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HISTORICAL INSTITUTIONAL ABUSE INQUIRY

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being heard before:

SIR ANTHONY HART (Chairman)

MR DAVID LANE

MS GERALDINE DOHERTY

held at

Banbridge Court House

Banbridge

on Monday, 7th December 2015

commencing at 10.00 am

(Day 165)

MS CHRISTINE SMITH, QC and MR JOSEPH AIKEN appeared as Counsel to the Inquiry.

Monday, 7th December 2015

(10.00 am)

CHAIRMAN: Good morning, ladies and gentlemen. As always, can I remind everyone to ensure that their mobile phone has either been switched off or either placed on "Silent"/"Vibrate" and no photography is permitted anywhere within the premises, particularly not here in the Inquiry chamber.

Whilst it is unlikely, it is possible that names of individuals who are covered by the Inquiry's redaction and anonymity policy may be mentioned in the course of the opening over today and tomorrow. I am sure I don't need to remind the media, but I will nonetheless, that the policy forbids the use or mention of any name without the written consent of the individual concerned.

This morning we commence our eighth module. We will be dealing over the course of the next two weeks with two voluntary children's homes operated in Northern Ireland by the well-known national charity Barnardo's. These are the former Macedon home, which no longer exists in any material or physical sense, because it was demolished to enable some motorway development to take place, and it was succeeded by another home called Sharonmore.

In a moment I think we may have appearances and then

I will ask Mr Aiken, Junior Counsel to the Inquiry, to commence his opening of this module, which will be the last module of this year, 2015, as we anticipate it will take us up to Christmas.

Yes, Mr Aiken.

MR AIKEN: Chairman, Members of the Panel, good morning. The appearances from the core participants you will have, save for Mr Sayers, who appears on behalf of Barnardo's. I will invite him to give his appearance now.

CHAIRMAN: Yes.

MR SAYERS: Good morning, Chairman, Members of the Panel. My name is Sayers and I appear in this module for Barnardo's, instructed by Carson McDowell Solicitors.

CHAIRMAN: Thank you, Mr Sayers.

Yes, Mr Aiken?

Opening submissions on Module 8 by COUNSEL TO THE INQUIRY

MR AIKEN: Good morning, Chairman, Members of the Panel. Today is Day 165 of the Inquiry's public hearings and, as you have said, Chairman, this morning marks the beginning of our Module 8 examination of two voluntary children's homes operated in Northern Ireland by Barnardo's.

Barnardo's is a long-standing and leading children's charity in the United Kingdom that has as its stated aim

transforming the lives of the most vulnerable children across the United Kingdom. It tackles that aim through a wide range of children's services that it provides. That used to include, and the origin of the charity was indeed, the operation of children's homes.

I will say a little more about the history of Barnardo's shortly, but first I am going to give a short overview of what I am going to cover in considerable detail over the next two days and identify in summary form the issues that are likely to be of particular interest and concern to the Panel over the course of the next two weeks of public hearings.

The Inquiry's focus in this module is on the children's homes operated by Barnardo's in the Newtownabbey area between 1950 and 1995; firstly, as you have mentioned, Chairman, Macedon, which operated between 1950 and June effectively of 1985, and then its bespoke replacement, Sharonmore, which operated between June of 1981 and continued beyond the HIA Inquiry's terms of reference, which end in December 1995. Sharonmore itself closed in 1998.

Four applicants have come forward to the Inquiry to speak of their time in these two homes. As is always the case, their oral evidence will be important to the Panel's work. In addition, much of the story of what

occurred in Macedon in particular and the systems issues that are raised thereby are seen through the documents obtained by the Inquiry, some of which I will open during the course of this opening.

These two homes, particularly Macedon, came to public attention around the Millenium, when a major police investigation began into allegations by ex-residents of sexual and physical abuse by staff during a particular period of time between the years and , save in one respect.

As with similar investigations the Inquiry has seen into Rubane and St. Patrick's, the Macedon Inquiry, as I am going to refer to it, following some initial allegations brought to the attention of police, involved the police proactively seeking out former residents from a particular time period and ascertaining whether they claimed to have been abused.

In the case of the Macedon Inquiry that was some fifty-one individuals. Ten of them made allegations to police. In addition, there were two further children who made allegations. They were children of a staff member who came to play at Macedon, making twelve individuals in all.

That investigation led to the 2004 Crown Court trial of two former members of staff, who have been given

anonymity by the Inquiry, relating to their alleged activities in Macedon during the period to in the main. Some nine ex-residents and one other individual, who visited the home , so ten individuals in total, testified against the two members of staff, alleging sexual and physical abuse.

The two staff members were convicted by a jury in June 2004 of a large number of sexual offences against those children in their care and were then sentenced by the trial judge to significant terms of imprisonment.

In June 2005 the Court of Appeal in Northern Ireland quashed the convictions of each of the members of staff for a number of reasons, including allegations that collusion had taken place between the former residents, who testified to make false allegations of sexual abuse against the staff. Indeed, the Court of Appeal heard evidence from one of the nine former residents who had testified at the original trial, who alleged in a letter written after the two staff members had already been convicted that he had, in fact, lied and conspired with other ex-residents to lie to make false allegations against the staff members. He subsequently recanted the content of that letter before the Court of Appeal, and we will look at that in more detail later in the

opening.

But prior to the trial -- the trial took place in 2004 -- indeed, by 2003 Barnardo's had already paid out £182,500 to ten of the twelve individuals who made allegations as part of the Macedon Inquiry, including £20,000 to the individual who gave evidence before the Court of Appeal that he had written a letter indicating that the allegations of sexual abuse against the two members of staff were untrue and that those who made the allegations had got together to make false claims.

This factual reality presents significant challenges for this Inquiry, because a huge volume of material was generated by the police investigation and subsequent court proceedings, and while this Inquiry is not determining anyone's civil or criminal liability, it will nonetheless have to look at the allegations made in the context of the Macedon Inquiry in order to ascertain whether there were systemic failings that caused, facilitated or failed to prevent abuse in these Barnardo's homes.

In addition, this reality highlights a wider issue that this Inquiry has to deal with that we saw through documents during the St. Patrick's part of Module 7 that not all allegations made, however graphic or appalling, are, in fact, true.

In fairness to Barnardo's, without expressing any view on the veracity of the allegations post the original trial and indeed before the Inquiry, it has indicated that the systems that were in place in Macedon during the relevant period were not what they should have been and consequently failed to keep children safe.

