at the case review on 27th May. Instead it was agreed that a place would be sought at St. Patrick’s. The Western Board’s staff who were interviewed by the Inspectors appeared to have limited knowledge of the services offered by the training school or what could be achieved there that was not possible in Harberton House which actually has better staffing ratios. In this light the Inspectors recommend that St. Patrick’s staff should prepare an information leaflet and distribute it to potential users giving details of the services that they can offer, their expertise in providing them and the types of children and young people that they consider can be suitably placed in the school.

3.5 The justification for the decision to move appears to be based on the threat that he posed to other children in Harberton House. Nevertheless, it is not entirely clear to the Inspectors why a placement in a residential setting in a training school was considered suitable when one in a children’s home was not and the more general question of the suitability of the training schools for such pre-teen children remains.

3.6 It is a matter of concern that training schools continue to be used by Boards for the placement of young children on care grounds. It was brought to the attention of the General Managers of the Boards at a meeting with the Chief Executive of the Management Executive in June 1992 and there was agreement that such use would diminish other than in exceptional circumstances such as those when secure accommodation could be justified. However, there does not appear to have been much progress. Between January and July 1994 twenty two children under the age of 13 years were admitted to training schools and on 31 July there were 18 in them. Ten of them were in St. Patrick’s. In the Western Board there is no policy directive to alert staff to the undesirability of using the training schools for young children although the subject was raised by the Chief Social Work Adviser at a meeting of the Board’s Senior Professional Advisory Group shortly after the meeting mentioned above.

3.7 The Inspectors understand that child care managers are reluctant to use the training schools for young children without careful consideration but they recommend that the board should establish explicit policy guidance for their staff on this matter. It is suggested that it should include a procedure that decisions to seek training school places for young children should be taken at a more senior level than other placement decisions. Furthermore the Inspectors also consider that boards and trusts should establish monitoring arrangements to ensure that the intentions of their policies are being achieved.

3.8 When it was transferred to St Patrick’s on 22nd July 1994, it was done under the provisions of a Place of Safety Order. This legal mechanism has grown up in Northern Ireland over the years and is now an established practice. It does, however, ignore questions of how a child can
be removed from one place of safety to another under such an order or the implication that children’s homes are not places of safety. In any event these questions will become irrelevant with the implementation of the Children (NI) Order 1995 since no legal processes will be required to move children in care to the facilities currently provided for them in the training school system.

3.9 Nevertheless, the Inspectors are concerned about the appropriateness of the use of a Place of Safety Order in such a case. In recent times there has been a significant increase in demand for training school places by boards. On occasions this has led to the admission units of the schools being full and the young person’s name being placed on a waiting list. In some cases his name was on such a list for almost two months. A Place of Safety Order is intended to be an emergency provision to provide protection for children who need to be moved from situations in which they are considered to be in such danger that they cannot safely remain until a court hearing can be arranged. They are “ex parte” proceedings in which neither the child nor his parents be heard or represented. In the Inspectors’ view it would be more appropriate to bring the child before the court as being in need of care, protection or control and ask for an Interim Order for Detention to be granted. This would enable all aspects of the case to be argued. It is recommended that Place of Safety Orders should not be used to transfer children to training schools except in emergencies when the school is in a position and willing to admit them immediately.
4. THE ADEQUACY OF INFORMATION ABOUT BACKGROUND AND BEHAVIOUR PROVIDED TO THE TRAINING SCHOOL BY THE BOARD.

4.1 As mentioned in paragraph 2.22, was referred to St Patrick’s by the Residential Team Leader on 31st May 1994 by way of telephone call. The conversation was recorded briefly on the Initial Referral Form by the Intake Social Worker. Over the next few weeks staff at Harborton House phoned Aisling on a number of occasions and notes on these calls were added to the form. They suggest that these discussions centred on when a vacancy might be available for SPT 81. Although the Western Board staff told the inspectors that they also used them to keep the training school informed about his behaviour. In line with their normal practice the training school staff did not ask for written reports and none was volunteered by the Western Board. Consequently there could not be any detailed planning of the placement until after admission.

4.2 was admitted to St Patrick’s on 22nd July and the Inspectors were told that no written information was provided at that time either. However, following the initial case review on 26th July a form was completed and, together with various other reports, it was forwarded to the school. These reports included the form sent to the Child and Adolescent Psychiatry Team, a report prepared for the previous residential care review and some other recent reports from Harborton House. Between them, they provided adequate information for the staff of the Training School to begin their assessment.

4.3 The Inspectors are, however, concerned about the lack of use of the period between referral and his admission to Aisling to provide information and plan the placement. The constructive use of this time could have enabled the St Patrick’s staff to consider in more detail whether they thought the placement to be appropriate and, if so, the way to make the best use of it. For example, the Board’s request for a psychological assessment was not made until 26th July. It is not clear why this referral was necessary since the Board’s own team had concluded that there was no need; one having already been undertaken by an educational psychologist. However, assuming that the referral for psychological assessment was justified, the delay in requesting one until after admission resulted in an immediate decision that it would be necessary to apply for an interim order for detention, with the possibility of a second such order being required. This was justified by the workload of the psychologists which meant that the assessment could not be completed more quickly. If the need for a psychological assessment had been established earlier it might have been possible to arrange for to be admitted at a time when the psychologists would have been able to complete their work in less than 15 weeks.
4.4 Similarly, the Board’s records contained other information that may have been helpful to the training school in planning its work. For example, it was noted that staff had a very ‘distorted’ attitude to women, especially those in authority. Such information may, or may not, have influenced the decision to allocate a woman as a keyworker at Aisling but it would certainly have been relevant for the staff there to be aware of it.

4.5 The Inspectors were told by the Intake Social Worker that, in the past, all admissions were made in emergencies using Place of Safety Orders, therefore there was no opportunity for pre-placement planning. However, it is recommended that when transfers from Board accommodation to training schools are not made in emergencies the time prior to admission should be used to provide the school with adequate information about the child’s history and behaviour and to make firm plans about how the placement will be used to achieve identified objectives.
5. THE ARRANGEMENTS FOR CARE AND SUPERVISION IN ST PATRICK’S TRAINING SCHOOL

Physical Care

5.1 When was transferred to St Patrick’s he was placed in Aisling House, the reception and assessment unit. It is a new building which was opened in May 1994 to accommodate 11 boys referred from the care system. It is pleasant with a fairly domestic atmosphere. The facilities include a recreation room, dining room, kitchen and single bedrooms for all the boys. In addition there is a general office for all the staff, plus separate ones for the Team Leader and Intake Social Worker, interviews and meetings.

5.2 Aisling is an open unit and although there is a considerable emphasis on locking and unlocking doors it tends to be to prevent the boys gaining access to some rooms rather than to stop them leaving the building. In fact, it has five external doors which would be difficult for staff to supervise if any of the residents did show a tendency to want to leave by them. The Inspectors did have some concern about the two fire exits which are a considerable distance from most of the activities going on in the house. They were assured that they are not currently used for abscending but if it does become a problem the Inspectors suggest that consideration should be given to fitting the doors with alarms so that staff would be aware whenever they are opened.

5.3 Although this review did not include an examination of all the arrangements for the care of the boys they appeared to be well dressed and cared for. The food provided was ample and nourishing.

