THE HISTORICAL INSTITUTIONAL ABUSE INQUIRY

MODULE 8 - BARNARDO'S

SUBMISSIONS ON BEHALF OF

THE DEPARTMENT OF HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

("The DHSSPS")

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1. Introduction

1.1. The Barnardo's Macedon home was registered as a voluntary children's home by the Ministry of Home Affairs ("MoHA") in June 1950. This home closed in 1981 and was demolished to make way for a road scheme. It was replaced in 1981 at a new location by the Sharonmore Home.

1.2. The focus of the evidence heard at the Inquiry has understandably been in relation to the period from 1977 to 1983. This period covers most of the allegations that formed the basis for the criminal prosecution in 2004, and known as the 'Macedon trial'. The Court of Appeal subsequently overturned the convictions arising out of this trial.

1.3. The statement of Dr. Harrison on behalf of the Department for Health, Social Services and Public safety, "the DHSSPS", has set out some of the engagement of the DHSSPS with the Barnardo's homes at Macedon and Sharonmore[1]. Essentially the Children and Young Person's Act (Northern Ireland) 1950, "the 1950 Act", and the subsequent Children and Young Person's Act (Northern Ireland) 1968, "the 1968 Act", created a power by which MoHA and from 1972 the Department of Health and Social Services, "the DHSS", could cause voluntary homes to be inspected from "time to time"[2]. It is of note the legislature only legislated to provide a power to inspect, rather than creating a statutory duty under which MoHA and later the DHSS would have been required to inspect. The responsibility for the management of each voluntary home lay with the "administering authority"[3]. The Hughes Inquiry found the divisional director of Barnardos to be the de

[1] BAR-966 to BAR-1017
[2] See Section 102 of the 1950 Act and Section 130 of the 1968 Act; the latter is found at HIA-383.
[3] Regulation 2 of the Children and Young Person's (Voluntary Homes) Regulations (Northern Ireland) 1975; HIA-444.

facto administering authority[4]. The administering authority was obliged to ensure that each home in its charge was conducted in such a manner and on such principles as would further the well being of the children in the home[5]. In addition to the responsibility of the administering authority to ensure the welfare of a child within its home, a child who was placed in a voluntary home by a welfare authority or a Health and Social Services Board (HSSB) remained the responsibility of the relevant placing authority. The welfare authority or HSSB therefore had an ongoing duty to monitor the adequacy of care provided in the home to the extent that it related to and affected the individual child.

1.4. Dr Harrison's statement was compiled prior to receipt of all papers held by the Inquiry and this submission will refer to the evidence presently available that identifies the interaction of the DHSSPS and its predecessors in title with both Macedon and Sharonmore.

1.5. The DHSSPS has not sought to directly challenge any of the evidence of the Applicants to this Inquiry. The Department trusts that in determining if abuse has occurred the Inquiry will carefully consider the findings of the Court of Appeal in the Macedon Trial along with the evolution of the allegations of abuse identified by Counsel to the Inquiry in his opening to this module.

1.6. Following the initial trial in 2004 an internal management report was compiled by Mr. Martin Ruddock on behalf of Barnardo's. The purpose of the report was to address the criticisms of practice made by the trial judge and organisational concerns as to whether this reflected contemporaneous practice[6]. Whilst it is appreciated this report was limited by its terms and Barnardos have accepted this was not an in-

[4] Day 165 Page 156.
[5] Reg 4(1) of the Children and Young Person's (Voluntary Homes) Regulations (Northern Ireland) 1975.
[6] Evidence of BAR 13, Day 172 Page 139.

depth historical review of practice[7], the DHSSPS submit it does not take into account the danger of hindsight nor does it fully appreciate the accepted standards of practice at the relevant time.

2. Interaction with Macedon.

2.1. Following its registration as a voluntary home in June 1950, Miss K Forrest observes in 1953 that the Home is *"For school-age children. Well-staffed, well-equipped, excellent care and training. Children attend outside schools."*[8]

2.2. There is a lack of primary evidence in relation to inspection and interaction with the home in this module. Macedon has now been closed thirty-five years and most of the files, which would have existed contemporaneously, are no longer available.

