THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 – 1955

CLOSING SUBMISSION ON BEHALF OF BARNARDO'S

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I. INTRODUCTION

1. Barnardo's is a core participant in Module 8 of the Inquiry into Historical Institutional Abuse ('the Inquiry')[1], which is considering evidence in respect of two children's homes formerly operated by Barnardo's in the Newtownabbey area:

- Macedon Children's Home (operated 1950 – 1981)[2]; and
- The Sharonmore Project (operated 1981 – 1998).[3]

2. The Inquiry's terms of reference require an examination of whether there were systemic failings by institutions or the state in their duties towards those children in their care between the years of 1922 – 1995.

3. Paragraph 4 of the Inquiry's *Definitions of abuse and systemic failings*[4] defines 'abuse' as:

> "*…behaviour which either (a) involved improper sexual or physical behaviour by an adult or another child towards a child; or (b) in the case of emotional abuse, was improper behaviour by an adult or another child which undermined a child's self-esteem and emotional well-being, such as bullying, belittling or humiliating a child; or (c) resulted in neglect of the child; or (d) took the form of adopting or accepting policies and practices, such as numbering children or ignoring or undermining sibling relationships, which ignored the interests of the children*."

4. Paragraph 5 indicates that:-

> "*A 'systemic failing' by an institution consisted of either:*
>
> *(a) a failure to ensure that the institution provided proper care; or*
>
> *(b) a failure to ensure that the children would be free from abuse; or*
>
> *(c) a failure to take all proper steps to prevent, detect and disclose abuse, or*
>
> (d) *take appropriate steps to ensure the investigation and prosecution of criminal offences involving abuse*."

5. It is recalled that the Inquiry requires that institutions be judged by the standards of the applicable time; an approach that avoids what the *Report of the Committee of Inquiry into Children's Homes and Hostels* described as the 'vindictive use of hindsight.'[5]

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[1] Having been so designated under Rule 5 of the Inquiry into Historical Institutional Abuse Rules (Northern Ireland) 2013 ('the 2013 Rules').
[2] Registered as a voluntary children's home 29 June 1950 to 7 July 1982: BAR 25003.
[3] Registered as a voluntary children's home 7 July 1982: BAR 25005.
[4] http://www.hiainquiry.org/index/definitions_of_abuse_and_systemic_failings_130829.pdf
[5] *Report of the Committee of Inquiry into Children's Homes and Hostels* at paragraph 1.13.

6. Issues such as corporal punishment, for example, must be approached with a constant awareness of that which was generally accepted by society at the applicable time.

7. It is also necessary, in the interests of fairness, to consider the position of the institution on the basis of the information available to it, or which could reasonably have been acquired by it, at the applicable time. Therefore where information is secreted from an institution (for example, *de facto* consensual sexual activity involving children, or the possession of an aerosol for the purpose of intoxication) the institution should not, unless culpable in its ignorance, be subject to criticism on the basis of knowledge that it did not in fact have.

8. Allowance must similarly be made, it is submitted, for changes in mindset that have accompanied increased awareness of the nature and extent of child sexual abuse. In this regard, the Inquiry may note the recent publication of Dame Janet Smith's *The Jimmy Savile Review Report* (25 February 2016)[6], Chapter 3 of which is titled *Changing attitudes and sexual mores* and contains a helpful overview of 'Child protection in British society' at paragraphs 3.70-3.80.

9. On a topic of particular relevance to incidents of (*de facto* consensual) sexual activity involving children, a number of which have been considered by the Inquiry, the report recalls discussion at around 1970 about whether the age of consent should be lowered. Dame Janet Smith observes that:

> "*…wiser counsels prevailed and it did not happen; the age of consent remains at 16 today. It was, I think, recognised that, although some young people will have intercourse under that age and in practice it is difficult to stop them, the law must be able to protect young people if they call for protection and should also seek to protect them from seduction by adults*." (paragraph 3.7).

10. Notably, the report goes on to say that:

> "*There was, however, still very little understanding or recognition at that time of the extent to which young people could be the victims of sexual predators. Sexual abuse was generally thought to be rare and to occur only in families with poor living conditions. Very occasionally there might be a media report about a paedophile ring but there was no significant public discussion as there is today of the need to protect children and young people from potentially damaging sexual contact*" (paragraph 3.8).

11. It is in such a context that much of the material before the Inquiry – and the response of Barnardo's to it – falls to be considered.

12. The evidence of four applicants to the Inquiry – three of whom gave oral evidence – has been considered in Module 8.

[6] http://downloads.bbci.co.uk/bbctrust/assets/files/pdf/our_work/dame_janet_smith_review/savile/jimmy_savile_investigation.pdf

13. Oral hearings in Module 8 saw particular focus placed on Macedon in the period [redacted] as a consequence of the emergence, from the 1990s, of a pattern of allegations of abuse made by former residents.[7] The investigation of those allegations (referred to in these submissions as 'the Macedon inquiry') led to the prosecution on indictment of two former members of staff (BAR 1 [redacted] and BAR 2 [redacted]) in 2004.

14. Each was convicted of a significant number of offences against children. On 21 September 2004 BAR 1 was sentenced to 11 years' imprisonment[8], and BAR 2 to 18 years' imprisonment.[9] In due course those convictions were quashed by the Court of Appeal, for reasons given on 30 June 2005.[10] On 16 September 2005 the Court of Appeal declined to order a retrial.[11]

15. Mindful of the purposes of the present Inquiry, Barnardo's approaches the material available to the Inquiry – including that relating to the events with which the Macedon inquiry was concerned – with a view to identifying whether the systems and procedures in place at material times were adequate for the purposes of child protection. The veracity of each allegation made is not therefore determinative of the question that Barnardo's asks of itself. Such determinations of fact as are required in relation to allegations made are respectfully left to the Inquiry.

16. The Inquiry is aware that Barnardo's has reflected closely, critically, and at length on matters disclosed by the Macedon Inquiry, and has publicly accepted that criticism of practices in Macedon at the material time is warranted. To a more limited extent, it is also accepted by Barnardo's that systemic failings as defined by the Inquiry can be identified in relation to Macedon at or about that time. It is the hope, and the belief, of Barnardo's that practices thereafter do not merit similar criticism.

17. Barnardo's acknowledges the regrettable reality that the risk of abuse cannot be eliminated but only reduced in so far as possible, and that constant vigilance is accordingly required.

18. That reality underscores the importance of the self-critical reflective practice that Barnardo's considers is a key characteristic of the organisation. In that spirit Barnardo's values the opportunity the present Inquiry has offered, and continues to offer, for reflection, questioning, learning, and improvement, with the constant aim of better protecting the children Barnardo's exists to help.

[7] It is noted however that Module 8 included little if any complaint about certain matters identified as 'common complaints' by senior counsel to the Inquiry on its opening, including matters such as the denigration of children's families, the separation of siblings, inappropriate physical labour, the removal of personal belongings, placing children in fear (for example, by locking them in cupboards), and public humiliation of children who wet the bed: *Day 1, pages 47-48*.
[8] BAR 6769.
[9] BAR 6773.
[10] [2005] NICA 45.
[11] [2005] NICA 38.

II. BARNARDO'S GENERALLY

History, Basis and Values

19. Barnardo's is the United Kingdom's oldest and largest children's charity: in 2016, it marks its 150th anniversary. Its work is enormously diverse, but no longer includes the provision of residential children's homes with which the name of Thomas Barnardo was, and remains, so closely associated. The methods deployed in 1866 for the assistance of children are plainly of little use in 2016, and it has been necessary for Barnardo's to adapt to the myriad ways in which children face disadvantage. The charity that bears Barnardo's name nonetheless remains driven by the belief that underpinned its foundation: that every child, irrespective of background, deserves the best possible start in life.

20. Thomas John Barnardo was born in Dublin in 1845. Following his conversion to Protestant evangelicalism, and having decided to become a medical missionary in China, he went to London in 1866 to train as a doctor at the London Hospital in Whitechapel. He arrived in a city struggling to cope with the effects of the Industrial Revolution, with a dramatically increased population concentrated in the East End, where overcrowding, poor housing, unemployment, poverty, and disease were rife. Some months after his arrival, an outbreak of cholera killed more than 3000 people in the East End and left many stricken families destitute.

21. The charitable work that Barnardo became engaged in saw the establishment in 1867 of a 'ragged school' providing a basic education to poor children. In later years he repeatedly spoke of a profoundly affecting encounter with a destitute child named Jim Jarvis, who showed Barnardo around the East End, where they found children sleeping on roofs and in gutters. 1870 saw the establishment of Barnardo's first home for boys in Stepney Causeway. By that year, it had become apparent that Barnardo's plan to undertake missionary work in China had been overtaken by his work in London.

22. Barnardo's experiences continued to shape the fundamental principles on which he sought to operate. He initially placed a limit on the number of boys who could be accommodated at his shelter. One evening, an 11 year old boy named John Somers, known as 'Carrots', was turned away. He died two days later of exposure and malnutrition, having spent the night in a sugar barrel. This event led directly to a new policy and, in due course, slogan for all Barnardo's homes: 'No Destitute Child Ever Refused Admission'. Thus was established the Ever Open Door receiving house.

23. Inherent in this policy was a radical refusal to accept the orthodox Victorian distinction between the 'deserving' and the 'undeserving' poor. At the time, poverty was seen as a shameful result of laziness or vice. But while other institutions imposed restrictions on the provision of assistance, Barnardo's accepted black, disabled, and illegitimate children. Barnardo's sought to save children from a life of destitution by preparing them for employment. He promoted his charity as a surrogate family, but was aware that large homes were not necessarily the best place

for children; he was therefore eager to ensure that children were part of a family and introduced boarding out, paving the way for the charity's fostering work.

24. By the time of Barnardo's death in 1905, the charity ran 96 homes caring for more than 8500 children, and more than 4000 were boarded out. The influence of the charity's founder was such that methods of child care considered to be positive during his lifetime continued to be followed for some time after his death by an organisation that could be slow to change. Ideas continued largely unchallenged until after the Second World War, when the emphasis shifted towards keeping children and their families together in their own communities (the disruption of war having improved understanding of the impact of family breakup and the effect on children brought up away from home).

25. The publication in 1946 of the Curtis Report on children 'deprived of a normal home life' paved the way for the Children Act 1948 in England and Wales; this enactment brought about a revolution in childcare and a new emphasis on supporting families to stay together. For the first time, children were acknowledged as the responsibility of the nation and the care of children in need became a duty of Government.