The Assessment Process

5.4 Aisling House is described by St. Patrick’s as its assessment unit for "care" children. All the boys admitted to it are the subjects of Place of Safety Orders or Interim Orders for Detention. Place of Safety Orders last for a maximum of 35 days and, if it is deemed necessary to keep a boy in the unit for longer than this period, the Board or Trust that arranged for him to be admitted under the Place of Safety Order must apply to the court for an Interim Order. Each Interim Order lasts for a maximum of 35 days and up to two consecutive ones can be granted. In this way a boy can be held in Aisling for up to 15 weeks. In order for a boy to remain in the training school for longer than 15 weeks an application must be made to the court for a Training School Order and at this point he will be transferred to a long stay unit.
5.5 During 1994 thirty boys were admitted to St Patrick’s for assessment. The numbers of boys and their various ages are shown below:

- 3 boys of 11 years of age at the time of admission
- 5 boys of 12 years of age at the time of admission
- 7 boys of 13 years of age at the time of admission
- 3 boys of 14 years of age at the time of admission
- 6 boys of 15 years of age at the time of admission
- 4 boys of 16 years of age at the time of admission.

Eight boys representing over a quarter of admissions were of pre-teen children but if this group of younger boys is extended to include the 13 year olds, who are also legally categorised as children rather than young people, it represents half of all admissions.

5.6 When a boy is admitted to Aisling House he is allocated a key worker. In this case this was a woman with a Certificate in the Residential Care of Children and Young People and long experience of residential work with children. Unless there are particular reasons otherwise, the choice of keyworker is usually based on providing an equitable distribution of work among the staff.

5.7 The keyworker takes a particular interest in the boy during his stay. These responsibilities include basic tasks such as checking that he has adequate clothing and ensuring that he has an adult in whom he can confide. In these aspects the keyworker was undoubtedly well looked after. The keyworker role also entails taking the lead in the assessment process. The keyworker attempts to get to know the child both as a member of the group and during one to one sessions which are held once a week. In this case the keyworker had three such sessions with him during his stay. Brief reports were written on these sessions which show that after the first few days he began to settle in the unit.

5.8 Following admission the Aisling House staff encouraged the Western Board staff to continue to maintain an active interest in him and they responded to this. The day after admission to Aisling, his key worker there telephoned the Harberton keyworker and also had an opportunity to speak to her. Two days later the key worker again contacted Harberton House and arranged for the staff there to keep in contact with every few days. Subsequently his Board key worker telephoned the Harberton Board office and wrote to him on another occasion. Contact with the Harberton staff was also encouraged.

5.9 The Aisling House staff and particularly the key worker provided a number of other benefits for him during his stay. His threats to injure himself were specifically mentioned to the APRU psychologist who explored them with him and advised that they did not appear to be particularly significant. He was encouraged to behave in a manner
appropriate to his age by playing with the toys that he had brought from Harbouron House and apparently this had benefits for some of the other boys who then felt able to play in such a manner. His interest in helicopters was also encouraged through material sent by the Irish Air Corps and visits to the Model Shop in Belfast. There were also other outings to Jungle Jim's, to play football, to Derry to collect another boy and to Ballycastle to go fishing, all of which he appears to have enjoyed and increasingly responded well to. The reports suggest that he settled more rapidly than would be expected from the reports about him emanating from Harbouron House and he was building positive relationships with the staff.

5.10 The move from Londonderry inevitably meant some disruption in education. He had been at a school that showed a large measure of tolerance for his bad behaviour but the placement in training school at least meant that his educational needs would receive attention from the teaching staff on the campus. Similarly the school was able to provide for his spiritual needs and comment is made in the records of the satisfaction that he gained from being able to act as a server at Mass.

5.11 The Aisling House staff kept a case file on him. When it was read by the Inspectors it was orderly and up to date but most of the entries tended to be limited to description of events that occurred and few conclusions were drawn from them. It did not sufficiently demonstrate what the residential social workers were doing, the progress that was being made in the assessment or the achievement of other objectives.

5.12 The use of a more structured approach to the assessment such as the Problem Profile Analysis that is in use in another training school might provide the assessment process with a greater focus. At present it is not always possible to determine the basis on which the recommendations have been made to the courts and referring agencies during and at the end of the assessment. The Inspectors recommend that consideration should be given to providing a more structured approach to the assessment process.

5.13 From the other end the Western Board continued to show a commitment to the children. Three members of staff attended the initial case review and brought with them. Two weeks later one of the residential social workers from the children’s home visited a former member of staff at St. Patrick’s. There is no evidence to suggest that the Board interest in him would have diminished if the placement had continued as planned or that they would not have fully co-operated in any plans to return him to their care if such a course of action had been recommended.

Control and Discipline

5.14 The Inspectors were told that the preferred sanctions for misbehaviour in Aisling House are small deductions of pocket money or the loss of
privileges such as trips out of the school. However, the low staffing levels sometimes mean that when a child has lost such a privilege he has to be taken away because there are insufficient people on duty to supervise both the group going out and anyone being made to remain behind.

5.15  Aisling House has two rooms, known as "quiet rooms". They are in fact secure accommodation in that they are used to lock up a child so that his liberty is restricted. The furniture is limited to a mattress on the floor and a soft upholstered cube. The records show that between the time that Aisling House was opened and the Inspectors' visit these rooms were used 92 times, on occasions as a response to quite minor misbehaviour. They were only placed in a quiet room once for eight minutes when he threatened to hit another boy with a pool cue and was verbally abusive to members of staff. In the Inspectors' view the use of locked rooms is an unacceptable response to misbehaviour by disoriented children who may be as young as ten years of age. If a child needs to be removed from the group either for his own protection or the protection of others he should be taken to his bedroom by a member of staff who should remain with him.

5.16  Reference to paragraph 2.26 shows that was removed to Slemish House on his second night at St Patrick's. The records show that he had been demanding to have his light left on and that he had used "spicy" language to the night supervisor. This behaviour does not appear to justify the use of secure accommodation. Consequently it is recommended that the use of such accommodation as a response to misbehaviour should be reviewed.

5.17  Currently there is no legislation in force on the use of secure accommodation in Northern Ireland. However, Article 44 of the new Children (NI) Order 1995, which will be implemented within the next two years states that a child may not be placed in secure accommodation unless it appears that:

"(i) he has a history of absconding and is likely to abscond from any other description of accommodation; and

"(ii) if he absconds he is likely to suffer significant harm; or

"that if he is kept in any other description of accommodation he is likely to injure himself or other persons."

5.18  In addition it is anticipated that when the Order is implemented it will be accompanied by Regulations similar to those emanating from the English Children Act 1989 which further restrict the use of secure accommodation. In the Inspectors' view many of the situations in which the quiet rooms and Slemish House are currently being used will not be possible under the new legislation and are not desirable as good practice today.
5.19 Nevertheless, in the Inspectors’ view the lack of any regulations or
guidance on such a sensitive topic as the use of secure accommodation for
children is too serious an omission to remain until the implementation of
the new legislation. They recommend that the Northern Ireland Office
should issue guidance to the training schools as soon as possible and the
schools’ management boards should incorporate it into revised
procedures for their staff.