2.3. Barnardos only retained a 10% random sample of records from homes that are closed[9]. Consequently unlike in other modules it has not been possible to use the events log and other statutory record logs/books to identify the inspections at Macedon from 1950 onwards as was done in previous modules by for example identifying the signature of Miss Forrest or other inspectors in the corporal punishment and other books when she would visit[10].

2.4. At this remove, it has not been possible to identify any witness on behalf of the Department who can provide oral evidence in relation to the regime of inspections and interaction between Macedon and initially MoHA, then from 1972 the DHSS. It is perhaps unsurprising that given the Departmental file destruction arrangements and the

[7] Evidence of Bar 13, Day 172 Page 140.

[8] HIA-1462 to HIA-1464.
[9] Day 171 Pages 13 and 14.
[10] An example of this can be found at SPT-54366.

closure of Macedon in 1981, coupled with its absence from consideration within the Hughes Inquiry, that the documentation held on it was not retained.

2.5. Even in 1984 as seen in what papers have been made available to date from the Hughes Inquiry, files relating to inspections had been destroyed pursuant to the governmental review and destruction process. The Departmental evidence to the Hughes inquiry suggested, *"Not all files relating to visits carried out and reported on by the Children's Inspectors are still in existence; this is due to the normal process of review and destruction of old files. However, from the information available, the visits to statutory homes appear to have been less frequent than those to voluntary homes."*[11]

2.6. A list found at SND-13963 has been described by counsel to the Inquiry as a *"file list that appears to have been prepared by the Department probably at the time of the Hughes Inquiry."*[12] Whilst the provenance of this list is not entirely clear what it does suggest is that two files existed at some time in relation to Macedon, namely TC 166 *"Voluntary Homes – Macedon, Whitehouse, Co Antrim"* [13] and 16670/80 *"Voluntary Homes – Macedon Whitehouse (Dr Barnardo's) Inspections"*[14]. Neither file is held by the Department nor are there records held in relation to when these files were reviewed or destroyed. Given the title it is likely the latter file was commenced in 1980.

<u>The 1950s and 1960s</u>

2.7. The Department suggests the TC 166 file is likely to have contained the type of annual inspection reports conducted by Miss M Hill, Miss K

[11] HIA-4010 at paragraph 3.58.
[12] Day 165 Page 48.
[13] SND-13966
[14] SND-13980

Forrest and Dr. N Simpson as were identified in other homes. Dr. Harrison suggests the inspections in the 1950s were annual with *"perhaps slightly diminishing frequency, during the 1960s"*[15]

2.8. The Inquiry will be by now familiar with the format and style of the reports prepared by the Children's inspectors for MoHA in the 1950s and 1960s. Viewed against the standards of today these inspections may not seem to have been sufficiently thorough, taking place over a short period of time whilst being required to cover the full range of physical conditions and amenities, staffing, and the maintenance of the various statutory records[16]. That the Inspectors were reviewing the corporal punishment records suggests some awareness of the potential for physical abuse within Homes. However, during this period there is little if any evidence of knowledge in Northern Ireland in relation to the potential for sexual abuse by peers or staff working with the children, in particular systematic abuse.

<u>The 1970s to 1981</u>

2.9. From the evidence provided to the Hughes Inquiry in relation to the 1970s, available within the HIA material to date, it appears clear: -

2.9.1. Following the transfer of responsibility for inspection to the DHSS in 1974 the Social Work Advisory Group, "SWAG", reviewed and discontinued the use of printed report forms for Homes but rather suggested the areas that should be covered in reports[17].

[15] BAR-969.
[16] See Para 3.41 of the Hughes Inquiry Report at HIA-701.
[17] The Departmental Submission to the Hughes Inquiry at Paragraph 3.59.

2.9.2. A policy objective was introduced in February 1976[18] that Social Work Advisors would make a full annual report on each facility and that visits other than for annual reports should be recorded, outlining the reason for the visit, personnel interviewed and any action required. These reports were confidential to the Department[19] and not provided to the Voluntary homes. Consequently no copies of these reports will be found in papers held by any body other than the Department.

2.9.3. Any lack of full implementation of the procedures was due to constraints on professional resources rather than inspections being given a low priority by inspectors[20].