26. This shift along with social developments and legislative changes in the 1960s meant that the number of children received by Barnardo's homes was decreasing. Barnardo's started to reduce the number of its children's homes, and began to develop new work with children suffering from emotional and behavioural problems, and families facing unemployment, poor health, bad housing and poverty, with the aim of addressing the issues that might lead to family breakdown and child abuse.

27. To reflect this, the charity changed its name in 1966 from 'Dr. Barnardo's Homes' to 'Dr Barnardo's'.

28. Between 1886 and 1985 Barnardo's was home to over 375000 children who spent all or part of their childhood in its care in the United Kingdom, Canada and Australia. Some grew up in Barnardo's homes, some were boarded out, some were adopted and some experienced a combination of different types of care situations.

29. In 1988 the organisation changed its name again, from 'Dr Barnardo's' to 'Barnardo's', to reflect the contrast with its Victorian past. The last remaining traditional-style home closed in 1989.

Barnardo's Today

30. Today, the Articles of Association of Barnardo's[12] define the charity's objects as for the public benefit:

2.1 To promote the care, safety and upbringing of children and young people by:-

[12] Available at: http://www.barnardos.org.uk/what_we_do/barnardos_today/governing_documents.htm

2.1.1 Supporting and assisting those in need, their families and carers;
2.1.2 Promoting their health; and
2.1.3 Advancing their education.

2.2 ***The relief of those in need by reason of age, ill-health, disability, financial hardship or other disadvantage.***

31. Barnardo's is placed under an important obligation by virtue of article 3:

In pursuing the Objects, Barnardo's shall have regard to its Basis and Values being:

3.1 Basis

3.1.1 Barnardo's derives its inspiration and values from the Christian faith.

3.1.2 These values, enriched and shared by many people of other faiths and of no religious faith, provide the basis of our work with children and young people, their families and communities.

3.2 Values

Barnardo's work is carried out in accordance with the following values:

3.2.1 Respecting the unique worth of every person;
3.2.2 Encouraging people to fulfil their potential;
3.2.3 Working with hope;
3.2.4 Exercising responsible stewardship.

32. Barnardo's UK is part of an international family, with sibling charities supporting children and their families in the Republic of Ireland, Australia and New Zealand. These agencies have taken their values and direction from Barnardo's UK but each operates independently and has adapted to its local context.

33. In the UK, Barnardo's is a contemporary children's charity, which prides itself on working with the hardest to reach children and young people. It works directly with 240000 children, young people and families every year through 960 services. The work undertaken has changed from providing traditional children's homes to supporting children in their own homes. Today the range of Barnardo's work across the UK includes services that build stronger families, support safe childhoods and promote positive futures for young people. The charity's strengths include its willingness to work in the most challenging areas affecting children and its ability to respond rapidly to emerging issues: priority issues presently include female genital mutilation, Aids and HIV, child sexual exploitation, and the needs of prisoners' children and trafficked and asylum-seeking children.

Barnardo's NI

34. The first Barnardo's project in Northern Ireland was a soup kitchen opened on Great Victoria Street in Belfast in 1899. During the period of the Inquiry's remit 3500 children came into Barnardo's care in Northern Ireland and the charity had responsibility for the provision of 15 residential children's homes in Northern Ireland.

35. Today Barnardo's NI delivers 63 services for over 8000 children, young people and their families. The charity employs 500 staff and has over 500 volunteers.

36. In line with the charity's general move away from its original provision toward new services for children, Barnardo's NI no longer runs traditional children's homes and the work of the charity in Northern Ireland today includes family support, safeguarding, trauma, suicide and bereavement services[13]. Barnardo's NI also provides services to young people with disabilities, young carers, young people not in education, employment or training, children affected by alcohol and substance misuse, interventions for young people on the margins of the criminal justice system, and family placement. In addition, Barnardo's NI delivers education support, parenting and counselling programmes in over 150 schools.

37. Barnardo's has an annual budget of £14.5m, of which approximately £2.5m is received by way of charitable donation and invested in innovative work not supported through statutory funding (on issues including child sexual exploitation and the support of children of prisoners).

38. For over a century, Barnardo's has been helping to improve the lives and opportunities of tens of thousands of children across Northern Ireland, working wherever needed by children. Its focus today remains on those children who are most at risk, vulnerable, and disadvantaged.

Barnardo's and the past:-
Making Connections / Barnardo's Archive / retention of documents

39. While the focus of Barnardo's is on providing services in response to the needs of children today, the organisation places a particular emphasis on its responsibility to those historically in its care. This duty is most directly discharged through Making Connections, which is a national and international service to adults providing access to care and adoption records, support and counselling.

40. Barnardo's retains a vast archive of records, including photographic records, about children previously in its care, with the oldest available records dating from the 1870s. Since 1995 former residents have been able to see their original records; a social worker is assigned to each individual availing of the service to help them cope with revelations about the past. Making Connections engages with around 2000

[13] Barnardo's does however operate a small nurture unit for six children under 12 years old, who transition to the charity's Family Placement Service). Barnardo's also has a four-bedded residential respite facility for children with learning and physical disabilities, and provides supported accommodation for up to fourteen young people who are in the process of moving from social care to independent living.

people every year, with the aim of helping them to come to terms with growing up in care by providing information about their backgrounds, helping them to trace relatives, and assisting with reunions. For some the experience can help to make sense of their lives; for others, it can of course be distressing.

41. The importance of the Making Connections service, in both its fulfilling and its cathartic aspects, is apparent from materials considered by the Inquiry. Happily, Barnardo's facilitated contact in 2006 between HIA 216 and her sister BAR 15, who lives in [redacted] and assisted with the cost of HIA 216 traveling to [redacted] for the sisters to meet[14]; no less importantly, the service also facilitated the disclosure of allegations of abuse in the case of BAR 53 .[15]

42. Documentation available in the case of BAR 53 discloses close attention paid to the detail of the allegations made, and the making of comprehensive records in response to each allegation[16]. It is apparent that in such circumstances the primary focus of Barnardo's is on the provision of support, both directly to the former resident and by way of counselling if that is in accordance with his or her wishes. The importance of guiding the former resident through the experience of interaction with police is clearly recognised.

43. As extensive as the Making Connections archive is, it is of course unfortunately the case that not all material of relevance to the present Inquiry can be expected to be available at this time, such is the period of time defined by the Inquiry's terms of reference. In accordance with Barnardo's policy in respect of retention and destruction of documents[17], it may be noted that:

- *residential care records in respect of a child* are held until the child's 75th birthday (or, if the child dies before the age of 18 years, for 15 years from the date of death);

- *management documents* should be retained for a period of 15 years.

44. Importantly, an additional Barnardo's archive containing material dating back to 1872 is now held at Making Connections (having formerly been held at the University of Liverpool): a considerable volume of material submitted to the Inquiry on behalf of Barnardo's was retrieved from this archive.[18]

45. It is however necessary to recognise the limits of the archive, which contains a 10% sample of material, randomly selected for archival purposes.

46. Where documentation cannot now be made available, the Inquiry is asked to treat that *absence* of documentary evidence as only an absence of evidence (rather than as evidence that no such documentary evidence existed at any time). The Inquiry

[14] See materials at BAR17806-17820.
[15] Addressed from BAR 1024.
[16] BAR 1035-1062
[17] See BAR 18550-18551.
[18] The Barnardo's Archive holds approximately 16 boxes' worth of information relating to Northern Ireland.

should of course have regard in such circumstances to such other evidence as is available in reaching any necessary conclusions. In such respects, it is noted that the Inquiry has had the particular benefit of oral evidence from current and former Barnardo's staff members BAR 8, BAR 7, BAR 9, BAR 14, and BAR 13.

III. BARNARDO'S: THE INQUIRY'S FOCUS

Structure

47. In the 1970s, the operating model of the Barnardo's organisation was Divisional, and included an Irish Division.[19]

48. Within the Divisional structure, accountability was achieved through direct management, reporting, policy and procedure directives, and a system of UK meetings that aimed to ensure consistent implementation across the UK.

49. Primary management of a Barnardo's home was the responsibility of the Superintendent and Deputy Superintendent[20]. The management of homes in Northern Ireland was subject to a system of oversight with two aspects. Firstly, there was oversight and monitoring by senior management within Northern Ireland[21]. Secondly, there was also oversight and monitoring by Barnardo's Head Office in Barkingside, London, which received copies of Incident Reports and annual reports from a Domestic Advisor, Medical Advisor and Social Work Advisor, and managed recruitment and training.

50. Divisional Directors reported to a UK Director of Child Care (Mary Joynson[22]) and Deputy (Roger Singleton).[23] The Director of Child Care reported to a Barnardo's UK Council comprised of Trustees, which met six times per year (as well as engaging in an annual residential strategic forum). The Council received reports from Departmental heads.[24]

51. Visits to Northern Ireland homes were also undertaken by Trustees, with a Trustee designated as the visitor for Northern Ireland. The designated Trustee visited annually, but also at times of significant events, for example, the closing or opening of a service. Visits were also received from the chair of the Council on special occasions. During the period 1977 – 1981, Council minutes from September 1977, November 1979, and July 1980 disclose that visits made by Council members included visits to Macedon.

52. Four Barnardo's Advisors – Domestic, Medical, Social Work and Education – held a UK-wide remit. In the 1970s to 1980s the Advisors were significantly engaged in operational matters (advising, for example, on nutrition, furniture and equipment purchases, and specific care issues). The preparation of annual reports by the Domestic Advisor, Medical Advisor, and Social Work Advisor (and in homes with residential schooling, an Education Advisor) continued into the late 1980s.[25] Save for

[19] A process by which Barnardo's (Republic of Ireland) moved from inclusion in the Barnardo's UK structure began in or about 1978, following which it became constituted as a separate charitable entity.
[20] In keeping with the importance placed on the traditional family model by Barnardo's, it was long the practice of the charity to seek to recruit a married couple to these positions.
[21] Seen, for example, in the complaint by HIA 101 grandmother, with which both the Assistant Divisional Director and Divisional Director were closely involved: BAR132-136.
[22] Minutes of a Superintendents' meeting on 2 March 1978 make reference to an anticipated visit of Miss Joynson to the Division on 31 May and 1 June 1978: BAR25936.
[23] See *Barnardo's Organisation Chart* BAR799-800.
[24] For example, finance, properties, and facilities management.
[25] A snapshot of the work the Advisors did may be found at BAR 26033-26037, 26207-26224, 26230-26249.

the Education Advisor, the Advisors generally visited Barnardo's homes in Northern Ireland at least once per year. By the late 1980s the role of the Advisors had become predominantly concerned with the provision of policy advice, and with contribution to the confirmation of Divisional Plans and service design proposals.