Abandoning

5.20 SPT 81 had absconded twice while he was in the Western Board’s area.
On the first occasion he left Nazareth House and was found the following
morning at his grandmother's home. On the second he went missing from
Harberton House with another boy and they were both found a few hours
later by a member of staff. It appears that the two boys were "milking"
school for the morning. In themselves these two incidents were not
regarded as being very serious.

5.21 At the time that SPT 81 was admitted to Aislin House, there
had been a spate of abandonings which were brought to the attention of the
Western Board’s staff only at the initial case review, four days later. In
the two months prior to 14th August there had been twenty eight
abandonings from the unit. Eighteen of them involved the four boys who
later absconded with SPT 81. One of them had left the school on seven
separate occasions, a second boy on five occasions and the other two had
each left three times without permission. A culture of abandoning appears
to have been established with incidents involving small groups of boys
occurring every five or six days on average. In the whole of St Patrick’s
there were 353 abandonings from the school in the first six months of 1994.

5.22 In the Inspectors’ view it should have been a matter of concern that a new
boy to the unit, especially one as young as SPT 81, would be at real risk
of being influenced by others to become involved in their abandoning
activities. The staff who had worked with him, however, felt that he was
unlikely to abscond and told the Inspectors that they were surprised when
they were told that he had become involved in the incident on 14th August.

5.23 With the benefit of hindsight this proved to be an incorrect assessment and
it is now clear that he was subject to the influence of a group of
persistent absconders to the point where he collected and hid the food and
clothes that they needed. The staff involved were aware that SPT 81 was
easily influenced by others and in the Inspectors’ view more cognisance of
the dangers of his becoming involved in absconding should have been taken
at the time of his admission. It is recommended that more consideration
should be given to the dangers of children being drawn into absconding
behaviour if they are placed in a group containing persistent
absconders.
5.24 Some of the records in Aisling House examined by the Inspectors suggest that absconding from the school is not always treated as seriously as it might be. For example a number of the reports on case files do not suggest that the dangers of an eleven or twelve year old boy being missing for several days are fully recognised. Some of them are written in style which suggests that they may not be treated with the seriousness they deserve. Furthermore there is little indication that the reasons for the absconding are followed up or discussed with the boy following his return. Staff appear to take the view that, since it is an open unit, there is little that they can do to stop absconding if the boys are determined to go whereas experience elsewhere shows that a considerable amount can be done to reduce the risks by identifying them systematically and providing additional direct supervision when necessary.

5.25 Absconding is a serious issue and steps need to be taken to address the problem as a matter of urgency if the current levels are to be reduced. There are obvious dangers when children as young as eleven remain out of adult supervision and care overnight or for even longer periods, particularly during a period of civil unrest as is amply demonstrated by the tragic death. However, there are also risks that the young people can become involved in delinquent activities. It can instil a sense of failure among staff and seriously damage the reputation of the school.

5.26 A review of the literature on absconding suggests that there is likely to be more absconding by young people in short term care units, particularly when they are uncertain about their futures. It is also more likely to occur when there are high occupancy levels. All these factors apply in Aisling House which would suggest that the risk of absconding may be higher there than in other units on the St. Patrick's campus.

5.27 The incidence of absconding from the other large training school in Northern Ireland has also been high. As a result of public concern about it a special study was undertaken by APRU in 1991. This study helped the school's management to identify a pattern of absconding in terms of the type of young people most likely to abscond, the times of the day and even the season of the year at which they were most likely to leave, the house units with the highest levels of absconding and the types of supervision which gave the highest and lowest levels of risk. Having identified the risk factors management were able to develop a fifteen point strategy to tackle the problem. It is significant that when the situation was reviewed a year later the levels of absconding in the school had been significantly reduced. The Inspectors were concerned to be told that the lessons learnt in the exercise were not shared with the staff of St. Patrick's. It is recommended that at least the conclusions and recommendations should be made available and that a similar exercise should be conducted in St. Patrick's.
5.28 Incidents of absconding from Aisling House are recorded in a book and on the child’s file. The information, together with similar data from the other house units, is collected centrally and is forwarded to the NIO. However, it is not analysed and returned to St Patrick’s in a form that would enable the senior staff to determine any remedial action that might be appropriate. One of the outcomes of the study in the other training school was the introduction of a more detailed information system to allow the problem to be monitored. In the Inspectors’ view similar information should be readily available to staff in St Patrick’s. It could be done by analysing the information currently forwarded to the Northern Ireland Office so that the management staff can adopt a strategic approach to tackling the problem. It is recommended that an information system should be developed to enable staff to monitor absconding and enable them to adopt a strategic approach to tackling the problem.

5.29 Where absconding has become established in an institution, as appears to be the case in St Patrick’s, there needs to be a fundamental review of the care arrangements. To some extent this was done in the other training school with beneficial results. A similar exercise should be undertaken at St Patrick’s and the results kept under review. In this way it should be possible to reduce the level of absconding. Failure to take such action would leave the school open to the charge that it had not taken sufficient steps to address what is seen to be a serious problem. It is recommended that a fundamental review of the care arrangements should be conducted to identify ways of reducing the level of absconding.

5.30 Nevertheless, since the events covered by this review took place some beneficial changes have occurred. For example, in paragraph 2.42 it is mentioned that an hour elapsed between the time it was noticed that the boys were missing and their disappearance was reported to the police. The staff used this time to search the surrounding area. Since then the staff have been instructed to notify the RUC as soon as a boy’s absence is noticed. It is, however, recommended that this change in procedures should be incorporated into a revised manual of guidance for staff.

Staffing

5.31 The Northern Ireland Office funds St. Patrick’s to staff the school according to the Castle Priory formula. At the time of William’s placement the calculations were based on an assumption that there was a waking week of 80 hours in all the units but the ratio of staff to bed spaces varied between them. In Shemogue the ratio was 1:2; in Aisling, 1:3.5 and in the long stay units, 1:4. In the case of Aisling NIO allowed for 7.5 staff including the Team Leader. In fact only 6 staff were employed within the unit for 11 boys, which compares poorly with Harberton House’s 9.5 for 10 children. It is recommended that St Patrick’s management should ensure that Aisling House is at least staffed to the levels allowed for in the funding provided by the Northern Ireland Office.
5.32 The 80 hour working week assumes that house units are not staffed during school hours. This is probably a reasonable assumption in long stay units particularly if the boys remain in school for their lunches. However, in an assessment unit there is a considerable amount of work to be done in addition to the direct care of the boys as a group. The process requires one-to-one work, report writing, attendance at intake and case reviews and liaison with the staff of Boards and Truss. In the past the school has argued that the waking week is in excess of 100 hours per week. There is some validity in this argument although, in the Inspectors’ view, it is probably not necessary to have three people on duty during the time that the boys are school. It would, however, be justified during the school holidays. If the argument for a 100 hour waking week is accepted it would bring Aisling’s staffing needs to over 11 people, almost double the current six. It is recommended that the funding made available by the Northern Ireland Office for staffing Aisling House should be reviewed. This would, however, need to be tied to an increased staffing level generally.

5.33 It appears, then, that Aisling is significantly understaffed both in terms of the needs currently accepted by the NIO and considerably more in terms of the waking week that the school argues is justified. Possibly partly because of this level of understaffing there are some aspects of the care provided in Aisling which cause the Inspectors some concern. The staff of the unit are divided into two teams of three, one of which includes the Team Leader. This arrangement means that he is only regularly on duty with half his team which must create difficulties for his supervision of the other half. Reports in other parts of the United Kingdom have also highlighted the dangers of small closed groups of staff working together. The Inspectors recommend that the Team Leader be removed from the duty rota to enable him to devote his time to the management of his staff.