2.9.4. SWAG tended to devote more attention to voluntary homes than to statutory homes[21]. The rationale underpinning this was that voluntary homes did not have such well-defined structures for the administration and management of homes and they consequently required professional attention[22].

2.9.5. Notwithstanding the lack of full implementation the Hughes Inquiry found *"the new format for inspection reports introduced in 1976 was an advance on what had gone before…"*[23].

[18] The Hughes Report, Para 4.17; HIA-758.
[19] The Hughes Report, Para 4.18; HIA-758.
[20] The Hughes Report, Para 4.19; HIA-759.
[21] The Hughes Report, Para 4.17; HIA-758.
[22] Barnardos would of course have been an exception to the principle that voluntary homes did not have such well-defined management and administration structures.
[23] The Hughes Report, Para 4.19; HIA-759.

2.10. Dr. Harrison considers that the influence of the Seebohm Report[24] on practice and procedure during the 1970s and early 1980s does not appear to have been brought to the attention of the Hughes Inquiry[25]. Seebohm suggested a new model of inspection was required which concentrated less on regulatory functions of central Government Departments and more on advisory, consultative and supportive engagement with service providers. This model, which appears to have been promoted and implemented throughout the UK, was very much of its time[26]. In giving consideration to any potential failure to formally inspect during the 1970s the Inquiry should take into account the influence of the Seebohm report and how it may have affected the prioritisation of resources between annual inspection and other advisory, consultative and supportive interaction with homes.

2.11. BAR 19 who worked within Barnardos as [redacted] from [redacted] to [redacted] gave evidence that he recalled SWAG interaction with Barnardos. He suggested the SWAG advisors would have interacted with the Superintendents of the homes rather than him but notwithstanding this he recalls being made aware via the superintendents of the SWAG advisors visiting the homes "from time to time"[27]. The fact BAR 19 was able to recall the names of Miss Mabel Hill and Miss Kay Forrest being in the homes, despite not having had any direct contact with them, is significant and is likely to suggest a significant level of interaction between SWAG and Barnardos. It is of note Miss Hill retired in 1980 and Miss Forrest in 1976[28]. This level of interaction would have enabled the inspectors whether formally inspecting the Home or not to identify overt issues of concern.

[24] Report on the committee of Local Authority and Allied Personal Social Services HMSO London 1968.
[25] DHSSPS Module 4 statement dated 22 April 2015 paragraph 58 (SNB-9569).
[26] DHSSPS Module 4 statement dated 22 April 2015 paragraphs 51-56 (SNB-9566 to SNB-9569).
[27] Day 171 page 32.
[28] RUB-40527 and RUB-40532.

2.12. BAR 19 recalled writing for feedback on two occasions following visits to the home. He did not identify in evidence the homes referred to, the exact terms of his request, whether he followed his requests up or escalated the matter with the DHSS. He believes that he did not receive feedback, as that was not the practice at the time. As identified above the practice at the time was for the reports to remain confidential to the Department although aspects of them would have been discussed and taken up if it was considered appropriate[29]. It is likely his complaint is in relation to not being provided with the details contained within the actual report. There is no reason to suppose that SWAG would not have given consideration to the inspection reports produced and considered if it was appropriate or necessary to discuss report findings.

2.13. BAR 8 was the attached social worker. In her statement to the Inquiry she recalled inspectors coming from Dundonald to see the children on a regular basis.[30] In oral evidence[31] she recalled the inspectors in Sharonmore sitting down with the children, eating with them and speaking to them individually if they wished.

2.14. In [redacted] there was an allegation that staff member BAR 3 abused a boy in his care, BAR 46. This allegation was not reported to the police or the DHSSPS, as it ought to have been. Had this allegation been reported this would have allowed it to be contemporaneously investigated and would have added to the cumulative knowledge of abuse. Further, if the allegation had been substantiated, Macedon would have been included in the Hughes Inquiry and that Inquiry would have heard evidence, drawn conclusions and perhaps made recommendations.

[29] See Hughes Inquiry Report at Para. 4.18 HIA-758.
[30] BAR-1019.
[31] Day 169 Pg. 108 and 109.