In addition to the complexity that the Macedon Inquiry brings to Inquiry's work for the reasons I have just explained, nonetheless it and indeed other police investigations that we will look at relating to Sharonmore and Macedon uncovered various incidents of potential abuse, including incidents reported contemporaneously, which for various reasons did not come to public attention through a trial process. This Inquiry will have the opportunity to consider those matters and, as with previous modules, expose to public scrutiny abusive activities and practices that hitherto have not been known about.

Indeed, I will shortly look at a contemporaneous complaint of sexual abuse made in in Macedon, which was disclosed to staff in Macedon, passed on to the superintendent of Macedon, who then elected to do nothing with it. Barnardo's, as we will come to see, reflecting on this incident, recognise, and I quote:

"If there is a crucial moment when Barnardo's failed

to address potential child abuse, this is it."

Those were the words of Martin Ruddock of Barnardo's in 2004, when reflecting on the trial that had taken place.

As this Inquiry knows, January 1980, with the breaking of the Kincora scandal, was a seminal moment in relation to matters being considered before this Inquiry. Events that subsequently came to light led to the setting up of The Committee of Inquiry into Children's Homes and Hostels, commonly referred to as The Hughes Inquiry, which sat during 1984 and 1985 and reported at the end of 1985.

Due to a particular incident of abuse in 1982 relating to a boy who was resident in Barnardo's Sharonmore, but who was abused by someone outside the home, Sharonmore being operational from June 1981, Sharonmore was then involved to a limited extent before The Hughes Inquiry and Barnardo's appeared before Judge Hughes.

I want to end this short summary review by mentioning publicly some matters that the Panel continuously bear in mind as part of the Inquiry's work and will do again when considering matters I am about to outline.

Obviously it is important that context is

established in respect of the matters being looked at and that incidents are judged based on what was known and understood as to the best practice at the time as opposed to with hindsight.

Further, as we will come to explain in greater detail in due course, the numbers of children who say they were abused in Macedon or Sharonmore are a very small minority of those individuals who spent their childhood in the care of Barnardo's in these two homes and beyond. It will not come as any surprise to the Panel if I say that Barnardo's has helped literally thousands of children down the years, which equally, of course, does not diminish in any way its responsibility to those whose experience was sadly different.

In addition, it will be borne in mind that those who make allegations do so against the small minority of the staff who worked in the homes, and indeed many of those children continue to have very positive relationships now as adults with members of Barnardo's staff. Indeed, it will become apparent that many of the disclosures that we will look at come about because of the relationship between residents -- former residents and particular Barnardo's staff. Again that context is not in any way to minimise the often life-long effects of abuse on each individual who did suffer it.

It is also the case that whilst Barnardo's continues to operate services for the most vulnerable children in society, they no longer do that through the provision of traditional children's homes, albeit they have explained to the Inquiry that they have some limited specialist services that still are residential in nature.

Before I begin to look at the evidence in detail I want to say something about the core participants before the Inquiry in this module and the format and extent of the evidence bundle.

The first core participant is Barnardo's itself as the provider and operator of Macedon and then Sharonmore. In addition to providing the Inquiry with replying witness statements to the witness statements of the four individuals who have come forward to the Inquiry to speak about their time in Macedon and/or Sharonmore, Barnardo's have also provided detailed general witness statements for the assistance of the Panel.

The first such statement is of 9th October 2015. That's a general overview statement of how Macedon and Sharonmore, their history and origin and how they operated. That's provided by Linda Wilson, the present Director of Barnardo's Northern Ireland. That can be found in the bundle at BAR-044 to 050 with exhibits that

run from 051 to 059.

Now I want to look at -- if we can bring up, please, BAR-049, because in paragraphs 22 and 23 of the statement Linda Wilson, having identified various systems failures that Barnardo's acknowledge as well as highlighting approaches and practices operating at the time, which in light of what is now known about abuse and safeguarding is not ideal, she went on to make these points:

"As an organisation Barnardo's takes complaints seriously. We continue to work to ensure our systems are as good as they can be to reduce the risk of abuse."

If I pause there, Chairman, Members of the Panel, to recognise the recognition by Linda Wilson that it can't be removed completely. She goes on to say:

"The stringent systems we now have today are designed to protect the children with whom we work. The most important thing is that we listen to what children and young people say and take immediate action if it is necessary. People intent on abusing children have shown themselves to be very determined to harm children and we can never be complacent that there is no risk to children in our care.

It is important that no matter how long after their abuse occurred victims feel that they can come forward,

and we welcome the work of the Inquiry in this regard. We know that it takes a great deal of courage to come forward. We have attempted to the best of our ability to respond to the needs of the ex-residents of Macedon, but as an organisation we continue to be deeply saddened by the events which took place at Macedon."

That's a reference, Members of the Panel, as you will come to see, to counselling services being offered to those who came forward to Barnardo's to say what happened to them in addition to the civil claims compensation that was received.

The second statement from again Linda Wilson in particular about Macedon is of 13th November of 2015 and that statement runs from BAR-607 to 617 in the bundle with exhibits running from 618 to 687. That statement will be of particular interest to you, Members of the Panel. It covers the history of Macedon, the type of facility that it was, the care that was offered there, the origin of those who resided in it, the number of places that were available, the staffing arrangements, the staffing structure, the daily routine, the rules that operated within the home at the time, services that were provided, including how medical care was provided, record-keeping, the management structure, how the home was regulated and then looking at abuse and

systems issues.

I want to look at paragraph 28 of that statement, please, at 616, where systems failures issues are identified. Having quoted from Martin Ruddock, who carried out a review in 2004 post the Macedon trial prior to the convictions being quashed in 2005 before the Court of Appeal, having set out some of his systems issues, Linda Wilson then goes on to say this about Macedon:

"In relation to what happened at Macedon Children's Home I am on public record as having stated that 'For those children at that particular time'" -- that's -- we are talking about the period to , potentially through to , taking into account one complaint in Sharonmore -- "'For that children at that particular time in that particular children's home we failed to protect them'. Barnardo's recognises that while the risk of abuse can never be eliminated, it must be reduced insofar as reasonably possible. This aim underpins the core safeguarding principles and framework of a safe organisation to which Barnardo's is committed. Barnardo's, however, accepts that its practices at Macedon at the time to which the criminal proceedings related were inadequate to safeguard children. It is now apparent that there was at that time a failure to

identify and address levels of concerning behaviour by residents, and a failure to respond adequately to concerns about the conduct of members of staff (including, in the case of BAR 3 " -- whose name shouldn't be used beyond the chamber -- "an obvious instance in which management failed to address potential child abuse in accordance with applicable Barnardo's policy)."

That's the reference to the matter that I will refer to:

"Such concerns about conduct were not linked with other matters of concern and addressed appropriately; this it is considered was as a result of a combination of factors that inhibited reflective practice. The systems in place at that time at Macedon accordingly failed to ensure that children were free from abuse."