53. The title of the Divisional Director[26] role changed over time, but the role remained the same. Divisional Directors were line-managed by the Director of Child Care, and reported regularly on issues of risk and reputation management, and on issues of significant strategic and operational impact. All Divisional Directors met with the Director of Child Care on a monthly basis; these meetings concerned the oversight of strategy and operations and were also attended by other members of the Head Office team and Advisors. All Divisional Directors, the Director of Child Care and the Deputy Director also met three times per year, for a period of three days, with Advisors and corporate colleagues to formulate policy, consider practice and service development, and formulate implementation plans.

54. Some early devolution of responsibilities from London may be seen in a memorandum dated 16 June 1972 relating to the reorganisation of the medical department, which saw the appointment of a suitable General Practitioner for a residential establishment assigned to Divisional staff.[27] Significant functions such as human resources and finances were however centralised at Barkingside for some time further. During the 1980s greater Divisional devolution occurred: for example, finances, recruitment, selection and other personnel functions became the responsibility of Barnardo's in Northern Ireland.

55. Notwithstanding such devolution, the organisation sought to ensure consistency across Divisions by virtue of detailed policy and procedural guidance to staff. *The Barnardo Book*[28] and its successor instruments (now an online resource) provided highly specific direction on operational matters (including, for example, the provision of letter templates to be used across the organisation). *The Barnardo Book* expressed the Council's desire that homes be maintained in a spirit of practical Christianity, disclosing an approach to the care of children, it is submitted, well ahead of conventional thinking of the time on issues such as sexual development[29] and discipline.[30]

56. The April 1979 *Barnardo's Assisted Community Homes: Handbook for Managers and* Staff[31] adopted a similarly progressive approach to questions of control and discipline, focused on positive methods of control. The emphasis placed on encouragement and reinforcement of good behaviour may be considered, it is submitted, to be strikingly modern and contemporary.

57. In keeping with the increased prominence given to the rights of the child, in the mid-1980s Barnardo's provided a booklet titled *A Guide for Children in Residential Care*

[26] Formerly Divisional Children's Officer.
[27] BAR668-673.
[28] BAR19011: 2nd edition, February 1955.
[29] BAR19039.
[30] BAR19040.
[31] BAR626-663.

and their Parents.[32] This explained to children in clear and accessible terms matters such as the nature of a voluntary organisation and the relationship between Barnardo's and the Board, noting that the Board had final responsibility for the child but emphasising the importance of the Key Worker within the home with special responsibility for each child. The booklet used the language of rights and responsibilities, and explained that the two concepts go together. Some of the things that staff could do in response to misbehaviour were outlined (and things that should not be done – 'Food will never be withheld as a punishment' – were identified).

58. Issues relating to growing up and privacy were sensitively addressed. Importantly, the booklet sought to give advice about what to do if a child felt that he or she was not being treated well: a detailed list of situations was set out under the heading **TALK TO SOMEONE IF**, and that list included examples of both physical and emotional mistreatment, including intrusions on privacy and the imposition of inappropriate sanctions. It was emphasised that if unhappy about anything, a child should not be afraid to talk about it. This could be to the staff in the home, at any time, or if the child did not want to talk to the staff in the home, to the Board social worker (whose telephone number was included in the booklet). It was indicated that staff from the Divisional Office would be in the home from time to time and a child could ask to see them. The booklet then drew the child's attention to the Contact Card at the back of the booklet, which required no stamp and would be sent straight to the Divisional Director[33].

59. This made available to children a mechanism by which help could be sought quite separate from, and additional to, that provided by the Board.

Compliance with regulatory framework

60. The legislative framework applicable to the periods with which the Inquiry is concerned included the Children and Young Persons Act (Northern Ireland) 1950 ('the 1950 Act') and the Children and Young Persons Voluntary Homes Regulations (Northern Ireland) 1952 ('the 1952 Regulations'), and – of particular relevance to the Inquiry's focus – the Children and Young Persons Act (Northern Ireland) 1968 ('the 1968 Act') and the Children and Young Persons Voluntary Homes Regulations (Northern Ireland) 1975 ('the 1975 Regulations').

Monthly visits

61. Regulation 4(1) of the 1975 Regulations required the administering authority to ensure that a voluntary home was conducted in such a manner and on such principles as would further the well-being of the children in the home. Regulation 4(2) provided that:-

> "*The administering authority shall make arrangements for the home to be visited at least once in every month by a person who shall satisfy himself whether the*

[32] BAR25037-25072.
[33] A draft document from the Central Child Care Committee dated September 1984 provides more detail on the procedure triggered by use of the Contact Card at BAR885-886.

home is conducted in the interests of the well-being of the children, and shall report to the administering authority upon his visit and shall enter in the record book referred to in Schedule 2 his name and the date of his visit."

62. For the purposes of the 1975 Regulations, the 'administering authority' identified by Barnardo's was the Divisional Director.[34] The task of monthly visiting (and reporting thereon to the administering authority) was discharged by the Assistant Divisional Director (ADD).[35]

63. A 'Monthly Reports on Residential Units' form was included with the Barnardo's submission to the Hughes Inquiry.[36] Following the evidence to the Hughes Inquiry on behalf of Barnardo's, a letter dated 31 October 1985 was sent from BAR 111 [redacted]) to the Barnardo's solicitor.[37] BAR 111 noted that since he had joined Barnardo's, all residential units had been visited at least once a month and often more frequently. It was explained that, about mid-1981, a pro-forma monthly report form was developed for completion after each statutory visit: notably, this appears to have been a development in respect of the method of recording, rather than a change of substance in respect of the visiting or reporting done.

64. The Social Work Advisory Group (SWAG) report of 1983[38] had noted at paragraph 7.2 that the monthly reports from the ADD to Divisional Director satisfied the legal requirements, but recommended more detailed monthly reports in future. The ADD also complied quarterly reports, descending to considerable detail, for discussion with the Divisional Director.[39]

65. Barnardo's mid-1980s *A Guide for Children in Residential Care and their Parents*[40] notes that:-

"*...the person in charge of Barnardo's Homes is called the Assistant Divisional Director, who visits at least once a month* (*but sometimes the Divisional Director himself visits*)"[41] (emphasis in original).

66. Almost a decade after the SWAG recommendation of more detailed monthly reports, the Social Services Inspectorate report of 1992[42] addressed compliance with the 1975 Regulations at section 9[43], noting at paragraph 9.2 ('Regulation 4(2) Official Visitor') that:

'BAR 99 [redacted], [redacted] *completes official visits on a monthly basis. Appropriate checks are made on the operation of the units*

[34] See evidence to the Hughes Inquiry at BAR22039.
[35] BAR 7 [redacted] (who was [redacted] from [redacted]) gave oral evidence that the Senior Residential Officer, and later the Assistant Divisional Director, visited approximately monthly and checked menu books, punishment books, etc.: *Day 170, pages 71-72*.
[36] BAR22207.
[37] BAR22340.
[38] From BAR26533.
[39] Report for quarter ending 31 May 1984 available at BAR22209-22212.
[40] From BAR25037.
[41] BAR25055.
[42] From BAR26729.
[43] BAR26761-26763.

including progress of the residents. A quality assurance approach has been adopted which assists with effective monitoring. A pro-forma for monthly reporting to the Divisional Director is used. At the top of this form is the Statement 'during the month I have visited the unit and am satisfied that the monthly regulations are being carried out'. This form is signed and dated."[44]

67. Direct documentary evidence of monthly inspection of Macedon does not appear to be available, but the operation of such a system – and of other similar systems contributing to the monitoring of Macedon, and to the maintenance of a significant standard of recording – appears to be supported by extracts from the minutes of Superintendents and Deputies meetings.[45]

68. The minutes of a meeting on 10 March 1975 describe the role of the Senior Residential Officer (SRO).[46] At 6(a) a discussion in relation to weekly log sheets discloses the Superintendents' understanding that these were read by the SRO, and that some of the entries were made for her benefit. Miss Bass agreed to read these weekly log sheets in future: this would accordingly see a mechanism put in place by which the SRO might in this way monitor units. At 6(d) it is stated that the SRO will 'continue to conduct reviews' (relating to children). At 6(e), reference is made to the SRO's duty to sign diet sheets periodically (of which it was observed that these should be examined by someone more suitably qualified to comment on them). At 6(f) reference is made to the necessity of consulting senior staff in advance of administration of corporal punishment, and to the requirement of recording corporal punishment when administered: the minutes expressly recognise that '...there are statutory regulations to be adhered to.'

69. At a meeting on 18 February 1976, the review and reform of Barnardo's punishment and discipline was discussed.[47] The DCO quoted from the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1975, which define corporal punishment. It was recommended that the statutory regulations be made known to staff. While the discussion concerned only corporal punishment, the knowledge of and familiarity with the requirements of the 1975 Regulations may be considered to support other evidence indicating the operation of a system intended to achieve compliance with all aspects of Regulations.

70. Minutes of a meeting on 15 September 1977[48] include reference to the circulation of Daily Logs, and two articles, to Superintendents, and to the agreement of the meeting that staff should be encouraged and helped to observe and record children's behaviour methodically.[49] The minutes record a discussion of the Daily Register, Diet Books, Visitors Book, Petty Cash records and Punishment Books. It may be

[44] These visits are recorded in Annual Monitoring Reports in respect of Sharonmore, which detail dates of statutory visits by BAR 99 [redacted]: 1[redacted] - [redacted] (from BAR26713), at paragraph 8 (BAR26718-26719); and 1 April 1992 - 31 March 1993 (from BAR26905), at paragraph 8 (BAR26909).
[45] BAR25876-26272.
[46] BAR25884-25887
[47] BAR25900-25902. A number of meetings clearly involved thoughtful discussions on the issue of care and control, in the context of a draft circular on the issue and a memorandum dated 27 October 1976: *Minutes 11 January 1977* [BAR25909-25912], *Minutes 9 February 1977* [BAR25913-25915]. It is clear that staff feedback was received and taken into account.
[48] BAR25920-25924.
[49] BAR25922. The service user file of BAR 46 [redacted] contains reference, in an email relating to aftercare records, to the maintenance of daily log-books in his era: BAR18201.

noted that punishment was taken to include sanctions used with young persons in care.

Records

71. Regulation 5(3) of the 1975 Regulations required that specified records be compiled by the person in charge of the home and kept at all times available for inspection by any inspector appointed by the Department. The specified records were identified in Schedule 2 (headed **Records to be kept under the provisions of regulation 5(3)**), which read:-

> (1) A register in which shall be entered the date of admission and the date of discharge of every child accommodated in the home.
> (2) A record book in which shall be recorded events of importance connected with the home.
> (3) A record of every fire practice or drill conducted in the home, together with records of all fire precautions agreed upon after consultation with the Fire Authority.
> (4) Menus of the meals provided for the children in the home kept in sufficient detail to enable any person inspecting them to judge whether a balanced diet was available.