3. Interaction with Sharonmore.

3.1. Sharonmore was opened in June 1981. It was registered to operate as a voluntary home pursuant to Section 127 of the 1968 Act and the Inquiry can conclude that proper consideration was given by DHSSPS as to whether registration of the home was appropriate. It was brought within the remit of the Hughes Inquiry by virtue of an incident of abuse in 1982. The victim of the abuse was a boy resident in the home and the abuser was a person who was outside of and not connected to the home. The Hughes Inquiry evidence made available to date is helpful in identifying the relationship between Sharonmore and the DHSSPS and a number of inspections.

3.2. Dr. Harrison suggests that from the 1950s onwards MoHA and later the DHSS were making funds available to voluntary organisations for the training of residential staff [32] and were thereby encouraging the organisations to have their staff properly trained. For example evidence to the Hughes Inquiry identified the DHSS paying for Sharonmore staff training, travelling expenses and in respect of the replacement of staff on secondment. The Divisional Director of Barnardos commenting that *"we always find that our demands to the Department in respect of training are usually met."* [33] This policy ultimately led to Northern Ireland having the highest level of professionally qualified social workers in residential child care of anywhere in the UK[34].

3.3. A witness in module 7 described how a change of practice developed in Great Britain in the early 1980s, describing the emergence of an "inspection culture" [35]. At the same time with the disclosure of a number of allegations of child abuse at Kincora, the DHSS policy in

[32] BAR-970.
[33] BAR-22070
[34] SND 15676
[35] Statement of Wesley Donnell, paragraph 14, SPT-3006.

relation to inspection shifted to a more formal regulatory regime. A change in nomenclature from SWAG to SSI occurred in 1986 and witnesses confirm a perception that by this stage the name change reflected the change in prevailing policy to a more formal regulatory inspection[36].

3.4. Dr. Harrison suggests the allegations within Kincora and consequential focus on improved scrutiny by SWAG, resulted in Northern Ireland being "ahead of the curve" in relation to this change in practice[37]. One example of this can be seen in a Barnardo's response paper to a DHSS consultative document on a complaint's procedure for children in residential care and their parents. Barnardos make the point that whilst this was as a result of a recommendation of the Sheridan report (completed by DHSS London), the DHSS in Great Britain had not been implemented this and it had been left to local authorities and voluntary agencies there to devise and implement their own[38]. They go on to note that in practice very few local authorities and voluntary agencies have devised and implemented their own procedure and that *"DHSS (NI) is to be congratulated on issuing the Consultative document on this very difficult subject, and for their initiative and desirability (sic) for a consistent formalised process for complaints to be dealt with."* [39]

3.5. In its submission to the Hughes Inquiry dated April 1985 Barnardos suggested Sharonmore was *"subject to periodic inspection by the Department and a regular formal liaison is maintained between Senior Divisional Management and the Social Work Advisory Group."*[40]

[36] Day 161 Page 33.
[37] Day 163 Pages 70-71.
[38] Paragraph 1.4, BAR-916.
[39] Paragraph 1.5, BAR-917.
[40] BAR-765.

3.6. From at least 1983 there is evidence of very regular contact between SWAG and BAR 79, the Divisional Director of Childcare for Ireland within Barnardos (from October 1982). BAR 79 gave evidence to the Hughes Inquiry that for the last two years he would meet someone from SWAG every 6 weeks to discuss developments and the progressing of the implementation of departmental circulars.[41] He gave evidence that the purpose of the meeting from the Departments point of view was *"…to ensure that we are complying with the Voluntary Homes Regulations; and that we are complying with the recommendations in these reports; that we are complying with circulars. I think that they are all concerned, I hope, about good practice".*[42]

3.7. The first formal inspection of Sharonmore took place over five days and evenings in November 1983 and was carried out by two Social Work Advisers[43]. Prior to the inspection, information including details of staff, children and procedures was provided by Barnardos. This was analysed and discussed in a meeting with Barnardos staff prior to the inspection[44]. During the inspection all of the staff available were interviewed and opportunities were taken for informal discussions with the young people. Time was spent observing the staff at work and interacting with the children and all parts of the project were visited to observe the living arrangements for the children and the condition of the buildings[45]. The inspection report ran to fifty-one pages plus appendices and made twenty-two recommendations.