We will look in greater detail as we go at the reasons behind those admissions.

The third statement provided again by Linda Wilson on behalf of Barnardo's is again dated 13th November of 2015 and that is a statement that deals specifically with Sharonmore. The statement runs from 688 to 699 in the bundle and then has voluminous exhibits that run from 700 to 965. The statement in structure covers the same broad issues as the Macedon statement, but in

paragraphs 42 to 46 -- and I want to look at this now, please, at 697 -- Barnardo's explain why they take a different view about how Sharonmore operated. They express the view, as we will see, that systems failures were not apparent there. They say this:

"Barnardo's has carefully considered the allegations raised within the statement", and they identify two individuals the Inquiry will hear from, HIA50 and HIA101, "and the conviction of Mr Jarvis (who had no connection to Sharonmore) ..."

That's a 1982 matter that brought Barnardo's Sharonmore into the Hughes Inquiry, and we will look at that in due course:

"... for an offence involving a resident of Sharonmore. We have reflected upon the definition of systemic failings as defined by the Inquiry. We have concluded that we do not consider that there were systems failures that could be considered to be systemic failings at Sharonmore. There were systems in place to provide proper care to children and young people and to reduce the risks of abuse occurring. The records document high levels of staff supervision with a clear move towards a more professional model of child-focused social work. There were systems of internal governance, inspection and managerial support as well as external

inspection. There were a range of meetings within the unit which would have allowed staff to raise difficult behaviour or any uncertainty which staff had about how to deal with a situation. There is evidence of a commitment to improve record-keeping, undertake regular review and encourage practice improvement. The level of care documented does not suggest that there was a failure to ensure that the children at Sharonmore would be free from abuse. The Hughes Inquiry report commented within Barnardo's the emphasis on training and professionalism was notable and that there was a comprehensive policy and procedure guide."

The particular extract is provided, and we will see when we look at the SWAG report from 1983 looking at Sharonmore that particular reference was made to the number of qualified staff that were working within the Sharonmore project.

Linda Wilson goes on to say on behalf of Barnardo's:

"There is no evidence of a failure to take all proper steps to prevent, detect and disclose abuse."

She is not saying events did not take place, but they were properly dealt with, and we will look at the incidents that arise from Sharonmore in due course.

"The services provided in Sharonmore adopted a more rights-driven approach which empowered young people and

young people were advised about what was unacceptable treatment while they were in Sharonmore and what to do if they experienced unacceptable treatment. In addition to having the ability to contact their Area Board Social Worker, Barnardo's established a system which allowed the young people to contact the Divisional Director directly if they were unhappy about their treatment. They were provided with a contact card which could be sent to the Divisional Director and did not need a stamp, and if a complaint was raised, the Divisional Director would arrange for a senior member of staff not directly involved in the care to meet with the young person as quickly as possible."

What's being described there, Members of the Panel, is a system that ran in tandem with the complaints system that was devised and implemented by the various Health Boards in response to the Kincora scandal. So there were in effect two routes available to the children within Barnardo's to complain in the post-Kincora era.

"If a young person made a disclosure of abuse, staff would have been aware of the requirement to notify someone more senior within Barnardo's and record the disclosure of abuse."

We will see many instances of this taking place:

"Staff would have expected the matter to be referred to the relevant statutory authorities and also have been aware for the potential for criminal investigation. There is evidence that the appropriate procedures were followed when disclosures for abuse were received to ensure the investigation and prosecution of criminal offences involving abuse. The Hughes Report commented on the prompt handling of the incident involving Mr Jarvis by Barnardo's staff.

The records and complaints do not suggest that those who had contact with children at Sharonmore adopted abusive childcare practices in common."

One of the features of the Macedon police inquiry that we will look at was the identification that for all those who complained that they were abused in Macedon only one said that they continued to be abused in Sharonmore:

"The staff in managerial positions or those in positions of responsibility within Sharonmore did not initiate, encourage or condone abusive childcare practices. Managerial inspections took place and management did not encourage or condone abusive practices or fail to take appropriate steps to identify or remedy abuse. Barnardo's policy and procedure was well regulated at organisational level and was regularly

reviewed, revised and updated to reflect changes in practice and the statutory requirements. Barnardo's did not condone or encourage abusive practices and policy was in place to enable staff to identify, prevent or remedy abuse."

They say again they take:

"... allegations of abuse seriously and have reflected carefully on the issues raised in the statement to the Inquiry."

They point out the response statements that have been provided and ask the Inquiry to note the content of them. They go on to say:

"Any hurt experienced by residents while in our care is deeply regretted. Plainly, however, it is not the case that any such hurt necessarily means that there were systemic failings on the part of Barnardo's. It is appropriate to recognise that Sharonmore was a developing service, and Barnardo's is committed as a learning organisation to continual improvement in practice. It is not, however, accepted that the evidence available in respect of Sharonmore discloses systemic failings on the part of Barnardo's."

So if I can pause there, Members of the Panel, so that you have this in your mind as we look at matters in some detail, Barnardo's are saying to the Inquiry, "We

accept and recognise that for a particular period of time in Macedon there were systems failures that failed to protect children, but when it came to Sharonmore, although one can't remove all incidents of abuse occurring, the procedures and processes that were in place were appropriate and that matters were dealt with appropriately in terms of being reported both to the Social Services and the police as and when they occurred".

With that basic premise we can then look at the material that's available. Obviously whether or not there were systems failures is entirely a matter for the Panel.

The fourth statement provided by Barnardo's is of 4th December of 2015. It brings together at the request of the Inquiry the position in respect of civil claims that Barnardo's have dealt with in respect of Macedon and Sharonmore. I have indicated to you already that the civil claims, almost all of them relate to the same individuals involved in the Macedon police inquiry, with one or two exceptions, and I have highlighted the issue that arises in respect of that.

The statement can be found at 1124 to 1131 in the bundle, and then all of the relevant pleadings and medical reports from the civil claims run from 13205 to

13505 in the bundle. I have drawn your attention to the significant sum that in total was paid out to ten individuals.

In addition -- and I am going to look at the issues that these statements disclose at this point -- we have three further statements from Linda Wilson on behalf of Barnardo's dealing with specific issues that the Inquiry raised that emerged from the Inquiry legal team's analysis of the material received.

I am going to call the first of those the fifth statement, because it's the fifth statement provided by Linda Wilson. It is of 1st December 2015, albeit out of date order from 4th, but if you bear with me. The fifth statement deals with what was known about a particular member of staff. The Panel are aware of who he is. He worked in Barnardo's Macedon during the period. His name came up during the Macedon Inquiry in respect of one allegation and the Inquiry sought information relating to him and the statement provides that information. It's a matter we will return to when I come to deal with the Macedon Inquiry.