72. Regulation 13(4) required that particulars of the administration of corporal punishment under Regulation 13(3) be entered in the record book referred to in Schedule 2.

73. In 1955 *The Barnardo Book* identified at page 96 *Minimum Standard Records to be kept at all Homes* (BAR19060). These included:

- Daily Register (showing children present each day, their absences and the reason, wet bed and fire drill records)
- Diary of Events
- Diet book
- Punishment Book
- Medical Record Book
- Daily Record Book

74. The Inquiry has not had sight of a record book for Macedon as described at Schedule 2, paragraph 2 (an 'events of importance' log). It is however respectfully submitted that the clarity of the requirement under the regulations, of which Barnardo's was plainly mindful, is such that compliance by Barnardo's should be considered likely[50]; in this regard it is noted that a discussion of the recording requirements of the regulations took place at a Superintendents' meeting on the 2 March 1978, at which range of staff from Macedon were attendance.[51]

[50] It may be noted that the compilation and keeping of records under Regulation 5(2) of, and the Schedule to, the 1952 Regulations was to be subject to inspection by the Ministry (Regulation 5(2)). There is nothing within an available inspection report to suggest that Barnardo's failed to keep any documents required by the regulations: see BAR25014.
[51] BAR25936-BAR25942.

75. The minutes include a section headed 'Discussion of the Kinds of Registers Kept in the Establishments'[52], which begins:

> '[redacted] *began by referring to a booklet of the regulations which governed voluntary homes and was issued by the Department of Health and Social Services. Barnardo's have additional regulations adding to that of the Law of the Land*."

76. This is an important recognition that Barnardo's record-keeping was intended, and considered, to meet and exceed that required by regulations of which management in Northern Ireland was plainly aware.

77. An Accident Book and a Punishment Book were kept at Macedon and (leaving aside the question of whether a separate log was kept) any events of importance would have been recorded in the service user files.[53] Within Barnardo's the practice of ensuring that information of importance was recorded in the service user files was recognised as important, given the danger that simply recording an event in a log book may not lead to any action that may be required in the case of the individual service user.

Control and discipline

78. Regulation 13 of the 1975 Regulations addressed the issue of control, and required that the person in charge of a home ensure that order be maintained as far as possible by the personal influence and understanding of the staff, and that resort to corporal punishment be avoided as far as possible.

79. Barnardo's policies in this regard were however more restrictive than the 1975 Regulations (which in Regulation 13(3) expressly envisaged caning as a form of corporal punishment of children over 8 years of age, and did not preclude the corporal punishment of children known to have a physical or mental disability).

80. Consideration in 2016 of any issue relating to corporal punishment requires particular care in order to reflect the standards of the material time, in particular by way of recognition of that which was, at a given time, considered to represent *reasonable chastisement* for the purposes of the criminal law.

81. Whether judged by the standards of 1955 when it was issued, or of today, the second edition of *The Barnardo Book* discloses an approach to the control of children that is in line with contemporary thinking and marked by commendable good sense:-

> "*Never punish for enuresis, masturbation, nail-biting or other nervous affectations. The physical or psychological root of the trouble must be sought. Encouragement here can work marvels and definite rewards should be given for*

[52] BAR25941.
[53] See for example BAR098, a report by [redacted] detailing an incident on the collection of a child from a weekend home visit, a copy of which went to Social Services and the Divisional Office.

a bad habit overcome. It is essential that confidence be established in the child's mind. Care must be taken not to comment on a child's misdemeanours before the other children or the child's feeling of insecurity will be intensified.

Infinite patience, humour, a sympathetic understanding, a great ingenuity in finding suitable diversions, these and not a code of punishments are the essentials for the happy control of little children."[54]

82. The Inquiry considered at hearing a particular incident by which the Barnardo's approach to corporal punishment might be measured, involving HIA 101 and taking place in early [redacted][55]. This example is instructive both for its rarity as an example of the administration of corporal punishment in practice, and for its exposition of the Barnardo's response to the administration of corporal punishment in breach of its policy.

83. The Barnardo's Corporal Punishment policy then applicable (DCC/77/9/DCO)[56] stated that:-

1. The only form of corporal punishment permitted by Barnardo's is in relation to a child under ten years of age and is limited to a smack on the child's hand with the bare open hand of the person administering the punishment. An entry must be made in the punishment book and on the child's personal file. No child suffering from a mental or physical disability should be smacked.

2. Any other form of corporal punishment is forbidden. The term 'corporal punishment' includes striking, cuffing, shaking, the use of a cane, strap, slipper, tawse or other implement, or any other form of physical violence.

3. It is sometimes necessary to restrain physically a child who is about to harm himself or others. Only such effort as is needed strictly to calm the situation should be employed. No element of physical punishment should be used. A record of such an incident should be made on the child's file.

4. Any breach of these rules by a member of staff will be investigated and may lead to disciplinary action which could include dismissal.

5. In making these rules, Barnardo's is exercising its right to apply restrictions in addition to those prescribed by various statutory regulations. Staff should be aware, however, that if corporal punishment of a type with is not allowed by the statutory regulations is used, not only are they in breach of a Barnardo rule

[54] BAR19040.
[55] See BAR132-183, 143-148.
[56] BAR137-138.

but they are also breaking the law. A copy of the statutory regulations is kept in the school/home/centre/office.

6. Staff are required to ensure that any infringement of these rules is brought to the attention of the home/school/centre's supervising officer.

84. Contrary to this policy, corporal punishment was administered to HIA 101 by three members of staff in the form of smacking with a wooden spoon. This followed the apparent theft of a sum of money from BAR 1 's handbag, which had been left in the unlocked staff bedroom.

85. This incident was reported by one of the members of staff to [redacted], BAR 7 . The response of Barnardo's management was, it is submitted, swift, decisive, and indicative of the seriousness with which the breach of policy was considered. In its reasoning as to the impropriety of the staff response (in addition to the breach of Barnardo's policy), the File Note of the Divisional Director is thoughtful and measured:-

> "*The reason for the use of physical punishment in this incident is unclear. While a slap on the hand on a younger child may be allowed, the use of a wooden spoon on a child of* HIA 101 *'s age is not acceptable. He was punished approximately two weeks after the alleged event and therefore his punishment lacked immediacy, and was inappropriate in relation to the offence which he accepted responsibility for.*
>
> *Three members of staff punished* HIA 101 *, it appears without consultation with each other or without reference to the Superintendent. Two of the members of staff involved are experienced residential social workers and one was personally involved in the incident, i.e.* BAR 1 *. Their response to* HIA 101 *did not arise out of any sustained provocation and is completely indefensible*."[57]

86. In exchanges at hearing, the Inquiry noted the absence of sanction beyond admonishment by senior staff, and the making of a note on each staff member's file. A more serious outcome could clearly be countenanced; it is however also respectfully submitted that the outcome for each staff member – who importantly appeared to the Divisional Director to have punished the child without consultation with each other, rather than (more culpably) knowingly punishing the child more than once[58] – was within the range of responses open to management. The matter was treated, it seems clear, with the utmost seriousness, and involved visits of senior Barnardo's staff to the child's grandmother, and to Macedon for the purpose of expressing concern.[59]

87. From exchanges, it is also understood to be of concern to the Inquiry that in administering punishment, each of three staff members looked to the use of a

[57] BAR134, paragraphs 2 and 3.
[58] BAR134, paragraph 2.
[59] BAR146.

wooden spoon: this, it is understood might suggest that such use of a wooden spoon was a common method of punishment at Macedon (as well as suggesting, as it may be considered to, that corporal punishment by wooden spoon remained relatively common in a domestic context in the late 1970s).

88. In this regard the Inquiry is asked to note both the detail and the content of the contemporaneous documents dealing with the incident, and the oral evidence of BAR 7 in which she indicated that having to deal with this incident was a very unusual thing in the life of Macedon[60]. To similar effect, BAR 9 gave oral evidence of having no recollection of corporal punishment being administered.[61]

89. This incident therefore sits uncomfortably with the weight of other evidence, which may be considered to suggest that in practice the later Barnardo's policy of forbidding all forms of corporal punishment[62] was largely observed some time before its implementation.

From Macedon to Sharonmore

90. The Inquiry's attention is directed at two services, the provision of which spanned the second half of the twentieth century.

91. That span of time saw significant advances in the understanding of the needs of children in care, and in the thinking within Barnardo's as to how those needs might best be met. The Inquiry has heard evidence indicating that the practices of Barnardo's were at least in line with, and often ahead of, accepted good practice, marking the organisation out as a leader in the field.

92. The point at which Macedon gives way to Sharonmore provides a convenient marker, sitting at the junction of the 1970s and 1980s and coinciding with a realisation of the importance of residential social work as a profession, and with a developing public awareness of the nature and extent of child abuse and the vulnerability of children in care in light of the emerging Kincora scandal.[63]

93. It is unquestionably the case that Sharonmore is viewed by Barnardo's as an improvement upon Macedon; more focused upon the individual needs of the child and how these might be therapeutically addressed. This is as it should be: Barnardo's is a progressive, learning organisation, committed to continually reflecting upon and improving the service it provides.

Macedon

94. It would however be inappropriately reductive to conclude that the point of transfer from Macedon to Sharonmore represents a single fulcrum on which these shifts in

[60] *Day 170, pages 77-85*.
[61] *Day 172, pages 118-119*. When asked about wooden spoons in particular, BAR 9 indicated that he '… certainly never witnessed any of that': *Day 172, page 119*.
[62] BAR892, 28 November 1983.
[63] As an indicator of where the issue of child abuse sat in the public consciousness, it may be useful to recall that it would be 1986 before the Childline service would be launched.

thinking turned: throughout the lifespan of Macedon it is apparent that steps were being taken, within the physical limitations presented by the property itself, to move from the model of a large institution to smaller units enabling greater individual attention (foreshadowed by the building of the cottages in the Macedon grounds as early as May 1953).

95. For similar reasons, it seems clear (notwithstanding some apparent inconsistency in available documentation) that by approximately 1973 it was recognised that the number of children by then accommodated in Macedon should be reduced.