3.8. Victor McElfatrick describes in his statement[46] how the report was more descriptive and less analytical than might have been the case in

[41] BAR-22037.
[42] BAR-22037.
[43] The November 1983 report can be found at BAR 26534. See BAR 26536 in relation to the conduct of the report.
[44] BAR 26536.
[45] See Para 4 of the statement of Victor McElfatrick at BAR-1143.
[46] See Para 5 of the statement of Victor McElfatrick at BAR-1143.

subsequent years after SWAG was replaced by the Social Services Inspectorate, "SSI". This is clearly an opinion looking back with hindsight in light of later standards. The Hughes Inquiry heard evidence in relation to that inspection and found *"the report was comprehensive and detailed"* they regarded the report as *"representing a good standard of inspection by the Department."*[47] Whilst this Inquiry is not bound by previous findings it is submitted that in considering the standard of the 1983 inspection the findings of the Hughes Inquiry point strongly to it being a good inspection in relation to the standards of the time. Further the finding that it was reasonable for SWAG to allow the project to function for two years before undertaking a full inspection is illuminative of the thinking of the time, as it was perceived as *"to a degree experimental"*.[48]

3.9. Following the inspection there was a meeting on 8th December 1983 between Barnardos and the two SWAG advisers who had carried out the inspection in which verbal feedback was provided[49]. Whilst there does appear to have been some delay in the report being issued BAR 79 gave evidence to the Hughes Inquiry that he was aware of the report findings following the December 1983 meeting. He further acknowledged the unique quality of the inspection and that inspections were being carried out throughout Northern Ireland in all of the children's homes by a limited number of SWAG inspectors who also had their other duties[50].

3.10. There is written evidence within documentation provided to the Hughes Inquiry that suggests "statutory visits/inspections" occurred on the 11th

[47] Para 11.22 HIA-937.
[48] Para 11.22 HIA-937.
[49] See evidence to the Hughes Inquiry at BAR-22068.
[50] BAR-22069.

May 1984 and 11th April 1985[51]. This April 1985 visit is further referred in the oral evidence of BAR 79 and described as a "follow up"[52].

3.11. From 1985 voluntary Children's homes were inspected annually[53] and the DHSSPS suggest Sharonmore was so inspected.

3.12. From his diary entries Victor McElfatrick identified inspections occurring from 18th to 20th April 1988 and 19th, 20th and 24th April 1989[54].

3.13. A Barnardo's 'Sharonmore Project Monitoring Report' refers to an *"annual D.H.S.S. inspection"* as having occurred in later April/May 1991; Barnardos responded to the recommendations in November 1991[55]. The use of the term 'annual' by Barnardos further confirming that the inspections occurred annually.

3.14. Sharonmore was inspected in July 1992 and the report is available[56]. The inspector spent one week at the project, interviewed staff, reviewed the procedures of the home and examined records held both by the residential social work staff and a sample of case files held by field social workers. The children's views were sought in conversations, interview and questionnaire. The views of parents and former residents were also sought by the use of questionnaires[57]. The report ran to thirty-three pages, made eighteen suggestions and comments, and six recommendations. It is of note that one of the recommendations is that the composition of staff and ratio of shifts be reviewed to examine the feasibility of having two staff on duty at any point[58]. This would have the effect of protecting staff and young

[51] BAR-22331.
[52] BAR-22051.
[53] BAR-26735.
[54] Para 2, BAR-1133.
[55] BAR-26713.
[56] BAR-26730.
[57] BAR-26735.
[58] BAR-26771.

people in circumstances where a member of staff was faced with a child of the opposite sex who was exhibiting challenging behaviour.[59]

3.15. Sharonmore was inspected from the 17th to 24th June 1993 and the report is available[60]. As per the 1992 inspection the records and policy documents held were examined, case files examined, questionnaires completed by children, parents and former residents. The inspection fieldwork included discussions with a selection of staff members, children and young people, volunteers and former residents. The report runs to twenty-nine pages and makes fifteen recommendations.