5.34 The present staffing complement of six barely allows for the normal number of hours in a week to be covered without taking into account additional demands created by sickness and leave commitments. Possibly because of this a considerable number of “additional hours” are worked. These are hours in addition to the normal 37 hour week that staff work. Reference to paragraphs 2.37 to 2.39 shows that one of the members of staff on duty the day that was punched and the other four boys absconded was actually based in Saul but worked additional hours in Aisling. He told the Inspectors that in the past he has worked as many as 100 hours per month in addition to his normal hours. In the Inspectors’ view the practice of moving staff between units in this way significantly undermines the benefits of accommodating children in small house units rather than in a large school setting. It is recommended that each house should be staffed to provide adequate cover without having to rely on the assistance of others.
5.35 The events of that weekend also raise a number of other staffing issues that the inspectors think need attention. The member of staff mentioned above was planning to work four shifts in a weekend. Reference to the staffing cover for that week shows that [redacted] key worker was on duty for the following hours in the days before the absconding:

<table>
<thead>
<tr>
<th>Date</th>
<th>Shifts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday 11th August</td>
<td>2pm - 11pm (9 hours)</td>
</tr>
<tr>
<td>Friday 12th August</td>
<td>8am - 10pm (14 hours)</td>
</tr>
<tr>
<td>Saturday 13th August</td>
<td>8am - 10pm (14 hours)</td>
</tr>
<tr>
<td>Sunday 14th August</td>
<td>8am - 3pm (7 hours)</td>
</tr>
</tbody>
</table>

The inspectors were also told that the normal duty rota entails staff working on two weekends during a four-week cycle. It is intended that they should work one shift on the Saturday followed by another on the Sunday. However, it has apparently become common practice for members of staff to arrange between themselves for one of them to cover the whole of Saturday and the other to cover the whole of Sunday. Staff cannot remain fresh and capable of responding adequately to the demands of difficult and disturbed young people if they are working such long hours. These arrangements may suit the staff in giving them either additional payments or days when they do not need to come to work but they are not in the interests of the boys. It is recommended that double shifts and other long periods of duty should cease.

5.36 Given the inadequacy of the present staffing levels the inspectors were surprised to note that almost every day at least one person is on what is termed "mid duty", that is they work from about 10.30am to 2.15pm; times when the children should be in school. They were told that these hours are worked in order to make up the 37 hour week. It is recommended that the staff hours used in "mid duty" shifts should be used to provide better staff coverage at weekends.

5.37 On the morning of 14th August at least three of the house units in St. Patrick's had only one member of staff on duty in each. Such a level of staffing is not adequate to ensure safety in simply supervising the children and certainly does not allow for any individual work to be undertaken with them. The inspectors recommend that at least two people should be on duty in each house at all times when children are present irrespective of the number of them. It would be preferable if staffing were so arranged that there were three staff present at times when children are in the unit.

5.38 There are also two matters relating to management that require attention. The first is that the problems over finding adequate cover for Saul on Sunday 14th August appear to have been left to the residential social worker on duty to resolve in spite of the fact that he maintains that he informed a member of the senior management team of the difficulty. Ensuring that there is adequate staff cover is, of course, a primary
responsibility of management and should not be left to RSW staff to resolve. It is recommended that management should take responsibility for ensuring that house units are adequately staffed.

5.39 The second is that there does not appear to be an adequate system of providing senior staff cover in the event of difficulties. The Inspectors were told that if staff on duty need to contact a member of the senior management team they are expected to dial an extension number and then wait until someone gets back to them. They were also told that there is sometimes a delay of up to 20 minutes before anyone responds and, on occasions there has been no response at all and additional time has been spent in seeking assistance from the brothers’ house. This arrangement is unacceptable. It is recommended that a member of the Senior Management Team should always be available on the campus and that staff should have a means of gaining direct and immediate access to him.
6. LESSONS TO BE LEARNT FROM THE CASE PARTICULARLY IN AREAS SUCH AS THE TRANSFER OF CHILDREN TO TRAINING SCHOOLS, SUPERVISION OF YOUNG PEOPLE WITH CHALLENGING BEHAVIOURS AND ABSCONDING.

6.1 The circumstances of reception into the care of the Western Health and Social Services Board, his behaviour in Nazareth Lodge and Harberton House, the reasons and the arrangements for his transfer to St. Patrick's and the care and supervision that he received there have been described and commented on in the preceding sections. The recommendations that the Inspectors have made constitute the lessons that they think should be learnt from these tragic events. However, some of the broader and more important factors are summarised here.

6.2 Although this review has concentrated on the circumstances surrounding the move from Harberton House to training school and the care that was provided for him there, the Inspectors think that it should be noted that if a suitable foster home had been available for him it is unlikely that any of these events would have occurred. It is in this light that they recommended that a review of the fostering service in the Board's area should be conducted.

6.3 In section 3 the reasons for the transfer from Harberton House to St. Patrick's were discussed. Although it is agreed that residential care was not a suitable placement for him he was making some progress in Harberton House in the early part of 1994 when the allegations about his involvement in a sexual assault on a girl came to light. Almost immediately the question of a transfer to training school was raised with him which he may well have perceived as yet another rejection in his life. Given the stress of the Police investigation on top of all the other problems he had been experiencing in his short life, it is not surprising that his behaviour deteriorated further. This gave further cause for consideration being given to moving him. Although the Inspectors recognise the importance of protecting other children it is possible that further consideration may have shown that the work the Western Board's staff envisaged being done during a comparatively short placement in the training school before returning to Harberton House could have been accomplished without the additional trauma of moving him.

6.4 Given the general agreement that residential care was not the most appropriate form of care for him the reasons for his move remain rather unclear. The records show that it was referred to as a period of "time out", apparently meaning that the move was only intended to be temporary. However, the Board staff had little knowledge of the services that St. Patrick's could offer or whether they could realistically be expected to significantly alter behaviour in a short period to justify it. There would have been a number of factors to suggest that moving him would be likely to have at least some negative effects. They include the
established evidence that any move, in itself, can be expected to have an adverse effect on a child in the care system. There would also inevitably be some dangers in moving a boy from his own home area to West Belfast particularly at a time when civil unrest was still continuing. Furthermore, while in training school he would almost certainly come under the influence of older children. All these factors, together with Aisling House’s lower staffing ratios than those in Harberton House make it difficult to come to the conclusion that St Patrick’s could be expected to achieve enough to more than balance the likely negative effects of the move.

6.5 Aisling House is described as an assessment unit and the records also show that the staff in Harberton House were asking for various aspects of a boy’s life and his behaviour to be assessed during his stay there. However, Harberton House is also an assessment unit so it is again difficult to see what a period of assessment in the training school could achieve that could not have been achieved in the children’s home. The Western Board staff did request that [REDACTED] be referred to APRU for a psychological assessment (the effect of this request immediately extended the likely period of his stay to beyond the initial five weeks) but the Board’s records show that he had already been referred to its own Child and Family Psychiatric team who had concluded that a further psychological assessment was unnecessary.