96. Macedon was registered for 35 children when it was opened[64], but a file titled *Welfare Authorities Homes and Voluntary Homes: Medical Inspections by Ministry's Inspectors* includes a reference dated January 1958 to the home being registered for 52.[65] Annual reports of the Executive Officer for Ireland (1960 and 1961) also refer to a capacity of 52[66]; reports in later years note the number of children cared for at Macedon as 39 (at 31 December 1964)[67] and 43 (at 31 March 1966)[68], and 53 (31 March 1968).[69]

97. The report of a visit by Dr Bywaters (Chief Medical Advisor), understood to date from approximately 1973, appears to say there were 52 children at that time.[70] It also however appears that the question raised by Dr Bywaters – '*Incidentally, are we right in replacing the same numbers in the new home as there are at Macedon? (52). It does seem a large number of children to have on one site*' – was met with action to reduce the number accommodated.

98. The 'Architect's Brief - Macedon Replacement' (apparently dating from 1978) states at paragraph 1.1 that:-

> "*Macedon, Whitehouse, Belfast, has been owned by Barnardo's since 1950. Until 1973, fifty children were accommodated there, though by to-day's standards accommodation was crowded. Since 1973 numbers have been reduced to thirty*."[71]

99. Macedon is referred to in a document dated 28 August 1979 as '... a children's home for 32.'[72]

100. Macedon was originally intended to be a single-sex home for boys[73], but – consonant with the importance placed by Barnardo's on the maintenance of family groups – both boys and girls were in fact accepted and a flexible approach was taken to the age of child accepted. It is plain that the model of care originally represented by Macedon –

[64] BAR1466.
[65] BAR25007. An undated document in the same file however refers to the availability at Macedon of accommodation for 35 boys and girls up to 15 years of age: BAR25012.
[66] BAR26274 and 26277.
[67] BAR26286.
[68] BAR26290.
[69] BAR26293.
[70] BAR624.
[71] BAR25176.
[72] BAR25188: 'REPLACEMENT FOR MACEDON – SHARONMORE'.
[73] BAR 25126.

that is, care focused primarily on provision for the child's physical needs –was increasingly seen over time as old-fashioned, and the product of a limited understanding of the lasting, potentially institutionalising, effect of long-term residential care.

101. The period of Macedon's operation saw changes in the basis on which children were admitted to care: from, in the early years, voluntary admissions at times of family crisis, to, as the closure of the home approached, a prevalence of statutory admissions from welfare authorities[74]. By that time, placements in Macedon were generally long-term; occasionally, for the entirety of childhood.

102. Detailed information as to the operation of Macedon may fall short of conveying the experience of living there, and in this regard the Inquiry is asked to consider that much can be gleaned from a letter held on the Service User file of [redacted] HIA 417[75] (addressed to a Welfare Committee Children's Officer and received on [redacted], approximately one week after Faith's arrival at Macedon):-

> "*I like this place very much. I have a feeling that I will settle down quickly. I go to bed at 9, and I get my pocket money on Friday. I don't know yet how much we get. Instead of calling the people who look after us nurse we call them Auntie. My Aunties are Auntie* [redacted]*, and Auntie* [redacted]*. There is budgies goldfish and tropical fish in our place. There is a piano, and wireless and* BAR 5 *shows films. There is a big party on Saturday. I will be going to Hopefield Secondary School. The view is lovely. It is all sea. I am only after looking out to see a large red boat. It was wet all day. Tell Matron I was asking for her and hoping she is well and I hope you are well too*."[76]

103. In a few sentences, this letter discloses a favourable view of the physical environment at Macedon; the availability of interests in the form of animals, a piano, entertainment by way of wireless and film screenings; a bedtime suggestive of a routine with clearly defined boundaries; the fostering of independence and financial management skills by way of pocket money. It will be noted that children went out from the home to local community schools, and that, at the home, a deliberate effort was made to provide a sense of family for the children.

104. The care provided at Macedon, it is acknowledged, was in large measure concerned with meeting the immediate physical care needs of the children. This model of care was recognised by Barnardo's as increasingly old-fashioned, and a new model was developed. However simply because Macedon lacked the sophistication, theoretical underpinning and vision of the more therapeutic model that Sharonmore would seek to provide, it does not automatically follow that, judged by the standards of its time, the care provided in Macedon was inadequate.

105. At hearing, the Inquiry received evidence from BAR 14 [redacted] about the reflective process by which the design of the service that it was intended to provide in

[74] BAR 609 (statement of BAR 13 [redacted]) at paragraph 7.
[75] In oral evidence HIA 417 indicated that she does not recall writing this letter: *Day 168, pages 5-6*.
[76] BAR583.

Sharonmore was arrived at. It was agreed in 1974 that a proposed replacement for Macedon at Ballyhanwood would not be proceeded with, and instead:-

> "*That began a process of again thinking through the kind of service that was needed for children who needed substitute care. That process took a few years. It was done along with staff. A lot of the thinking about it came from staff who were employed in Macedon at that time, and if I recall correctly, BAR 24 produced a document called 'The Sharonmore Project', which he had worked up with the staff. So that took a few years*."[77]

106. A report of visits undertaken by Miss Dixon (Social Work Advisor) is instructive in its consideration of a visit to Macedon on 23 March 1977, which identifies that Barnardo's was by that time already dealing with 'the disturbed and delinquent older child' whom Sharonmore would specifically seek to help[78]:

> "*Macedon is now catering for the disturbed and delinquent older child, which means increased pressures upon all members of staff. Parents are encouraged to visit regularly and RSWs see themselves as working with some parents in increasing their understanding of what is happening to their children. In view of the deprived and unsettled background of many of the children, RSWs are faced with the difficult task of exercising some form of control over children who are 'beyond control'. The political situation within the province does not make their job any easier*."[79]

107. A record of a meeting in Dundonald House on 21 September 1981 provides an indication of how Barnardo's hoped to assist children through the Sharonmore Project, noting:-

> "*…the change in emphasis which has gradually involved in Barnardo's work in Northern Ireland especially over the last five years and the likely trends for the future. Barnardo's have deliberately moved away from providing services which are purely complementary to the services provided by the Statutory authorities. As far as possible they want to provide services and projects which are innovative and in some instances experimental*."[80]

Sharonmore

108. Macedon Children's Home was replaced by the Sharonmore Project when it became apparent that motorway development would require the closure of the former. This simple statement, accurate though it is, fails to reflect the manner in which highly significant advances in thinking underpinned the transition from Macedon to Sharonmore (and the associated Professional Fostering Service). Documentation available from that time is of particular benefit in identifying the philosophy that

[77] *Day 171, page 22-23*.
[78] From BAR26242.
[79] BAR26243, paragraph 1.7.
[80] BAR25682.

underpinned Sharonmore and the methods by which that philosophy was given practical effect.

109. The homogenous model of care provided by a large, 'group living' home in Macedon ceded to that facilitated by a smaller residential setting of a more domestic nature. This transition was not, it should be noted, reflective only of policy direction within the Irish Division of Barnardo's, but of the outworking of developments in childcare thinking since the Second World War, following the Curtis Report and subsequent legislative change. The underlying philosophy of the project was explained in a document headed *Sharonmore Project: Operational Policy*:

> "The Sharonmore Project replaces Macedon Children's Home, 349, Shore Road, Newtownabbey, and seeks to take forward our thinking about residential social work provision for children and young people. The Project is based at 208, Ballyduff Road, Newtownabbey, though not all of the residential units are located at this site.
>
> As far back as 1967, Barnardo's received notice to vacate Macedon to facilitate the construction of the M2 motorway extension; initially they planned to relocate in the Tullycarnet area of Dundonald. Plans to build a block unit for 32 children was shelved in 1975, partly because of the civil unrest in that area, but also because it was increasingly clear that this model of institutional care was inconsistent with the needs of young people in the 1980's. An additional factor taken into consideration in deciding not to proceed with a 32 bed unit was that Area Boards were working towards relative independence by developing their own children's home on a District basis. It was quite clear that Barnardo's contribution in the residential sector would change radically in the next decade.
>
> The Black Committee was established in 1976, but Barnardo's could not wait until it reported in 1979 to decide in what way Macedon should be re-instated, so some judgements about future needs had to be made in 1975.
>
> From various discussions and a study of the needs of children being referred to Barnardo's by Area Boards, Barnardo's committed itself to a Project aimed at providing for the more disturbed young person, on a treatment or task centred basis.
>
> In other words we recognised that the era during which voluntary agencies provided 'bread and butter' accommodation for Area Boards was virtually at an end, and our contribution to residential social work in the 1980's was to focus work more sharply on providing for the more disturbed / maladjusted young person and to develop social work skills in this field."[81]

110. This recognition led to the identification of a number of principles in a section of the *Sharonmore Project: Operational Policy* document headed 'Philosophy.'[82] It was a

[81] BAR25177.
[82] BAR25178.

central tenet of the Sharonmore Project that the needs of young people should be responded to differentially. This required that those needs be identified as clearly and as honestly as possible at referral, and only if the Project was likely to have the capacity to meet them would admission be agreed. Institutionalisation should be avoided where possible and young people should generally be cared for in a community setting, where they have as much opportunity as possible to relate to neighbours.

111. The difficulty of sustaining a harmonious and neighbourly existence was not to be underestimated, given that those to be accommodated at Sharonmore were disturbed / maladjusted young people. Unlike Macedon – a large property set in substantial grounds – Sharonmore afforded only minimal distancing from the immediate community of owner-occupiers and the Satellite Units were ordinary family dwellings, purchased on the open market.

112. Young people were to remain in the Project only for as long as is necessary to complete the treatment plans agreed for them. Barnardo's operated two complementary services – the Adolescent Project and the Home-Finding Project – to which young people could progress if appropriate (with the Sharonmore Parent Unit available as a retrieval unit in the event of a failed placement with a family under the Home-Finding Project).

113. In assessing the early years of Sharonmore, the Inquiry has the benefit of the April 1985 *Barnardo's Submission to the Committee of Inquiry into Children's Homes and Hostels* ('the Hughes Inquiry').[83] The Submission was prepared at a time when information relating to the period of the present Inquiry's focus was more likely to be readily available: job descriptions in respect of Project Leader, Assistance Divisional Director (Child Care) and Divisional Director (Child Care) were appended.[84] Several years had passed since Sharonmore had opened, and its early operation was described as follows:-

> "*Sharonmore was opened in 1981, and replaced Macedon – a large group-living home which had to close to make way for a motorway extension. Upon receiving preliminary notice of the compulsory purchase, a series of discussions took place and a study of the needs of children being referred by the Area Boards, in order to determine the kind of facility that should replace Macedon. Sharonmore's design and structure was a response to the changes which we anticipated, together with the needs as identified by the study. It was clear that more disturbed and maladjusted children were being referred to Barnardo's and so it was decided that the development of residential social work skills, in caring for this group, would be the focus of the Sharonmore Project. The publication of the 'Black' Report in 1979, gave a clear endorsement to the necessity of providing care for more difficult and disturbed young people than Children's Homes had previously been accustomed to.*

[83] From BAR22079.
[84] Index to Appendices is found at BAR22114.