3.16. No inspection report is available for 1994 but the 1995 report is referred to within the 'Sharonmore Project Annual Monitoring Report'. This Barnardo's report refers to the 1995 inspection identifying a number of health and safety issues in relation to accommodation at the Ravelston site[61]and inspecting the statutory records[62].

4. The Ruddock Review.

4.1. The Ruddock Review was an internal management report compiled by Mr. Martin Ruddock on behalf of Barnardo's. BAR 13 giving evidence on behalf of Barnardos accepted that the Ruddock review was designed to address the criticisms of practice made by the trial judge and organisational concerns as to whether this reflected contemporaneous practice[63]. The Review was limited by its terms and Barnardos have accepted this was not an in-depth historical review of practice[64]. It is perhaps unsurprising that within these parameters it does not take into account the danger of hindsight, places an

[59] BAR-26745.
[60] BAR-26865.
[61] BAR-26925.
[62] BAR-26928.
[63] BAR-679 at Para 1.2 and evidence of BAR 13, Day 172 Pg. 139.
[64] Evidence of BAR 13, Day 172 Pg. 140.

overreliance on present day standards and does it fully appreciate the norms and standards in practice at the relevant time[65].

4.2. In particular this review failed to consider that Barnardos had a high number of staff that were trained, either as social workers (CQSW) or in relation to certificate for residential care (CRCCYP). The 1983 SWAG report identified the high percentage of staff that were qualified and the secondment programme to allow unqualified staff to gain qualifications[66]. Dr Harrison suggests she has no knowledge of any other residential unit in the late 1970s and early 1980s employing professionally qualified social work staff[67].

4.3. The review failed to consider that at the relevant time in units with smaller numbers of children it would not have been unusual for a member of staff to be on his or her own with the small group of children[68]. Again during that period it would not have been unusual for a member of staff to take a child out on their own and/or to introduce them to family events[69].

5. Conclusion.

5.1. The Inquiry has now heard the evidence in relation to this module. The DHSSPS has not sought to directly challenge any complainant in relation to abuse. Whilst the Inquiry will undoubtedly turn a forensic eye to each allegation, in particular given the circumstances of the Court of Appeal decision in *R-v-*[redacted] *&* [redacted] *[2005]* [redacted] the DHSSPS regrets any abuse that did occur and condemns both the

[65] Evidence of Dr Harrison, Day 172, Page 54.
[66] BAR-26554 and BAR-26555.
[67] Evidence of Dr Harrison, Day 172, page 50.
[68] Evidence of Dr Harrison, Day 172, page 50.
[69] Day 172, Page 51.

perpetrators and any others who by act or omission allowed abuse to take place.

5.2. The Inquiry will no doubt be aware of the dangers of hindsight in considering systemic failings. Evidence of this if needed can be seen in the Ruddock Review. It is respectfully reminded, however, that the appealing but misguided tendency to look back and see things as obvious must be tempered by considering the social, policy and practice context in which the events occurred.

5.3. Whilst at this remove many of the files that would have been in existence at the time are no longer available to assist the Inquiry, the evidence that is available suggests regular engagement and inspection by the predecessor bodies to the DHSSPS. Such engagement and inspection was in accordance with the practice and policy of the day. If viewed by the standards of today, together with the findings of the Hughes Inquiry, this policy and practice can be criticised as not being sufficiently robust or adequate. However, the practice was very much reflective of the prevailing state of knowledge and the policy was in accordance with what was considered to be appropriate, taking account of the ethos promoted by the Seebohm Report. These factors must weigh heavily in any consideration of whether proper steps were taken at any particular time.

5.4. There is no credible evidence within this module to suggest that SWAG and SSI acted in a manner other than was appropriate in terms of contemporaneous practice and policy.

5.5. Further, when the adequacy of the prevailing policy and practice was called into question, SWAG/SSI and the NIO took immediate steps to address the issue in an effective manner. SSI continued until its inspection remit for children's institutions eventually ceased, to develop more robust forms of scrutiny, which sought to promote

continuous improvement in the institutional care of children and in the prevention, detection and disclosure of abuse within such settings.

Dated this 11th day of March 2016.

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Bar Library