The sixth statement of 3rd December 2015 again from Linda Wilson dealing with what Barnardo's could say about allegations made by a former resident of Macedon. Her name was BAR 54 , . The name

shouldn't be used beyond the chamber. She resided in Macedon between and between the ages of and . Her time period is the earliest documented allegation of abuse the Inquiry is aware of. The allegations were not made at the time. They were made to Barnardo's aftercare service, which is a records retrieval service that's available for people to get in contact and look over their history and time in Barnardo's. The allegations were made to that service in 1998 during an access to records interview, following a BBC documentary about Barnardo's homes that was broadcast in 1997. There had been earlier documentaries of a similar nature in 1995.

BAR 54 complained about physical and emotional abuse by three members of staff: the first, BAR 62 , who was between the opening of the home and ; secondly, a BAR 63 , who was a college mother from to ; and a BAR 6 , another housemother, who was a member of staff between and .

If we look, please, at BAR-1097, we can see the 12th October 1998 record of the allegations. The date that allows me to say 12th October is on the page prior. If we scroll down to the bottom of the page, please, we can see what allegations were made to Barnardo's staff:

"We talked at some length about the treatment she received in the homes and she described three staff members who in particular made their lives very difficult. They are:

BAR 62 , now deceased, whom she described as cold, uncaring and unemotional. She also described how he often caned them on bare flesh, making them pull their pants down, etc."

If we scroll down, please, on to the next page. That's what's said about BAR 62 :

" BAR 63 , also deceased, very physically abusive to the children at any time. As punishment she would cut the hair of the children for spite to make them look as unattractive as possible."

Then, thirdly:

" BAR 6 ",

who is recorded as still alive at the time of this document, and I can say she is no longer alive, and at the time this is being said she was known to be:

"... alive and working with disabled children".

according to BAR 54 , who is making the complaint:

"She emotionally abused the children and would often refuse to speak to the children completely sometimes for perhaps periods of three to six months."

She is described as having:

"... made BAR 54 's life unbearable, refusing to speak to her until she was about to leave the home."

The information that Barnardo's is able to provide, if we can look, please, at 1083, in the statement of 3rd December from paragraphs 10 through to 13 Barnardo's set out the information they do have on each of the individuals.

I want to say this at this point. All three of those former members of staff are now deceased and not in a position to defend themselves. Consequently I want to point out that there were no records on their files of any complaints of abuse and no disciplinary proceedings relating to them at any time.

In respect of BAR 62 , , and BAR 63 , a housemother, both of whom served for long periods of time, these are the only known complaints to have ever been made against them. In respect of the third individual, BAR 6 , one of the applicants to the Inquiry does speak about her and I will look at this issue with her in due course.

The seventh statement to the Inquiry by Linda Wilson on behalf of Barnardo's is of 2nd December. I am calling it seventh, because although it came just before

the last statement, it covers a time period after the previous statement. It deals with the allegations of a man now, a child then, called BAR 53 made to Barnardo's in August and September 2000. Again his name should not be used beyond the chamber. He resided in Macedon between and and then again from to , so between the ages of and . BAR 53's allegations were recorded in a similar form by a member of Barnardo's aftercare staff, who met with him in 2000.

If we can look, please, at 1035, he reported physical and emotional abuse, including , perpetrated by a succession of at Macedon Children's Home.

"BAR 53 was in Macedon ..."

The dates are set out. What he says is:

"During his time there BAR 5 ..."

Now BAR 5 became after BAR 62 :

"... perpetrated physical abuse on BAR 53 and on other children on a fairly regular basis. This was in approximately, when BAR 53 was or . BAR 53 felt that BAR 5 did not like him and singled him out for ill-treatment. BAR 53 is not sure whether this was because of his background or not. If BAR 53 had

done something wrong or had been cheeky or difficult, BAR 5 would say, ' BAR 53 , I want to see you'. This struck terror into his heart as he knew what was coming next. He was beaten by BAR 5 with a belt and with hands. He did this to other children as well.

BAR 49 came next probably in the early and he too physically abused BAR 53. He was a very unpredictable man and would lose his temper all of a sudden after giving BAR 53 a talking to. He used to beat BAR 53 with his fists. He would lash out unexpectedly. BAR 53 was aware that this happened to at least one other child."

So that is the , as it were, the that comes after BAR 62 and BAR 5 .

Then comes BAR 24 , who was in the . We will come back to him for other reasons shortly:

"BAR 53 was aware that fellow residents were in fear of the actions of a certain member of staff at this time (no name is given)."

Particular reference is made about BAR 53 presuming they were being sexually harassed at the very least. He then says:

" BAR 24 used to indulge in inappropriate horseplay with the girls, but BAR 53 remembers that the

girls were more fearful of the other staff member", whom he doesn't identify. He makes reference to a reunion taking place in 1992 and how BAR 5 was dealt with.

The allegations were passed on by Barnardo's to the police at that time. The reference for that is at BAR-1051, though the individual BAR 53, having been spoken to by police, didn't wish to proceed with the allegations.

The allegations were made against BAR 5 , who was between September and March , of physical abuse, and one of the applicants to the Inquiry speaks of him. That's a matter we can return to.

The second was against BAR 49 , who Barnardo's have explained was between and It is again an allegation of physical abuse, and I point out there are no other known allegations against this man.

Then, thirdly, BAR 24 , between and He also was for a brief period in around In between that time he moved to a post in headquarters, so effectively a promotion within Barnardo's. That was of engaging in inappropriate horseplay with females. There are no other allegations against this man of this or any other

nature in terms of abuse. There is one issue of a failure to act, which we will look at shortly.

Barnardo's do point, if we look, please, at 1026 in paragraph 14, that:

"The Inquiry's attention is drawn to a letter dated 6th June from BAR 53 to Mr Andrews, [who was] based at the Barnardo's regional office for Ireland."

So, if you like, the top man:

"BAR 53 writes to Mr Andrews complaining about sanctions which were imposed when he stole money from an office in Macedon."

That letter is available. I am going to look at it, because it will assist the Panel with context. If we can look, please, at 1074, so this is a complaint to the head office in -- if we just scroll up to the previous page, please -- in . BAR 53 at that stage was aged , and he was unhappy about the sanctions that were imposed on him following a theft.

He explains who he is and he explains then he had had an argument about his bedtime. He was up late one morning:

"... and it is a rule in our group that if you are not down in time for breakfast coming round, you will be fined 5p. Well, that night I gave my 5p over ..."

So he accepted his fine:

"... and then I was told I was to go to bed at 9.00 pm as well as paying the fine."