6.6 Also in Section 3 reference is made to the more general problem of the placement of pre-teen children in training schools. It refers to the agreement between the Chief Executive and the General Managers in 1992 that such use of the schools would diminish other than where secure accommodation could be justified. However, in the subsequent two years there did not appear to have been much progress. The Inspectors recommended that the Western Board should issue policy guidance to its staff on this matter including a procedure for decisions on such placements to be taken at a senior level.

6.7 The adequacy of the information on background and behaviour provided by the Board to St Patrick’s are covered in Section 4 of this report. Eventually a reasonable level of information was provided but the Inspectors were concerned that during almost two months between the time he was referred and when he was admitted there was no contact between the two agencies other than telephone calls. It appears that a good opportunity to share information, make plans for the placement and discuss whether it would be the best means to achieve the desired results was therefore lost.

6.8 In section 5 the Inspectors have made a number of comments on the arrangements in St. Patrick’s for care and supervision and recommendations for changes for the future. One of them concerns the inadequacy of the staffing levels. It is difficult to justify moving a difficult and disturbed boy from a children’s home to a unit in a training school if
that training school unit has significantly fewer staff than the children’s home. In the Inspectors’ view the staffing levels currently allocated by St Patrick’s management do not adequately take into account the special demands of work in an assessment unit. It was noted that the school does not even employ in Aisling House the full number of staff for whom it receives funding. Furthermore the duty rota does not make the best use of the people available and, in some respects, appears to be designed for the convenience of the staff involved rather than for the best supervisory arrangements for the children. A further concern was the apparent inadequacy of the arrangements for senior staff cover to resolve problems and difficulties. Given the additional duties associated with a short term reception and assessment unit the Inspectorate believes that there is a need for a review of the existing staffing provision in this unit. It is also necessary to review the way in which staff are deployed to ensure that it is in the best interests of the residents.

6.9 The assessment process in Aisling House currently appears to lack a firm focus. The Inspectors have suggested that consideration should be given to adopting a more structured approach.

6.10 There is considerable reliance on the use of the quiet rooms and Slemish House, both of which are forms of secure accommodation, as responses to poor behaviour. This may be because the current staffing levels are not adequate but it is not considered to be most appropriate way for a care unit to attempt to modify behaviour. Furthermore this method will probably not be legal following the implementation of the Children (NI) Order 1995.

6.11 Most importantly, however, is the response to absconding in the school. The records show that absconding levels are very high and it is an problem which staff find difficult to control. Whilst the Inspectors were told that both management and staff treat it seriously it is felt that a more strategic approach is needed if it is to be tackled effectively. While it is not expected that absconding will be completely eliminated the current levels are too high and they should not be treated as inevitable. Given that a considerable amount of work has been done to try to reduce absconding in another training school in Northern Ireland the lessons learnt there should be passed on to St Patrick’s. The Inspectors have made a number of suggestions which should enable the school to monitor absconding more closely and develop a strategy to reduce it.
RECOMMENDATIONS

1. It is recommended that the Western Board should commission a review of its fostering services with a view to achieving an improved level of availability. (Paragraph 3.2)

2. It is recommended that St. Patrick’s Training School should prepare an information leaflet for referring agencies outlining the services that they can offer. (Paragraph 3.4)

3. It is recommended that the Western Board should prepare guidance for its staff on the admission of young children to training schools. (Paragraph 3.7)

4. It is recommended that Place of Safety Orders should not be used to transfer children to training schools other than in emergencies when the school is in a position and willing to admit them immediately. (Paragraph 3.9)

5. It is recommended that when children are transferred from Board accommodation to training schools the time prior to admission should be used to provide the school with information about the child’s history and behaviour and to make firm plans about how the placement will be used to achieve identified objectives. (Paragraph 4.5)

6. If it is found that boys are absconding from Aisling House through doors that are difficult for staff to supervise consideration should be given to fitting them with alarms. (Paragraph 5.2)

7. It is recommended that consideration should be given to providing a more structured approach to the assessment process. (Paragraph 5.12)

8. The use of secure accommodation as a response to misbehaviour should be reviewed. (Paragraph 5.16)

9. It is recommended that the Northern Ireland Office should issue guidance to the training schools on the use of secure accommodation and the schools’ management boards should incorporate it into revised procedures for their staff. (Paragraph 5.19)

10. It is recommended that care should be taken to consider the dangers of children being drawn into absconding behaviour by their placement in group containing persistent absconders. (Paragraph 5.23)

11. It is recommended that the conclusions and recommendations made in the study of absconding in another training school should be made available to St. Patrick’s and that a similar exercise should be conducted there. (Paragraph 5.27)
12. It is recommended that an information system should be developed to enable staff to monitor absconding and develop a strategic approach to tackling the problem. (Paragraph 5.28)

13. A fundamental review of the care arrangements should be conducted to identify ways of reducing the level of absconding. (Paragraph 5.29)

14. It is recommended that the recent change in the procedures whereby the Police are informed that boys are missing immediately their absence is noted should be incorporated into a revised manual of guidance for staff. (Paragraph 5.30)

15. St. Patrick’s management should ensure that Aisling House is staffed to the levels allowed for in the funding provided by the Northern Ireland Office. (Paragraph 5.31)

16. It is recommended that the funding made available by the Northern Ireland Office to staff Aisling House should be reviewed. (Paragraph 5.32)

17. The Team Leader should be removed from the duty rota to enable him to concentrate on the management of his staff. (Paragraph 5.33)

18. Each house should be staffed to provide adequate cover without having to draw staff from other units. (Paragraph 5.34)

19. Double shifts and other long periods of duty should cease. (Paragraph 5.35)

20. The staff hours used in "mid duty" shifts should be used to provide better coverage at weekends. (Paragraph 5.36)

21. It is recommended that at least two people should be on duty in each unit at all times when children are present. (Paragraph 5.36)

22. Management should take responsibility for ensuring that house units have adequate staff cover at all times. (Paragraph 5.37)

23. A member of the senior management team should be available on the campus at all times and staff should have a means of gaining direct access to him. (Paragraph 5.38)
APPENDIX A

Terms of Reference for Review by SSI

To review the circumstances leading to the death of

- the reasons for his transfer to St Patrick’s from the Western Board;
- the adequacy of information about his background and behaviour provided to the Training School by the Board;
- the arrangements for his care and supervision in the Training School;
- circumstances surrounding his

- lessons to be learnt from the case particularly in areas such as the transfer of young children to Training Schools, supervision of young people with challenging behaviours and absconding.
Involvement with the Northern Ireland Office

1. I have been asked by the Department of Health, Social Services and Public Safety to comment on my role / responsibilities relating to the Northern Ireland Office (NIO) when I was a Social Services Inspector (SSI). I have no recollection of being involved in giving either advice on policy matters, or indeed professional advice, to the NIO over this period. It was my understanding that this area of responsibility was covered by our former colleague Mr Wesley Donnell who reported to the Chief / Deputy Chief Inspector. However, I assisted Mr Donnell with the first planned SSI inspection of the training schools which was undertaken in the late 1980’s.