The new Project was designed to provide a range of smaller residential care settings of a more domestic nature. In view of the level of disturbance of the children and young people, this makes more sense and allows for better management and more appropriate work with them.

Sharonmore is dependent on the statutory sector for referrals and all the children are legally in care of the Area Boards. A charge is made for this service but in recent years the gap between the cost of the service to us and the statutory income received has widened considerably. Because of under occupancy a recent decision has been made to close one 8 bedded unit. Sharonmore has established itself over the past three years. Initially it had to integrate the staff of the former Macedon with the new staff and also integrate former Macedon children with a number of new children admitted fairly quickly after the opening of Sharonmore. This meant facing the challenge of caring for a group of highly disturbed youngsters, almost all of whom had come from Homes where they could not be contained. The staff oriented themselves to the new concepts and patterns of care and adapted themselves to a new management approach in which there was a much greater emphasis on co-ordination, communication and delegation because of the geographical spread of the project.

The project has now developed its identity, and professional task and is able to identify more clearly those children whom it is able to help, and those whom it cannot."[85]

114. The Submission to the Hughes Inquiry provides a valuable summary of arrangements in place for the supervision of staff:-

"*It is Barnardo's policy that all staff should have formal supervision which is planned and structured. In addition to informal supervision, staff development and training activities, staff meetings, information sharing, senior staff meetings, and consultation. Barnardo's built in a formal supervision factor in determining the staffing establishment for Sharonmore*."[86]

115. The Submission also includes a copy of Barnardo's Staff Development and Training Policy, which sets out training opportunities provided by the organisation (including induction training, a Divisional in-service training programme, and Barnardo's national workshops and seminars). Secondment opportunities enabled qualifying staff to undertake professional training with the full support of Barnardo's – continuing payment of salary, course fees, a book allowance and expenses – in return for a commitment to remain with Barnardo's for a specified period following completion of training.

116. A volume of material is available from which may be seen the commitment of Barnardo's to the training of staff, including by way of secondment to courses of substantial duration: see, for example, a memorandum to the Central Child Care

[85] BAR22083.
[86] BAR22089.

Committee on the issue of selection of staff for secondment for training[87] and four letters dated 28 March 1977 confirming secondment to courses including the two year course leading to a Certificate of Qualification in Social Work.[88]

117. In the Submission to the Hughes Inquiry Barnardo's identified the residential child care task in the following terms:-

> "*There are several factors which are external to Barnardo's which have resulted in our reduced residential provision, these include:- demographic, financial, philosophical and political. Partly as a result of these external factors and partly because of our own changed aims and objectives, the children and young people we have in our care, are among the most damaged, difficult and disturbed, known to the statutory agencies which refer to us. Our staff are dealing with children and young people from disrupted and broken families, from other child care provision including Children's Homes and Training Schools and from Foster Homes. Often they are in their teens and have a long history of being 'in care'. Many have not been able to be contained in some Children's Homes because of the high level of acting out. They have been constantly subjected to unhelpful pressures, and to adult ideas and opinions which are not diluted or tailored to their limited life experience or maturity. Frequently these youngsters resort to confrontation, verbal and physical abuse as a first preference in their behaviour. They are extremely attention seeking through such behaviour as solvent, drug or alcohol abuse, non-school attendance and attempting or threatening suicide. They often have long histories of deep rooted emotional / psychological problems and occasionally may have symptoms of psychotic disorders which may require psychiatric treatment. First controlling them and then guiding them, calls for a high degree of skill and commitment on the part of staff, and it is both demanding and exhausting work*."[89]

118. Barnardo's recognised that as a result of the backgrounds and behaviours referred to, the residential care task carried an inherent element of risk. Significantly, an aspect of the appropriate response to that risk was identified by Barnardo's as the demonstration of a higher public regard for the commitment and work undertaken by many residential social work staff, in order to maintain morale and recruitment of suitable people.

119. Barnardo's ability, through much of its history, to attract staff to residential social work because of the ethos of the organisation gave way in due course to the formulation of an express aim of recruiting qualified staff to residential work.[90] The context in which Barnardo's made this commitment is apparent from the evidence that the Inquiry heard from Dr Hilary Harrison:

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[87] BAR 25996-25999.
[88] BAR 25992-25995.
[89] BAR22099.
[90] A decision approved of by the Hughes Inquiry: "It is Barnardo's policy to have a high level of qualified staff (the 1983 SWAG inspection noted that 60% of the Sharonmore caring staff held professional social work qualifications) and the organisation's salary structure must make such a policy easier to implement. The emphasis on training and professionalism is admirable in an organisation which is informed by a religious, though non-denominational, ethos. In our view this approach is preferable to absolute reliance on vocation and personal commitment": BAR22011, paragraph 11.16.

"*…there certainly was a dearth of trained staff in other – in statutory homes and indeed other voluntaries. There were none, if any, in the late 1970s or '80s. There were no to my knowledge professionally qualified social work staff working in residential units apart from Barnardo's, and they were the first to introduce social work staff into their units and also to pay them actually on a par with field social workers, which again was unheard of at the time*."[91]

120. The Barnardo's Submission to the Hughes Inquiry in April 1985 discloses how the challenges presented by the children now being cared for by Barnardo's made clear to the organisation the importance of attracting qualified staff to residential social work:-

"*Barnardo's, anxious to appoint qualified staff into residential work to care for an increasingly more disturbed and damaged group of children and young people adopted the policy in 1979 of paying staff who had a Certificate of Qualification in Social Work (CQSW) the same salaries as they could earn in field social work*."[92]

121. Assessments of the position at Sharonmore are available from a Social Work Advisory Group inspection in 1983[93] (which reported mixed feelings on the part of the advisers and made 22 recommendations) and a Social Services Inspectorate inspection in 1992[94] (which noted a staff group with a high level of commitment and experience, a high proportion of qualification among the staff, significant support from volunteers, a good standard of recording the involvement of young people in planning for their day to day life and future, the keyworker attachments conscientiously pursued, and the achievement of clear assessments and continual monitoring of young people).[95]

122. There is an abundance of material available from which it may be concluded that in Sharonmore Barnardo's was seeking to provide care for the most disturbed of young people, by way of an innovative model founded on individual attention, scrupulously documented, and operated by appropriately-qualified, respected professionals.

The Macedon Inquiry

123. The Inquiry has devoted significant attention to the series of allegations that led to criminal proceedings against BAR 1 and BAR 2, and to the 'tributary' investigations that were undertaken within what may be conveniently referred to as the Macedon Inquiry.

124. The events from which that inquiry arose commenced with an allegation made by a former resident in December 1994 and received by BAR 13 [redacted]). This allegation was reported in accordance with

[91] *Day 172, pages 49-50*.
[92] BAR22091.
[93] BAR26533-26608. A DHSSPS letter dated 27 June 2001 refers to the inspections to which Macedon would have been subject by SWAG after 1973, and BAR 14 gave oral evidence of his recollection of awareness of visits by Ms Mabel Hill and Ms Kay Forrest [*Day 171, pages 31-33*]. It is recalled that inspections by SWAG intensified following the emergence of allegations of abuse of children in residential care from 1980 [BAR 25859, 25861].
[94] BAR26728-26798.
[95] BAR26766.

statutory requirements and organisational requirements, and was investigated by the Royal Ulster Constabulary as a individual incident of alleged abuse.

125. This allegation was however followed by complaints from two further former residents over the next 36 months. With the apparent development of a pattern, it became apparent to Barnardo's, in consultation with the police and Eastern Health and Social Services Board (EHSSB), that a systematic response was required. From February 1999 Barnardo's was able to secure a formal named inquiry into allegations of historical abuse at Macedon, with dedicated RUC resources and reporting structures to ministerial level. A mechanism was agreed by which potential victims were proactively contacted: correspondence was hand-delivered by two Barnardo's staff, ultimately to 51 former residents cared for between [redacted] and [redacted].[96]

126. The structure and processes of the formal Macedon inquiry put in place involved the establishment of:-

- an *interagency strategy group* (chaired by the EHSSB Director of Social Services with representation including the Heads of Children's Services of the Trusts, the RUC at senior and operational level, and Barnardo's Director and Assistant Director of Children's Services); and

- an *operational team* (consisting of Barnardo's Director and Assistant Director of Children's Services, four Barnardo's contact staff, two detectives, and a senior RUC officer).

127. Within Barnardo's the applicable line of reporting ran from the Director in Northern Ireland to the Director of Children's Services (United Kingdom), to the Chief Executive Office, to the UK Board of Trustees. Policy support was provided by Barnardo's Head Office team.

128. Documentation in the Inquiry Bundle demonstrates the manner in which Barnardo's UK was involved with, and advised of, the progress of the Macedon inquiry. BAR 13 [redacted] provided detailed information to Barkingside by way of briefing: see 'Macedon Overview' forwarded under cover of an email dated 31 August 2000[97].

129. The Inquiry may note, for example, the attendance of senior Barnardo's UK staff Bob Cook (Principal Manager, Operations) and Martin Ruddock at a meeting in Belfast to discuss Macedon / Sharonmore issues on 30 November 1999.[98] Roger Singleton (Chief Executive) attended meetings, including a meeting of the Interagency Strategy Group, on 9 February 2001. Update notes went to senior staff, exemplified by Memoranda from BAR 13 dated 31 July 1998[99] and 21 June 2000.[100] From the latter, it may be noted that Barnardo's UK was also kept abreast of developments by

[96] See correspondence template at BAR 19174.
[97] BAR 19167-19179.
[98] BAR19183-19190.
[99] BAR19191-19192.
[100] BAR19193-19194.

way of Interagency Strategy Group and operational group minutes provided to Bob Cook.[101]

130. Barnardo's recognised at an early stage the necessity of carefully managing the twin objectives of supporting ex-residents and ensuring the integrity of the evidence to be provided. In the early stages a number of former residents contacted Barnardo's directly, sometimes providing significant information in the course of several contacts before being introduced to the RUC Child Abuse and Rape Enquiry (CARE) Unit. It was recognised that the integrity of the investigative process was best preserved by such disclosures being received by police, and steps were taken to ensure that this occurred, without the loss of the important support provided by Barnardo's.