So bed early -- earlier than others:

"Then we argued over it and I lost my temper. After I cooled down a bit I went to see the staff concerned and I said to him did he think he made the right decision on this, but he would not change his mind and this put me in a worse temper, and I found the office was open and I stole money out of it. I honestly wasn't thinking what I was doing, and when I -- when I spent the money -- and then I spent the money. A week after I was found out and Auntie ..."

At this stage the housemothers and fathers were known as aunties and uncles:

"... Auntie BAR 64 said she would punish me, but I didn't really think this was all my fault. So my punishment was to empty the bins, peel the potatoes and get moved down from the room that I was in into a junior bedroom. I had been doing these jobs for about five days when she said that part of my punishment was getting stopped from going to with BAR 65 and some of the other children from here. I didn't think this was fair, because I had been looking forward to going to for over a month, and another reason is that just before a boy was going to" --

I think that might be a name -- "and he stole money as well, but yet he was still allowed to go, so there is no reason why I should get stopped going. I have been talking to some staff about this and they think that this is unfair also. I am asking you to help me, sir. If you would phone Auntie BAR 64 and explain to her, because I don't think she really understands. I wouldn't mind if she made me work like a slave before I went as long as she lets me go. Please, Mr Andrews, please help me to get going to .

Yours sincerely,

BAR 53 ."

He received a reply from Mr Andrews, which is available if we look, please, at 1076. Move on to the next page. You can see -- sorry. If we just pause and scroll up a little, you can see the PS that's written:

"Don't show this letter to anyone else. I would be very embarrassed."

If we scroll down, please, the reply from -- on behalf of Mr Andrews, because he is away:

"Mr Andrews is away on holidays, so I got your letter. It will be three weeks before he gets back, so I thought you would want me to reply to you.

I am very sorry to see that you have found yourself in this position as I am sure you are very keen to go

with BAR 65 to , but although you feel you are not fairly treated by being fined 5p, I do not think that it was a very good excuse for you to go into the office and steal all that money.

The aunties and uncles are very concerned about you and they do their best at all times to make you happy and comfortable and are always very hurt when you show them that all their work has been in vain by doing something wrong and hurtful to them.

I find it very hard to believe that any of the staff would think that Auntie BAR 64 was wrong when she stopped you from going to . I am sure you know that auntie is doing this so that you will learn that if you take things which do not belong to you, that in the end you yourself will be hurt, and it is always like this in life.

By now I am afraid BAR 65 has someone else to go to and so you will not be able to go. As in life the good and enjoyable things always tend to go to those who are good and respect other people."

That was written by Maurice Nelson. I am not sure everyone would agree with that outlook on life, but that was the view that he expressed.

The points that might legitimately be drawn, given that in the year 2000 these remarks were being made

about three different superintendents -- that's part of why I've shown you these documents -- because the points that might be legitimately drawn from it you may think include a preparedness to complain even as a -year-old; a knowledge of how to do it; a lack of fear towards whoever the superintendent was that might otherwise have prevented one making the complaint; no mention of any physical abuse; and by this date two of the said to have abused have already moved on; and the sanction for poor behaviour was the loss of privileges.

In addition, Barnardo's draw attention to the fact that this individual's service user file -- that was the name given to a child's file maintained by Barnardo's -- does contain evidence of dental and medical treatment and that material is in the bundle and runs from BAR-1063 to 1072. Barnardo's say to the Inquiry that insofar as injury might have been expected to result from the type of physical abuse that was being alleged in 2000, there is no reference in the records to any medical treatment that would be consistent with the type of injuries that one might expect would have been sustained.

BAR 53 also described at BAR-1035, if we just go back to that, please, at 1035 -- just scroll down, please:

"BAR 53 was aware that the older inmates at Macedon would sexually abuse the younger children. (The senior boys used to take the younger ones to their bedrooms for sex.) This happened to BAR 53 until he grew sufficiently big and strong to resist. BAR 53 assumes that the staff knew what was going on but did nothing."

Now there is one of the applicants to the Inquiry who speaks about peer sexual activity, peer abuse, and we can return to that with her, but beyond what she has to say and what BAR 53 has to say there are no other recorded complaints about that type of issue until we get to the Macedon Inquiry and that period between and onwards.

What will become clear as we move through the material is that both in Macedon by the time period being looked at by the Macedon Inquiry from on and then the police material that's available thereafter through the existence of Sharonmore there was a lot of sexual experimentation going on that was coming to the attention of staff, being reported both to Social Services and to police.

In addition to the -- those three particular statements about specific issues that Barnardo's have provided the Inquiry with, Barnardo's -- the Inquiry has also received statements from former residents --

sorry -- former members of staff dealing with some specific matters that the Inquiry has asked them to comment on, but their evidence will be of general assistance to the Panel.

The Inquiry has received two statements from BAR 14 , who was the .

.

He in his first statement, which runs from BAR-1021 to 1023 -- that's a statement of 29th November -- makes the point in paragraph 14 -- if we can look, please, at 1022, he says that:

"In the 1990s (sic) Barnardo's was a progressive voluntary childcare organisation, committed to innovation and the development of childcare services. Within the organisation nationally there was zero tolerance of professional malpractice, including the abuse of children by staff. There were procedures for the reporting of all disciplinary matters to Barnardo's HQ; the divisional structure in Northern Ireland was well supported by a competent personnel department in Barkingside", in England.

We will look at the management structure in due course. I presume he will clarify that it does not just

mean it was only in the 1980s that that is his view. We can ask him about that.

His second statement is of 2nd December 2015 and it runs from BAR-1079 to 1080 and it deals with a particular incident in that we will look at, but I want at this point to draw attention to paragraph 10 at 1080.

BAR 14 points to something that you will see time and again in many of the documents that we will look at across all of the time span that will be touched on and that is the point that he is making:

"... helpful contextual information because it elaborates the difficult environment in which staff at Macedon were operating in the . Barnardo's was at that time caring for some of the most troubled children and young people in society."

He makes the point:

"The proportion of qualified staff was still low", although you may, looking at it, find it was higher than in other places we have looked at, "and the physical environment at Macedon was far from ideal. The supervision of disruptive residents was extremely difficult because of the physical layout of the buildings, which were replaced a few years later."

He is referring to Sharonmore, but it is the case

that in lots of documents that the Panel will see reference is made to the fact that Barnardo's, as with their stated aim, worked with the most damaged and difficult children, many of whom had been removed from other children's homes.