Role in St Patrick’s and Lisevin Training Schools prior to joining SSI

2. I was appointed to the staff of St Patrick’s as an Instructor / Teacher in the senior side of the school in August 1967. I also undertook extraneous duties there in the evenings and on Saturday morning i.e. supervising the boys during sporting, recreational and general activities. During the years I spent in St Patrick’s I met many visitors to the facility including the Minister (Mr John Taylor) MOHA and officials from his Department and later from the NIO. During my time in the senior school I was inspected by the Department of Education (DENI) which approved my appointment and reported on my work.

3. Sometime in 1972 I was withdrawn from my teaching role and, together with another colleague, tasked by management to initiate an assessment unit within St Patrick’s similar to the one which was operating within the Rathgael complex. Within weeks this plan was changed as, following consultation with the Management Boards of the four training schools, the NIO had decided to establish a new secure training school. We were brought together with the senior staff of the Rathgael unit, relocated in office accommodation at Dundonald, from where we provided advice and
assistance to NIO officials engaged in the project. Eventually suitable premises were found in Newtownards which required extensive adaptations to be made before it could be used for accommodating young people within a secure environment.

4. In 1973, when senior staff posts were advertised in for the new (Lisnevin) training school, I was fortunate enough to be recruited as a Deputy Headmaster. A short time afterwards, arrangements were made for myself and other colleagues to have short term placements in Red Bank, a secure unit for young persons, at Newton le Willows, Lancs. Thereafter we planned how to manage two separate units within the confines of the building. In this regard we worked closely with Mr Stirling and other officers from the NIO Training Schools Branch. At this time we were aided also by Miss Forest (SWAG) with particular regard to the number of boys to be accommodated and to the range of staff to be recruited. Many of them were not trained but even those who were qualified teachers or residential social workers had to learn how to manage young people within a secure setting. In this regard policies and procedures to be followed by staff were drawn up and delivered through in-service training which was led by the senior staff group.

5. I spent the 1975/1976 academic year at Bristol University training as a social worker and while there I visited a day assessment project for younger children in London. Upon my return I suggested to my colleagues in Lisnevin and to NIO officials that it may be valuable to try this approach within Northern Ireland. Subsequently I returned to the London day assessment project together with a party of NIO officials led by Mr Stirling and which included Mr Donnell from SWAG.

6. Upon our return the NIO approved moving the residential assessment unit at Lisnevin to Whitefield House where it would operate on a day attendance basis. I led the initial stages of this project including planning the resource, selecting the staff teams and initiating the first intake of referrals. During my time in Whitefield there were many visits from NIO officials and other official visitors including Sir Harold Black.

Involvement in the inspections of the four Training Schools
7. The first SSI inspection of the four training schools was undertaken in 1988. Mr Donnell was the lead inspector and I assisted him. The SSI standards for the inspection of children’s homes were adapted for this purpose and used together with the Training School Rules. Reference was made to the Castle Priory Report for staffing requirements but consideration was given to certain circumstances e.g. staffing in secure accommodation and also for units providing for boys and girls. However, in some areas of work we also had to draw upon our own knowledge of good professional practice. Every opportunity was taken to meet and communicate with the young people residing within the training schools on an informal basis. I do not recall any complaints being made to us by the residents or being advised of any child protection issues arising.

8. Following inspections Mr Donnell and I met relevant managers and gave them some verbal feedback which would have included acknowledgement of good practice together with the main issues arising. I recall that the Director of Rathgael invited the Chairman of the Management Board and many of the staff to this meeting. Afterwards inspection reports were prepared and issued to each school. I had no further involvement and did not undertake any follow up activity pertaining to the recommendations made, participate in regulatory inspections or the investigation of untoward incidents.

9. I have no knowledge of any NIO monitoring arrangements for the training schools. If there were any I am confident that Mr McElfatrick and Mr Donnell would have been involved. However, Mr Donnell was a regular visitor to the training schools and normally accompanied NIO officials to meetings with Directors and senior staff there. This may have been regarded as monitoring activity.

Date: 21 September 2015
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
building when anyone touched or tried to climb over the fence. At the entrance gate there was a sectional building which housed the principal’s office, the finance/administrative office and a security man, who controlled entrance and exit to the site through locked gates. To the right of the administrative building was a separate wooden gymnasium, which was big enough to play 5 aside football in. Beside this was a purpose built football pitch which had its own perimeter fence. At the side of the main building was a fenced around tennis court. The gardens were extensive and well maintained, with a number of specimen shrubs and trees. There was a large 30x12 heated greenhouse where the boys were taught horticulture.

6. The main house was three stories high and had been extensively refurbished to meet the needs of the training school. Living accommodation was on the ground floor. This had a large common room for the Assessment Unit boys and a similar sized common room for the Special Unit. There was a staff office adjacent to both common rooms and a tuck shop across the hall. In addition there was a large domestic style kitchen which the staff could use for making supper and so on, plus a sewing room/laundry. On this floor there was a small domestic style bathroom with a bath in it. This could be used by staff. Opposite was a purpose built shower/changing room. This had a bank of about 6 open showers and a very large circular-style wash hand basin at which 6 boys could wash simultaneously. There were also toilets/urinals and each boy had a wooden locker to store his day clothes in this area. All boys were expected to shower in this area before getting changed into their pyjamas in preparation for going to bed. A similar routine happened in the morning when they would wash and change into their day clothes. All activities in this shower/changing area were normally supervised by 3-4 care staff.

7. To the rear of the ground floor building, in what I believe was a single story return, was a bank of 4 (I believe) single rooms. Each room was no bigger than 6 feet by 8 feet and may have been smaller. They were sparsely furnished with only a mattress and bedding and had a narrow reinforced glass strip window, some four foot long by 8 inches wide. These rooms were used for isolating boys as a form of punishment. They could be used for as short as a few hours, or for as long as 4 days depending on the circumstances. If a boy was particularly disruptive in the dormitories he could be made to sleep in one on his own for a period of time in an isolation room\(^6\). These isolation rooms were in a very quiet part of the building and away from any normal thoroughfare.

8. On the first floor of the main building were the dormitories of the Special Unit. I think that there were four dormitories of varying sizes to accommodate the 20 boys – probably two six bed and two four bed. These were also sparsely

\(^6\) Exhibit 5 - Analysis of removals from class and teachers perceptions of problem behaviours – a paper produced by APRU 1991 and references to use of separation as a sanction - extracted from board minutes
furnished and had only beds in them. The beds were of a solid wooden
collection and mounted on the floor so that they could not be moved. On this
floor there was also a staff bedroom. The care and teaching staff took it in turns
to staff a rota of “sleeping in”\(^7\), for which they were paid an additional fee\(^8\). These
staff were only woken by the night staff if there was a disruption or emergency.
The night staff would have been on duty from 22:00 until 07:30 the next morning
and would have stayed awake all night. There would have been at least one
night staff member on each bedroom floor, and one on the ground floor. They
would have taken it in turns to relieve each other.

9. The top floor had a similar arrangement and layout to the first floor, but had
more of an attic feel to it. It provided bedrooms for the Assessment Unit boys. In
both cases the bedrooms were only accessed for sleeping purposes and were
not in use during the day.

10. There was a large, wide staircase leading to the upper floors. It was “netted” to
prevent any of the boys jumping over it. In my memory there were no suicide
attempts during the time Lisnevin was in Newtownards.