131. The contact with former residents, it was noted, was highly demanding: those disclosing alleged abuse were in a volatile and on occasion suicidal condition. Barnardo's staff were designated as contact persons and made available on a 24 hours basis. Medical and psychiatric guidance was sought. Barnardo's sought to ensure that its response to the allegations made was marked by its support for those who had been in its care, and by the provision of appropriate assistance such as counselling.[102]

132. By 2000, ten former residents had provided evidence to the investigation, and two children of a member of staff had made allegations. Six alleged perpetrators were identified:-

- three members of staff (BAR 1, BAR 2 and BAR 3);
- one Barnardo's volunteer (BAR 4);
- one 'befriender' (BAR 12 and
- one parent of a resident (BAR 30).

133. In due course, BAR 1 and BAR 2 stood trial. Following a trial lasting more than eight weeks, each was convicted of a substantial number of offences against children.

134. Two members of Barnardo's UK staff – Maurice Leeson (Assistant Director of Children's Services, Northern Ireland) and Martin Ruddock (Principal Policy Officer, Barnardo's UK) – attended the entirety of the trial of BAR 1 and BAR 2. Martin Ruddock had been involved in Macedon since late 1999 / early 2000, by which time he had accepted responsibility in Barnardo's for the management of historical abuse issues. These members of staff had obtained the permission of the court to take notes, and had attended for the purpose of identifying matters of practice from which lessons might require to be learnt.

[101] BAR19180, 19193.
[102] In oral evidence to the Inquiry on 14 December 2015, HIA 50 spoke of counselling arranged by Barnardo's. The service spoken of was not in fact counselling, but was provided at a time when referral to counselling would have been expected to take weeks if not months (an established Barnardo's contact, Graham Johnston, being at that time unavailable). Instead, Norman Porter, Barnardo's Safeguarding Manager, acted as a safety contact given the urgency of HIA 50's presentation and Barnardo's level of concern. That contact took place at Barnardo's Headquarters (Upper Newtownards Road).

135. At the end of the Crown Court stage of the proceedings, Barnardo's sought to take stock of its position in respect of child protection issues. The Inquiry has considered in some detail at hearing a resulting report by Martin Ruddock titled 'Macedon – Review of Judge Weir's comments.'[103]

136. Failings in practice, management, and policy identified by Weir J were systematically reviewed against Barnardo's contemporary policies and performance, and lessons highlighted. These reports were considered by senior management in Barnardo's and also shared with the Health & Social Services Board and the Department of Health & Social Services.

The Ruddock report (14 October 2004)

137. The focus adopted by Barnardo's the aftermath of the Crown Court trial of *R v* BAR 1 *and* BAR 2 was to seek to identify whether the criticisms of the court expressed in the course of sentencing remarks remained valid in 2004.

138. The exercise conducted therefore saw a measuring of the sentencing remarks of Weir J against Barnardo's *Core Safeguarding Principles* and *Framework of a Safe Organisation*. These documents incorporated major learning and changes in practice noted – importantly – to have resulted from a number of inquiries into child abuse and abuse in children's homes since the time to which the Macedon allegations related (including, in particular, Barnardo's experience of a major investigation in the West Midlands involving a number of organisations). The form of the Ruddock report is therefore such as to identify issues raised by Weir J and to comment on whether, and if so how, that issue remained of relevance to Barnardo's in 2004. It is a report that expressly acknowledges its reliance on hindsight, and one that is very clearly written for its intended audience: that is, in a manner comprehensible to the informed reader who was intended to consider it. It was not written for general publication nor intended to provide a balanced portrayal of Barnardo's performance at the material time: lessons are learned from things that could have been done better, rather than from things that are already done well.

139. The Ruddock report noted that Macedon was, at the material time, subject to review given its imminent closure. Appointing staff in the late 1970s involved difficulty, and staff morale was low. At hearing, the Inquiry received evidence from BAR 14 [redacted] [redacted]) about the effect on staff morale of a transitional period in which, for example, there is uncertainty as to job security. Asked about the potential for such a situation to be exploited by persons intent on abusing children, BAR 14 [redacted] was however quite clear that such a possibility simply did not feature in the organisation's thinking at that time.[104]

140. The *Framework of a Safe Organisation* referred to by Ruddock is a management framework comprising nine components based on external national standards and

[103] BAR679-687.
[104] *Day 172, page 20*.

Barnardo's internal core child protection standards. It opens with the following explanation:-

> "*This framework describes how we manage risk so as to minimise circumstances where harm may befall children using Barnardo's services through acts of omission (e.g. failure to make referral of a child protection concern) or commission (e.g. direct abuse of a child) by Barnardo's staff, volunteers, carers and service users*."[105]

141. Ruddock noted the historical context in which the material period required to be viewed, acknowledging that sexual abuse was not then understood as a serious issue in residential care as it would come to be. He however immediately qualified this acknowledgement with reference to Kincora, of which Barnardo's management would plainly have been aware (generally, and in particular given BAR 1 's link to BAR 85 , and BAR 24 's note following receipt of allegations about BAR 3).

142. Ruddock noted that:-

> "*Management failed to identify and address the level of concerning behaviour by residents and evidenced in files of the victims and other children resident in the home*."

143. It was further observed that:-

> "*Recruitment and retention issues were addressed in relation to* BAR 1 , *who was moved after concerns about performance from Windsor Avenue to Macedon, given promotion and disciplined during her employment. It is difficult to understand how management failed to address her performance more rigorously having been clearly aware of concerns*."

144. In a passage of central significance, Ruddock also notes concerns:

> "*…in relation to the short period of employment of* BAR 3 . *At termination of employment, observations are made about his demeanour. Soon after his departure, we have a complaint … which is inadequately addressed and does not lead to any investigation. If there is a crucial moment when Barnardo's failed to address potential child abuse, this is it*."

145. Importantly, and notwithstanding its purpose as a learning document, the Ruddock report notes that case files disclose regular reviews of children involving social work support staff and at times staff external to Barnardo's; appropriate referral to psychiatric services; the detailed recording of incidents; and examples of good work and staff working hard to understand and address difficult behaviour.

146. Ruddock's hypothesis was:-

[105] BAR682.

> "*…that the level of incidents, low staff morale, political environment (*BAR 24 *letter 21-4-80) management failure and lack of strategic leadership left a staff group managing a level of chaos that inhibited reflective practice to identify and address what was going on*."

147. Barnardo's accepted that when the decision was made to close Macedon, management focus shifted to the development of the new Sharonmore service. This shift in focus, it was further accepted, had detrimental implications for the robustness of oversight of the service to be closed.

The Ruddock report in the light of information now available

148. An issue now to be addressed is whether Barnardo's considers the conclusions of the Ruddock report to remain valid in light of information now available, including the quashing of the convictions by the Court of Appeal and the material that is before the HIA Inquiry.

149. It is crucial to Barnardo's that children who have been in its care know that the organisation will listen to them, will take their allegations seriously, and will be prepared to believe that which may at first seem unthinkable.

150. In the late 1990s, Barnardo's was faced with a pattern of allegations that required to be addressed by way of police investigation, and respects the decision of the Court of Appeal by which the resulting criminal proceedings concluded. The outcome of criminal proceedings is not however determinative of the issue of whether a situation discloses significant child care concerns.

151. In light of all the information available, Barnardo's has not attained a sufficient level of assurance that no child was subject to mistreatment in its care in Macedon at the time to which the allegations related. It is therefore the view of the organisation that the conclusions of the Ruddock report – which concerned not the truth or otherwise of allegations, but Barnardo's practice at the relevant time – remain valid. The decision of the Court of Appeal does not diminish the importance of the learning Barnardo's derived from the Ruddock report.

152. The Ruddock report however assessed Barnardo's practice in light of major learning and changes in practice that had resulted from a number of inquiries into child abuse and abuse in children's homes since the time to which the Macedon allegations related.

153. The failings it identified, and which Barnardo's accepted, may not therefore constitute systemic failings for the purposes of the Inquiry, where the behaviour of the past is not to be judged by today's standards.

IV. MATTERS OF CONCERN RELEVANT TO THE WORK OF THE INQUIRY

154. Given that the determination of facts in respect of allegations made is a function of the Inquiry on which Barnardo's does not seek to trespass, it is not proposed to rehearse in detail in this submission the materials disclosing incidents or matters of concern relevant to the work of the Inquiry. Instead, an indication is provided below of the manner in which it is submitted those incidents or matters should be viewed by the Inquiry, in so far as they sound on the question of whether (judged by the standards of the time, on the information available) they disclose systemic failings on the part of Barnardo's.

155. Barnardo's accepts that the failure to address the [redacted] allegation about the conduct of BAR 3 toward BAR 46 – the subject of a File Note dated 21 April [redacted][106] – represented the indefensible missing of an opportunity to address potential child abuse (both by way of investigation of an allegation, and if appropriate, action to seek to limit opportunities available in future to an alleged abuser). This acceptance, of long standing, is unequivocal.

156. It is now apparent from material before the Inquiry that aspects of BAR 3 's behaviour were such as to merit consideration by Barnardo's: the Inquiry heard evidence that BAR 3 indicated that he had medical training, and apparently gave others to understand that he was a priest or affiliated with a religious order (having, it should be noted, indicated in interview that he had spent time involved in '… mission duties in [redacted]').[107]

157. It is somewhat less clear whether (and if so how) the totality of the information available now in respect of BAR 3 was available to the Barnardo's organisation at the material time. The picture now available may be likened to a jigsaw puzzle, and it seems likely that all the pieces were either not available to Barnardo's in or about [redacted] or were not pieced together in a manner providing a clear picture. (It is for example noted that – notwithstanding evidence of BAR 3 's curious possession of such items – it was indicated by BAR 9 that he had not seen a stethoscope or doctor's bag).[108]

158. It will be recalled that BAR 3 worked for Barnardo's for a period of less than nine months.[109] On applying for a position he was noted to be well-informed about childcare, with a better than average insight into children's problems. It was predicted that his valuable expertise would be an asset to Macedon.[110] He was assessed in the following terms:

> 'BAR 3 *showed himself as a softly spoken, articulate, stable and confident man. In discussion, he indicated a depth of feeling and understanding well beyond what has become expected of newly appointed Residential Social*

[106] BAR4242.
[107] BAR8630.
[108] *Day 172, page 116.*
[109] 23 April [redacted] – 9 January [redacted]: BAR4237.
[110] BAR8625.

Workers."[111]

159. The Inquiry heard evidence suggesting BAR 3 was extremely capable, and somewhat secretive.[112] BAR 8 [redacted] at the material time) gave evidence that:-

> "*Nobody else had ever been like BAR3, and we didn't know if maybe he had been involved in some form of medical training*."[113]

160. At the time, therefore, it seems to have been unclear whether BAR 3 's claims – even if apparently unlikely – were in fact untrue. BAR 8 nonetheless took appropriate action in response to a concern, prohibiting BAR 3 from taking out a child's stitches as he had suggested. In an important exchange with counsel to the Inquiry, BAR 8 explained the situation as follows:-

Q. He wasn't there for years and years.

A. No, he wasn't. He wasn't. Actually it's only -- it's only as you find out a bit more information that you begin to build that bigger picture. You know, there was other stuff that he had said had gone on and we didn't find that out until later. So we couldn't deal with it, you know.