In addition to the statements from BAR 14 the Inquiry has received two statements to date from BAR 8 . Hers is a name you will become familiar with over the next two weeks. She worked for Barnardo's for years between and . She was significantly involved in aftercare and received the disclosures from many of the residents who complained in the Macedon Inquiry. She makes the point herself that she was well liked by the young people she cared for and one of the issues that arose on the contamination of evidence issue was former residents getting together to have her honoured

Her first statement of 1st December 2015 is at 1018 to 1020 and she in that statement draws attention to three occasions when she became aware of matters she felt needed to be reported. We will look at those in due course.

Her second statement deals with some further

incidents that we will look at. It is of 4th December 2015 and it runs from BAR-2502 to 2503.

BAR 8 faces one allegation from an individual before the Inquiry and she also deals with that allegation in her statement.

Then we have a statement from BAR 7 of 2nd December 2015. That's at BAR-2500 to 2501. She worked in Macedon and then Sharonmore. You will see her name in a number of the documents we will look at from until Sharonmore closed in 1998. She continued in social work elsewhere until her recent retirement.

There are likely to be further witness statements received during the running of the module as matters crystallise further.

The second core participant before the Inquiry is the Health & Social Care Board. Once again its predecessors in title and mainly for the Inquiry's purposes the Eastern Health & Social Services Board would have placed children in Macedon and was involved in the strategy group that arose alongside the Macedon Inquiry police investigation. The HSCB has provided replying statements to each of the statements from four individuals who have come forward to the Inquiry.

The third core participant is the Department of Health, Social Services and Public Safety. It is the

successor Department to the Ministry of Home Affairs and later the Department of Health and Social Services that had responsibility for the registration, regulation and inspection of children's homes that are being investigated in this module.

The Inquiry has received an initial statement from Dr Hilary Harrison on behalf of the Department. That can be found at BAR-966 to 972 and then with exhibits from 973 to 1017. The statement confirms that unfortunately the Department cannot trace any material relating to Macedon and very limited material relating to Sharonmore. The Inquiry does know files exist, which I will look at shortly, and the Department is presently engaged in a process to account for as far as can be done what may have happened to those files.

I want to just draw attention at this point, please, if we can bring up BAR-974, Dr Harrison indicates in Annex A to her statement she has previously alerted the Inquiry that she was herself a former employee of Barnardo's. She did not work in Macedon or Sharonmore but as the project leader of Tara Lodge, Barnardo's adolescent project in Belfast. However, she did have some involvement with two issues that we will have to deal with relating to a befriending assessment she was asked to carry out in , and also she was the project

leader in Tara Lodge after BAR 1 transferred there in and dealt with a particular incident involving her to which we will return.

In addition to the core participants the Panel is aware there is another category of participant before the Inquiry from those who come forward to explain what happened to them and the core participants. They are individuals who face allegations of abuse or failing to act when they became aware of such allegations. The Inquiry has identified sixteen such individuals who the Inquiry would like to engage and provide the opportunity as a matter of fairness for them to say what they want to say to the Inquiry about the allegations made against them.

As the Panel is aware, this is a difficult and time-consuming process for the Inquiry, because of the need to try to trace the present whereabouts of individuals who are being spoken of about events they were perhaps engaged in thirty years or more ago. Based on where we have got to at this point I can say that some of those individuals are either dead or their present state of health is such that they will not be able to engage with the Inquiry. However, there are others the Inquiry is likely to hear from in the coming days.

I want to turn now to say something about the evidence bundle, and perhaps if we can keep going just for a short while, Chairman, until we take a break before the main part begins, if that's acceptable.

The Inquiry evidence bundle for Module 8 is similar to that for previous modules. It is inevitably voluminous, despite efforts to keep the material to a minimum. The bundle contains significant amounts of very dense police material that tell the complicated story of the Macedon Inquiry as it unfolded and other police investigations involving those who were resident or worked in the homes, but the evidence isn't limited to that.

Section 1 of the bundle contains the witness statements provided to the Inquiry. In the normal fashion these include the statements from the applicants, replying statements from Barnardo's, who ran the subject homes, and from the Health and Social Care Board as successor to the Social Services organisations who placed the children in care. The replying statements as individual records are in the main available, including exhibits of relevant contemporaneous material compiled at the time the individual was resident in Macedon or Sharonmore.

In addition, the Inquiry has received detailed

statements from the core participants on particular issues and those are contained in section 1, and I have referred to them already.

The section also includes statements from those individuals who face allegations either of abusing children or failing to act on allegations of abuse. As the Panel is aware, where allegations are made against an individual, the Inquiry endeavours to trace the individual and provide them as a matter of fairness with an opportunity to respond to the allegations and say what they want to say to the Inquiry about them. At present this section of the bundle contains in excess of 1100 pages.

As the Panel is also aware, the process of contacting individuals, especially in the time frame available, is not an easy one and it is and will remain fluent during the currency of the module, and therefore the volume of material in this section is expected to rise.

Section 2 of the bundle, which begins at the 4000 level, contains the police material relating to what I am going to call for ease the Macedon Inquiry. That's the major police inquiry that began in the late 1990s and culminated with the quashing of the convictions of the two members of staff that I referred to early in

2005. As will become apparent, that investigation identified other wider instances of abuse and raised systems issues that will be relevant to the Inquiry's work. At present this section of the bundle contains over 2700 pages of dense, detailed police material.

Section 3 of the bundle, because the police involvement in Macedon and Sharonmore was by no means limited to the Macedon Inquiry, the material provided to the Inquiry by the PSNI reveals other allegations of abuse by staff, individuals engaging with the home and peer sexual activity and/or abuse. As I summarise that material in due course, the Panel will see that apart from one particular matter of interest to the Inquiry from 1980, which Barnardo's acknowledge was not dealt with appropriately, staff regularly contacted police when matters of concern came to their attention.

In addition, that material also demonstrates the extremely difficult and damaging backgrounds that many of the children came from that found themselves in the care of Barnardo's and will provide assistance to the Panel in understanding the extremely difficult job that faced the Barnardo's staff, the vast majority of whom face no allegations of abuse and who gave their working lives to caring for vulnerable children. At present that section of the bundle, which begins at the 7000

level, contains in excess of 2000 pages.

It is also clear from the Inquiry's work that there remain other relevant police files that have not yet been provided to the Inquiry by the PSNI. That may be because they simply cannot and will not be capable of being traced. That's a matter that the Inquiry legal team is continuing to pursue.

Section 4 of the bundle contains social work material provided to the Inquiry by the HSCB on those individuals who have come forward to speak to the Inquiry about their time in Macedon and Sharonmore. In keeping with the Inquiry's previous experience, that material is voluminous and detailed and poses significant challenges to the Inquiry legal team in analysing it in order to ensure that relevant matters are identified and brought to light in a timely fashion. This section presently contains in excess of 2600 pages. The figure will rise as the HSCB continue to deal with targeted requests from the Inquiry team in respect of relevant matters relating to individuals who did not themselves come forward to the Inquiry but whose relevance to the Inquiry's terms of reference has become apparent through other documentary material received.