11. Apart from having reinforced glass windows and the netting on the staircase, the
main building had the feel of a large domestic building. There were then two
separate wings, made of temporary sectional buildings. The first housed the
school with a series of small classrooms and workshops plus some offices for the
senior staff. Classes were rarely larger than three or four boys and a full range of
subjects were available, including woodwork, metalwork, art, and PE. A highly
individualised curriculum based on the needs of each boy was in operation.

12. The second wing housed the dining room and kitchens. On this corridor, but after
descending a flight of stairs, was another corridor which housed the
nurses/medical room, purpose built dental surgery, social worker and
psychologists offices and a large case conference room.

13. Later there were two additional sectional classrooms which were placed outside
on their own at the back of the main building. These classrooms were for general
subjects.

**Services provided at Lisnevin**

14. The reasons for referral of the boys to Lisnevin differed according to the unit they
were admitted to. The Special Unit was designed to cope with those boys, who
because of court appearances, for reasons such as non-attendance at school,
being in need of care protection and control, and juvenile offending, were already
in the care of the existing training schools but who were regarded as being in

\(^7\) Exhibit 6 – Night staff operational procedures
\(^8\) Exhibit 7 – National Joint Council for Local Authorities’ Administrative, Professional, Technical and Clerical
Services; Scheme of Conditions f Service (8th Edition) 1975
Part ONE: History of Lisnevin

Background of Lisnevin in Newtownards

3. In October 1973, the then Ministry of Home Affairs (MoHA) (later to become the Northern Ireland Office (NIO) and now the Department of Justice (DOJ)) opened a training school, known as Lisnevin Training School, on the outskirts of Newtownards, at the bottom of Bradshaw’s Brae (in an area known as Kiltonga), then the main thoroughfare from Belfast to Newtownards. The name Lisnevin was a term of historical connection to Newtownards and was believed to be one of the old names by which the town was known. Until that time there had been four existing training schools in Northern Ireland: one each for Roman Catholic Boys, Non-Roman Catholic boys, Roman Catholic girls and Non-Roman Catholic girls. Each catered for children aged 10-17 inclusive, who were sent to them under a court order. The four schools were provided and maintained under provisions contained in the Children and Young Persons Act (Northern Ireland) 1968, and were the equivalent to the former “approved schools” in England and Wales.

4. Lisnevin, which catered for boys between the ages of 10-17 years, was the first integrated training school, in that it was non-denominational and had both Catholic and non-Catholic boys. It was established in response to the need for additional facilities to serve the needs of the Juvenile Courts and the existing training schools. At that time it had two separate functions which were catered for by two separate units – a) an Assessment Unit for 20 boys whom the courts considered might be in need of residential training and b) a Special Unit for 20 boys who did not respond to the “open” non-secure environment of the existing training schools (many of these boys would have had an extensive record of absconding from the existing schools; although some were there by virtue of violent or very disturbed behaviour). The annual throughput of the Special Unit was quite small with most boys remaining there for around 15 months. It was normally running at full capacity of 20 boys. The throughput of the Assessment Unit was quite steady. Again it ran at full capacity and I would estimate that it had a throughput of more than 100 boys per year.

5. Lisnevin was built around a refurbished nineteenth century mansion house (which I think had been known as Kiltonga House). It was situated within its own extensive grounds of probably around 5 acres. It had a long driveway from the main road. An 8 foot wire fence had been built around the perimeter of the gardens. This fence was alarmed so that a bell would ring within the main

---

1 Exhibit 1 – MoHA – Development of Lisnevin at Kiltonga - Operational Policy August 1972
2 SPT-100587
3 Exhibit 2 - Lisnevin Training School – SSI Inspection Report 1988, pp??
4 Exhibit 3 – Admissions – An analysis of admission to Lisnevin remand Unit 1985-92
5 Exhibit 4 - Map of Lisnevin
need of more secure conditions. The decision to transfer to secure conditions was an administrative arrangement and agreed by the respective managements of the schools and was not a court decision. Some of the boys had no record of criminal offending before being transferred to Lisnevin.

15. It was a medium to long term facility with boys living in the unit for between nine months to three years, with a median of around 15 months. As I explained in my 1982 thesis by far the most common reason for transfer to the Special Unit was persistent absconding from the open schools (69 per cent), with need of care protection and control the next most common (18 percent) and beyond control (5 percent); other reasons included need of intensive care, special educational facilities and no progress being made in the open school or a combination of these reasons.

16. The opening of the Special Unit met a need which had been apparent since the passing of the 1969 Children and Young Persons Act in England and Wales. This Act abolished the Approved School Order and replaced it with a Care Order under which the young person became subject to the care of the local authority rather than the Home Office. This meant that because of the new legislation it was no longer possible to have “problem” boys removed from training schools in Northern Ireland to the “closed” facilities in England. In the past it had been possible to have a small number of boys, perceived as difficult, transferred to the Special Units at Kingswood in Bristol, Redhill in Surrey and Red Bank in Lancashire. The increase in civil unrest in Northern Ireland since 1969, which had been coupled with an increase in serious juvenile crime, also indicated a need for Northern Ireland to have its own Special Unit.

17. The Assessment Unit catered for a different range of boys. All were remanded by the juvenile courts for assessment after a finding of guilt or a case proven. The reason for the assessment was to assist the courts in deciding on an appropriate disposal. A small number of boys would also have been remanded because of their need for care, protection and control. The main legislation in use was the Children and Young Person's Act 1968.

18. This time was very rarely extended but did happen on occasion when a young person was charged with a very serious offence, such as murder. A significant number of the boys remanded for assessment were charged with “scheduled” offences relating to the Troubles. Some were charged with paramilitary activity and some with offences, such as riotous behaviour. Around 50 percent were charged with “ordinary” juvenile crime, such as theft, burglary and criminal damage, although some were still there for not attending school or being out of control in a children’s home. Most had already pleaded or been found guilty of an offence and the court was trying to decide on a suitable sentence.

9 SPT-100587
10 Exhibit 8 – Controlled study into the effectiveness of individual client-centred counselling for young offenders in residential care. Chapter 1. Thesis submitted for Doctor of Philosophy by B Lockhart 1982
11 SPT-100587
6.0 SPECIAL UNIT

6.1 The Lisnevin Special Unit provides for up to 15 boys, who are the subjects of Training School Orders. The majority of them have been transferred to the Special Unit from St Patrick's and Rathgael Training Schools, but exceptionally they come directly from the courts. The reasons for their placement in the Special Unit are many and varied but in general terms they have been admitted because they could not be held safely elsewhere.

ADMISSIONS PANEL

6.2 Requests for admission to the Special Unit are considered by a panel comprised of:-

i. A Lisnevin Board Member (chairperson);

ii. A member of the Northern Ireland Office Training School Branch, who represents the Secretary of State;

iii. A Social Services Inspector;

iv. A Psychologist;

v. Deputy Director (Care) Lisnevin

Three members of the above group constitute a quorum and, with the approval of SOS, can effect a transfer to Lisnevin. When the panel meets to consider applications for placement cognisance is taken of the following criteria:-

i. The boy is a danger to himself;

ii. The boy is a danger to others;

iii. The boy is in danger from others;

iv. Absconding is linked with any of i. to iii. above or serious criminal behaviour;

v. The boy's level of disturbance makes him unmanageable in an open training school;

vi. All possible avenues of social, psychological and/or psychiatric oversight have been pursued in an open setting.