Q. I think that's the point that I was making to you about hindsight.

A. Yes.

Q. When you look at it now, it looks wholly peculiar.

A. Oh, yes, yes.

Q. But at the time, while you were uncomfortable, there was nothing that he did with the children --

A. No.

Q. -- that caused you any concern.

A. No, not to my knowledge.[114]

161. A File Note by the Divisional Director dated 17 April [redacted] discloses that immediately prior to BAR 3 's resignation, it had come to light that he owed money to the petty cash account and to certain children's pocket money.[115]

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[111] BAR8628.
[112] *Day 172, page 115*.
[113] *Day 170, page 88*. On the propriety of a member of staff seeking to address medical issues, it may be recalled that at the material time Macedon continued to have the benefit of a Matron's services.
[114] *Day 172, pages 91-92*.
[115] BAR5924.

162. The File Note suggests that the former were authorised loans; the latter, unauthorised. When the matter was raised, the money owed was repaid and BAR 3 resigned, and the matter therefore appears to have been efficiently addressed. The concern that the matter gave rise to does not however readily find a place within the Inquiry's definition of abuse; nor, without more, does the unexpected claim to medicine or to religion.

163. It is however entirely clear that the BAR 46 allegation should have prompted a detailed consideration of what was known about BAR 3 The matters referred to above would have required scrutiny in that context, and may have led to further or more significant concerns of which Barnardo's was not by then aware. As a result of the failure to address the BAR 46 allegation, that detailed consideration did not occur.

164. Barnardo's accepts that the failure to take appropriate steps in response to the BAR 46 allegation about BAR 3 constitutes a systemic failing: see paragraph 5(c) / (d) of the Inquiry's *Definitions of abuse and systemic failings*.

165. The Inquiry is respectfully asked to see this failure as a rare lapse, more obviously so given the many examples of a wholly proper Barnardo's response to the emergence of child protection concerns: see, for example, how suspected cases of unlawful carnal knowledge, when they came to light, were routinely the subject of appropriate reporting, enabling investigation and consideration for prosecution[116]. Support for children disclosing allegations of other sexual offences is amply apparent: see, for example, the facilitation of police involvement and accompaniment of those making complaints to attendances with police.[117] The materials available repeatedly disclose the selection by children or former residents of members of Barnardo's staff as the clearly trusted recipients of highly personal disclosures. The Inquiry is also asked to note, as indicative of the organisation's proactive child protection focus, the taking of safeguarding action with appropriate agencies irrespective of the outcome of criminal investigation: see the cases of BAR 4[118] and BAR 82 .[119]

166. Some matters appear to have been raised, perhaps without information on which action could be taken, and not advanced for some considerable time before further, actionable, disclosure follows: a document headed *Notes of Supervision Session with* BAR 36 *on 7 November* records that:-

> "*In the course of* BAR 8*'s After-Care work with* HIA 216*, who left Macedon about four years ago,* HIA 216 *made the comment that at different times two ex-members of staff had attempted to make advances toward her. These comments were not made in the context of allegations, but in the context of difficulties that young people experience while in care.* BAR 36 *will ask* BAR 8 *to try to find out some more*

[116] See, for example, BAR8738 / BAR7562-7587.
[117] See, for example, BAR 149-155 / BAR7302-7303.
[118] BAR199.
[119] BAR8643-8650.

factual information – in order to see what action, if any, ought to be taken."[120]

167. In the mid-[redacted]s, it was considered by Barnardo's management that the allegations of a former resident – no longer a child, and no longer in the care of Barnardo's – were most appropriately progressed by way of complaint to the police by the complainant directly.[121] It is however abundantly clear that support was available to former residents who disclosed alleged abuse: see the involvement of BAR 8 with HIA 216 in and after Apri[redacted] when further information (presumed to relate to the matters referred to in November [redacted] was made available. Once information capable of being acted upon became available to Barnardo's, the organisation brought the information to the attention of the police.[122]

168. The issue of contact between HIA 516 and BAR 12 may be considered to exemplify the difficulties that arise when viewing the late [redacted] / early [redacted] from a 2016 perspective. At the material time, even the language of 'grooming' in which this matter would now be framed was not available, and from that it may be inferred that the matter would have been approached with a wholly different mind-set to that of the 21st century. It is not difficult to see how in the late [redacted]s the availability of the mentoring attention of a [redacted] to a boy of [redacted] years whose behaviour presented difficulties might have been considered to be a very fortunate development.

169. It is recalled that BAR 12 had first had contact with HIA 516 [redacted] (returning him to Macedon when he had run away in October [redacted]), and had thereafter become involved with the children at Macedon. It was Barnardo's suggestion that he concentrate on one child (on the basis, it is understood, that the children needed individual stable relationships outside of Macedon). Thus it appears that the relationship with HIA 516 developed somewhat organically, and did not in particular commence in the usual manner of a volunteer seeking to assist by befriending a child.

170. It is apparent that Barnardo's kept the relationship under review, and acted upon concerns during [redacted] about, for example, BAR 12 's excessive generosity, or his overlooking of misbehaviour on the child's part. A series of meetings resulted in agreement as to conditions under which the contact could continue; when matters did not improve, the relationship was terminated by Barnardo's.

171. Throughout, the question asked by Barnardo's was whether the child was likely to derive long-term benefit from the relationship.[123] A negative answer saw Barnardo's act to bring the relationship to an end. Documents from the time disclose Barnardo's indication:

"*…that at no time was there any evidence to us of any homosexual activity*

[120] BAR19126.
[121] See the statement of BAR 36 at BAR2535, paragraph 7.
[122] BAR17630.
[123] BAR 7114, 7119.

between BAR 12 *and* HIA 516 ."[124]

172. It was acknowledged by BAR 13 , , that it was at least poor practice for a befriending assessment not to have been undertaken before February [redacted] (by which time concerns – but not of abuse – had arisen).[125] It is however respectfully suggested that, in the circumstances as known to Barnardo's, judged by the standards of the time, the delay in undertaking a befriending assessment does not represent a culpable systemic failing for the purposes of the Inquiry.

173. In exchanges, the Inquiry noted BAR 1 's employment history with Barnardo's between [redacted] and [redacted], and raised the question of whether it was a failing that she was retained in employment and in fact promoted in [redacted]. It is clear that the timing of the promotion[126] is somewhat surprising in that it followed the wooden spoon incident early that year; but it is also clear that BAR 1 's employment was more frequently marked by failures to advance – probationary period extended, increment denied – than by successes such as promotion.

174. It may be that BAR 1 's telling of ghost stories to the children before bedtime was ill-judged and liable to frighten or (at best) excite the children, at the very time when calm and quiet were called for. Nonetheless the evidence of BAR 7 , for example, made clear that BAR 1 appeared fairly harmless, and that such stories were popular with the children.[127] Unless the additional layer of alleged abuse is added to the telling of ghost stories or playing of chasing games, a failure to take prompt action in response does not readily appear to constitute a systemic failing for present purposes.

175. The Inquiry also heard favourable evidence about BAR 1 's work, notably from Dr Hilary Harrison (who held management responsibility for BAR 1 at [redacted]):-

> "*She had a number of positive qualities. She in many respects was -- appeared to be a very caring person, was very, very good at practical duties, was always at work, not off sick. She was extremely diligent about carrying out instructions and so on…*"[128]

176. It may have been such qualities – perhaps together with the willingness of Barnardo's to offer chances to improve, as a matter of principle – that allowed BAR 1 to remain in the organisation's employ for as long as she did.[129] In oral evidence BAR 13 [redacted] noted that:-

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[124] BAR7115. See the similar Board conclusion at BAR7108: "At no time was there reason to believe that the relationship was other than that of a sympathetic adult taking an interest in a deprived child".
[125] *Day 172, pages 136-138*.
[126] Referred to by BAR 14 as "… a fairly minor upgrading": *Day 172, page 34*.
[127] *Day 170, page 93*.
[128] *Day 172, pages 69-70*. The same witness indicated that she had seen absolutely nothing in BAR 1 's behaviour to give rise to a concern about sexual abuse.
[129] See also BAR5905, where the Divisional Director records the view that BAR 1 was a hard worker and a committed worker, but had difficulty undertaking the professional task now required.

> "*…various procedures were exercised. Somehow or other we don't seem to have reached a threshold of dealing more formally with her. Barnardo's are a very values driven organisation. I think particularly at that period of time there would have been a lot of effort to keep giving people a chance to see if they could do better. I think in BAR1's case that was a mistake*."[130]

177. Such a view – that retaining a staff member was a mistake – may of course be held with the benefit of hindsight, without the decision to retain the staff member (even if disclosing considerable forbearance) constituting a systemic failing for the purposes of the Inquiry.

178. Barnardo's did not however undertake a risk assessment to assess BAR 1 's suitability to remain in Barnardo's employment (or indeed any protective action or enquiry) in response to knowledge that she was the fiancée of BAR 85, who had been charged with, and was in due course convicted of, offences [redacted].

179. The failure to address, by way of risk assessment and management, the engagement of a member of staff to a person charged with sexual offences against children is accepted to constitute a failing: see paragraph 5(c) of the Inquiry's *Definitions of abuse and systemic failings*.

180. Barnardo's has sought to engage fully and positively with the Inquiry process since its early stages, in recognition of the value that such a process could provide to both victims and institutions and in simple discharge of the duty placed upon an organisation by its past. That responsibility requires Barnardo's to approach the Inquiry in a spirit of openness and transparency, always mindful of the shared goal of safer lives for children.

181. For the organisation, engagement in the Inquiry process has been challenging, searching, and at times uncomfortable. Barnardo's remains willing to address any outstanding matters of interest or concern to the Inquiry not considered to have been sufficiently addressed in this written submission.

182. Above all else, Barnardo's recognises that the courage required of the individual victims who engage with the Inquiry is enormous. It is the fervent hope of Barnardo's that those who have engaged will have obtained a benefit from having done so. It is the courage of those victims that allows the Inquiry to extract from the past the lessons that still require to be learned; and it will be the learning of those lessons, to which Barnardo's is committed, that will allow children to lead safer lives in the future.

[130] *Day 172, page 163.*

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DONAL SAYERS

The Bar Library
11 March 2016