As the Panel is aware, in order to ensure that as complete a picture as possible is obtained, the Inquiry

does not limit its investigation to those individuals who come forward to the Inquiry, important as those individuals are to the Inquiry's work. Much relevant contemporaneous evidence is also to be found in the documentation relating to other individuals who for whatever reason have not come forward to the Inquiry, and that material will be looked at by me during this opening.

Section 5 of the bundle contains material in respect of civil claims brought by those who resided in Macedon or Sharonmore. That section did contain 200 pages up until this morning and now has significantly in excess of that.

Section 6 contains material brought to the Inquiry by those individuals who have come forward. On occasions individuals who come to speak to the Inquiry will bring material with them. They are just a few pages in that connection.

Section 7 contains over 300 pages of transcripts that are available to the Inquiry. These include Inquiry transcripts, because one of the four individuals due to give oral evidence this week has already given evidence about a different institution in an earlier module.

However, in addition, the Inquiry has also received

the transcript of oral evidence heard by the Court of Appeal during the 2005 appeal proceedings in respect of the criminal convictions of the two staff members who were subsequently acquitted. This transcript is time-consuming to read, but its importance to the matters this Inquiry will consider can't be underestimated. I will refer to certain parts of it later in the opening.

The Inquiry is grateful for the cooperation received from the Lord Chief Justice of Northern Ireland and his office in the very efficient production of this transcript to the Inquiry.

This section of the bundle presently has some 340 pages.

Section 8 of the bundle contains material provided to the Inquiry by Barnardo's. That includes what were known as service user files, the name given to the files held on the children who resided in a Barnardo's home. In addition, the section includes staff files on members of staff who worked in the home for Barnardo's. This section of the bundle presently contains in excess of 4000 pages.

Section 9 contains some relevant media articles and other evidential materials that will be of assistance to the Panel and that amounts to some thirty pages at

present.

Section 10 is left for the submissions, which will be received in writing in due course.

Section 11 contains -- as I referred earlier, Barnardo's did participate to a limited extent in The Hughes Inquiry, and I will say more about that in due course, but the Inquiry has been able to capture all of the Hughes Inquiry material that is to date to be found in PRONI, the Public Records Office in Northern Ireland, and The Hughes Inquiry material relevant to Barnardo's, which includes evidence given by their then BAR 79 , who took over from BAR 14 in , and its submission to Hughes can be found in section 11 of the bundle, beginning at 22000 level. That section contains in excess of 450 pages.

Section 12 contains governance material relating to the Barnardo's homes under investigation. It begins at the 25000 level and presently contains over 2700 pages. The material comes from the Inquiry's own work in PRONI, but also includes material provided by Barnardo's itself.

Therefore at present the Module 8 evidence bundle contains in excess of 15000 pages. As the Panel is aware, the Inquiry legal team has had to analyse much more material than that to try to limit the material

placed in the bundle, given the volume of material involved and the time constraints facing the Inquiry.

Perhaps this is an appropriate time, Chairman.

CHAIRMAN: Yes. We'll rise for ten minutes.

(11.30 am)

(Short break)

(11.40 am)

MR AIKEN: Chairman, Members of the Panel, just before we took our short break I was travelling rapidly through the format and layout of the evidence bundle and I had mentioned while doing so and prior to it with the reference to the Department that it is the case that the Inquiry is aware, as became apparent in earlier modules, that not all material that the Inquiry would consider relevant and would very much like to see is available.

For instance, the Inquiry is aware that the Ministry of Home Affairs files on Macedon did at one time exist. If we can bring up, please, SND13966, and what we are going to look at is a file list that appears to have been prepared by the Department probably at the time of the Hughes Inquiry, and if we can scroll down, please, we have gone to not the first page of the file but a particular page, and you can see that there was a file TC -- because these files are all TC files -- TC166, which is described as:

"Voluntary homes -- Macedon, Whitehouse, County Antrim."

Now if this file followed the pattern of similar files that we have come across for other homes, then it is quite likely that it would have contained the annual inspection reports conducted by the likes of Miss Forrest, Ms Wright and Dr Simpson, which the Panel has had access to in respect of other homes. The --

CHAIRMAN: Do we take it from that Barnardo's records themselves do not refer to inspections?

MR AIKEN: There is a -- again the events log or events of importance log, although one might be able to trace through that an inspection occurred, isn't available for Macedon and therefore that exercise that we have been able to do for other homes where the file has been missing we are not able to do certainly as matters stand in respect of Macedon. So what I can say to the Panel is there is evidence that the type of file that would have contained the inspection reports did exist, but it's not possible to say how often and on what date the inspections took place, which might have been capable of being done through an examination of the events of importance log or diary, annual diary, however the record was kept, which is unfortunate, and equally the inspection reports themselves don't appear to be

available.

The Department has pledged to do what it can to account for what may have happened to this file and another file that would appear highly relevant to the Inquiry's work. If we can look, please, at SND13980, this is again part of the same list, but it is Department of Health files. So they denote that they are younger not in date time, but younger as in tracing back from now, and if we scroll down to the file, please, 16670 -- just stop there, please -- you can see:

"16670/80: Voluntary homes -- Macedon, Whitehouse (Dr Barnardo's) inspections."

Now given that some of the matters we are going to look at in detail in Macedon relate to that period in

through to the closure of Macedon, it obviously would have been preferable to have whatever material there was that might have covered that time, although you will recall from previous modules that from the early '70s the Social Work Advisory Group was performing that advisory role rather than formal inspections. So there is that gap between inspection reports that go up to we can see from other homes the late '60s and the resumption of an inspection function in and around 1982/'83 after the Kincora scandal.

So whatever contact there was through SWAG -- and

you have some evidence from the likes of St. Patrick's that there was a regular advisory engagement between staff in SWAG and institutions that they were connected to -- that material isn't available to be looked at.

CHAIRMAN: Well, if this terminology is accurate, it would suggest that at some time in the past before 1980 there were inspection records available, but they are unlikely to have been immediately -- inspections of recent times, because SWAG weren't doing inspections in the 1980s.

MR AIKEN: Yes, although --

CHAIRMAN: So they probably on that assumption, which may or may not be correct, predate SWAG coming into existence.

MR AIKEN: That may be so, Chairman.

CHAIRMAN: We know from other modules that SWAG stopped doing formal inspections.