Exceptional cases, not covered by the above, are adjudicated upon by the admissions panel. Those admitted tend to be troubled and troublesome boys with social/psychological problems and have a history of delinquent activity.
Part ONE: History of Lisnevin

Background of Lisnevin in Newtownards

3. In October 1973, the then Ministry of Home Affairs (MoHA) (later to become the Northern Ireland Office (NIO) and now the Department of Justice (DOJ)) opened a training school, known as Lisnevin Training School, on the outskirts of Newtownards, at the bottom of Bradshaw’s Brae (in an area known as Kiltonga), then the main thoroughfare from Belfast to Newtownards. The name Lisnevin was a term of historical connection to Newtownards and was believed to be one of the old names by which the town was known. Until that time there had been four existing training schools in Northern Ireland: one each for Roman Catholic Boys, Non-Roman Catholic boys, Roman Catholic girls and Non-Roman Catholic girls. Each catered for children aged 10-17 inclusive, who were sent to them under a court order. The four schools were provided and maintained under provisions contained in the Children and Young Persons Act (Northern Ireland) 1968, and were the equivalent to the former “approved schools” in England and Wales.

4. Lisnevin, which catered for boys between the ages of 10-17 years, was the first integrated training school, in that it was non-denominational and had both Catholic and non-Catholic boys. It was established in response to the need for additional facilities to serve the needs of the Juvenile Courts and the existing training schools. At that time it had two separate functions which were catered for by two separate units – a) an Assessment Unit for 20 boys whom the courts considered might be in need of residential training and b) a Special Unit for 20 boys who did not respond to the “open” non-secure environment of the existing training schools (many of these boys would have had an extensive record of absconding from the existing schools; although some were there by virtue of violent or very disturbed behaviour). The annual throughput of the Special Unit was quite small with most boys remaining there for around 15 months. It was normally running at full capacity of 20 boys. The throughput of the Assessment Unit was quite steady. Again it ran at full capacity and I would estimate that it had a throughput of more than 100 boys per year.

5. Lisnevin was built around a refurbished nineteenth century mansion house (which I think had been known as Kiltonga House). It was situated within its own extensive grounds of probably around 5 acres. It had a long driveway from the main road. An 8 foot wire fence had been built around the perimeter of the gardens. This fence was alarmed so that a bell would ring within the main

---

1 Exhibit 1 – MoHA – Development of Lisnevin at Kiltonga - Operational Policy August 1972
2 SPT-100587
3 Exhibit 2 - Lisnevin Training School – SSI Inspection Report 1988, pp??
4 Exhibit 3 – Admissions – An analysis of admission to Lisnevin remand Unit 1985-92
5 Exhibit 4 - Map of Lisnevin
furnished and had only beds in them. The beds were of a solid wooden construction and mounted on the floor so that they could not be moved. On this floor there was also a staff bedroom. The care and teaching staff took it in turns to staff a rota of “sleeping in”\(^7\), for which they were paid an additional fee\(^8\). These staff were only woken by the night staff if there was a disruption or emergency. The night staff would have been on duty from 22:00 until 07:30 the next morning and would have stayed awake all night. There would have been at least one night staff member on each bedroom floor, and one on the ground floor. They would have taken it in turns to relieve each other.

9. The top floor had a similar arrangements and layout to the first floor, but had more of an attic feel to it. It provided bedrooms for the Assessment Unit boys. In both cases the bedrooms were only accessed for sleeping purposes and were not in use during the day.

10. There was a large, wide staircase leading to the upper floors. It was “netted” to prevent any of the boys jumping over it. In my memory there were no suicide attempts during the time Lisnevin was in Newtownards.

11. Apart from having reinforced glass windows and the netting on the staircase, the main building had the feel of a large domestic building. There were then two separate wings, made of temporary sectional buildings. The first housed the school with a series of small classrooms and workshops plus some offices for the senior staff. Classes were rarely larger than three or four boys and a full range of subjects were available, including woodwork, metalwork, art, and PE. A highly individualised curriculum based on the needs of each boy was in operation.

12. The second wing housed the dining room and kitchens. On this corridor, but after descending a flight of stairs, was another corridor which housed the nurses/medical room, purpose built dental surgery, social worker and psychologists offices and a large case conference room.

13. Later there were two additional sectional classrooms which were placed outside on their own at the back of the main building. These classrooms were for general subjects.

**Services provided at Lisnevin**

14. The reasons for referral of the boys to Lisnevin differed according to the unit they were admitted to. The Special Unit was designed to cope with those boys, who because of court appearances, for reasons such as non-attendance at school, being in need of care protection and control, and juvenile offending, were already in the care of the existing training schools but who were regarded as being in

---

\(^7\) Exhibit 6 – Night staff operational procedures

\(^8\) Exhibit 7 – National Joint Council for Local Authorities’ Administrative, Professional, Technical and Clerical Services; Scheme of Conditions f Service (8\(^{th}\) Edition) 1975
Headmaster or above. Any sanctions would have been in accordance with the 1952 Training School Rules\(^{20}\) in force at that time.

**Corporal punishment\(^{21}\)**

27. Physical punishment was allowed, but I cannot remember it ever being used in the Special Unit. Very occasionally it was used in the Assessment Unit, though sanctions such as loss of leave were not available there because of the short length of stay. Fighting or violence could result in caning – this was normally administered by a bamboo cane to the hand by the Head Master of each Unit or, in his absence, his deputy. Any use of corporal punishment was recorded in a “punishment” book. Any other form of physical punishment was not allowed and would not have been approved by senior management.

**Complaints**

28. I cannot remember any official complaints system being in place when Lisnevin was in Newtownards. That is not to say that boys did not make complaints and in my experience they were normally listened to and their complaints acted upon, if appropriate. I remember taking up several complaints on behalf of boys. If warranted, they usually received satisfaction.

29. In Newtownards there was no independent advocacy or visiting system in place. Although not formalized, the young people could have complained to certain people, such as parents, social workers, teachers, solicitors or chaplains.

**Uncertainty and tension in relation to the site in Newtownards**

30. Before it opened in October 1973, Lisnevin had been subject to a Public Inquiry because of the strong objections of the local residents to the siting of a training school in their neighbourhood. The Inquiry decided that the school could open in Newtownards on a temporary basis, pending the building of a purpose built unit at Rathgael in Bangor some five miles away. However, because of changes in the nature of the school, namely the moving of the Assessment Unit to Whitefield House\(^{22}\) and the establishment of a Junior Remand Wing (for mainly those charged with scheduled offences) at Crumlin Road Prison, which provided a guarantee that no young terrorist offenders would be housed in Lisnevin, an attempt was made to have the school sited permanently at Lisnevin. I recall that in the first year of its opening there was, in fact, an attempt to free a boy charged with terrorist offences from Lisnevin\(^{23}\). Armed men entered the building, held staff at gun point, relieved them of the keys and locked them in an office and made off with the boy. They were soon apprehended at a police roadblock set up at

---

\(^{20}\) SPT-80063 – SPT-80073

\(^{21}\) Exhibit 16 – Corporal punishment in Lisnevin – references found in Management Board minutes

\(^{22}\) Exhibit 17 – Newspaper cutting - 1987

\(^{23}\) Exhibit 18 – 1973 Board Minutes, para 9