MR AIKEN: Yes. It may also be the case, when one looks at the series of files and the "80" denoting the year, that files were opened at this point in time for inspections to re-commence, if I can put it that way, post the Kincora scandal coming to light. Unfortunately, unless it is possible to identify and look at what may have been in the file, it is a matter of speculation as to what it would have covered.

CHAIRMAN: Yes.

MR AIKEN: But what the Department are going to do as far as

they can is try and trace what happened to these files, because of their particular importance.

CHAIRMAN: There is nothing to suggest that Macedon was exempt from the pattern of the 1970s when homes weren't being inspected.

MR AIKEN: No, no. It is likely, and again the Department are going to look at whether it is possible to produce any oral evidence, as happened, for instance, in St. Patrick's, from someone who worked in SWAG who can comment on having been involved with Macedon, and obviously Barnardo's can try with what staff they are in a position to speak to as to whether they can recollect a connection with SWAG and what form that took. So it is the case that the regulator's position before the Inquiry in terms of its involvement in these homes will be, if matters remain as they are, substantially incomplete and that is a fact that we can't get round.

As I say, you heard evidence from witnesses who were still in a position to comment as far as other institutions were concerned on the SWAG relationship that it was a close working relationship, but even with that there simply were no SWAG records that the Inquiry has seen in any event.

So it remains to be seen whether the Department will be able to identify and be in a position to provide

evidence from any members of SWAG who may have been liaising with Barnardo's in the late '70s and early '80s, given the focus that's likely to fall on that era, and correspondingly whether Barnardo's are able to assist the Inquiry any further with those matters as well.

Before I begin looking at matters in detail I want to publicly acknowledge by way of a word of thanks. As the Panel is all too well aware, there are very significant pressures which the Inquiry has to deal with in terms of completing its work within the time frame available, especially given the volume of material that the Inquiry has to deal with and the rapid timetable that the Inquiry has undertaken.

The Inquiry has repeatedly said, especially in light of its inquisitorial model, that it requires collaborative, cooperative approaches with those with whom it has to interact. In that regard I want to acknowledge the assistance given to me by each of my colleagues representing the core participants before the Inquiry.

In particular I want to acknowledge the cooperation received from Barnardo's, appearing for the first time formally before the Inquiry today. It was among the first, as the Panel will recall, to provide material to

the Inquiry back in 2013, long before Barnardo's was to be reached in the Inquiry programme.

In addition, given our recent completion of Module 7, Barnardo's and their counsel, Mr Sayers, solicitors Carson McDowell led by Ms Bates have had to deal with of late repeated requests from the Inquiry for detailed information with a rapid turnaround time. Those requests are being efficiently and effectively dealt with and have been of great assistance to me as I begin to open Module 8 this morning.

The continuation of that collaborative, cooperative approach beyond this module is essential for the Inquiry to finish its work within the stated time frame.

I also want to acknowledge the work of the Inquiry staff, both administrative and legal. The amount of work being done behind the scenes remains enormous, and by dint of the fact it is done behind the scenes goes on largely unnoticed to the public. I want to publicly acknowledge that this morning. In particular in light of my own need to be able to stand in front of you today, in spite of the volume of material to be dealt with, I want to say a particular word of thanks to the members of the Inquiry legal team, who have been preparing this module for hearing, to Miss Donnelly, Mr Morrow, Mr McGlinchy and the soon to leave us

Miss Caslin and the others who have often had to leave what they were doing to lend a hand, including Ms Kirkwood today. In addition, Mr Butler, the Solicitor to the Inquiry, continues to deal with the difficult issues of contact with those who face allegations with the help of Mrs Gibson and others. I would like to put those matters on record this morning.

Now I want to begin, Members of the Panel, to briefly look at the history behind Barnardo's, who are the organisation that ran the two homes, so that you can understand the context and their ethos.

Dr Thomas Barnardo was born in Dublin on 4th July 1841. He became a committed Christian in 1858 just after his 17th birthday. He travelled to London to engage in his medical training to facilitate him travelling as a missionary doctor to China. However, having uncovered the deprivation of street children in East London, his life was to take a different turn, beginning with finding and becoming acquainted with what was then known as his "first street Arab" in 1866, a 10-year-old boy called Jim Jarvis. He found him a home, and this is seen as the beginning of what is today known as Barnardo's.

In 1870 Thomas Barnardo opened what was essentially

the first Barnardo's home in Stepney in London. He was prevailed upon to forego China and concentrate on his work with destitute children at home. He finished his medical studies in 1876 and by 1879 was a Fellow of the Royal College of Surgeons in Edinburgh.

Barnardo's began work in Ireland in 1889 when it opened its first ever open door soup kitchen facility on Great Victoria Street in Belfast.

By the time of his death on 19th September 1905, aged 60, Dr Thomas Barnardo had established a network of branch homes across the country, which provided shelter to destitute children, a network of ever open door facilities in major cities, hospital homes for the care of crippled and invalid children, as well as fostering schemes and a migration scheme to Canada.

He had a charter based on his experience of the death of a child he did not have room to admit that, and I quote:

"No destitute child ever refused admission."

Today Barnardo's is the United Kingdom's largest children's charity and will have its 150th anniversary in 2016. It presently works directly with approximately 240,000 children -- almost a quarter of a million children, young people and families across the United Kingdom through a range of some 960 services. It is

also connected to other charities overseas.

In terms of Northern Ireland between 1922 and 1995 some 3500 children came into Barnardo's care in Northern Ireland and the charity had responsibility for the provision of fifteen residential children's homes in Northern Ireland over that period. It opened its first residential home on the Holywood Road in Belfast in the 1920s. In 1946 it opened Manor House, Ballycastle, which would become a feeder home to Macedon for babies and infants.

Dr Barnardo's purchased Macedon in 1950. Today Barnardo's no longer runs traditional children's homes as they were understood, although they have a small nurture unit for six children under 12 years old who transition to the charity's family placement service. They also have a four-bedded residential respite facility for children with learning and physical disabilities and provide support -- supported accommodation for up to fourteen young people who are in the process of moving from social care to independent living.

Today the work is of a very broad range. It includes family support, safeguarding, trauma, suicide and bereavement services, services to young people with disabilities, young carers, young people not in

education, employment and training, children impacted by alcohol and substance abuse, interventions for young people on the margins of the criminal justice system and family placement. In addition, Barnardo's delivers education support, parenting and counselling programmes in over 150 schools in Northern Ireland.

Today Barnardo's Northern Ireland delivers 63 services for over 8000 children, young people and their families. It employs 500 staff and has over 500 volunteers.

As will become apparent as we look at the material during this module, Barnardo's set itself up, as indeed it continues to do, with the aim of working with and helping the most vulnerable, difficult and damaged children. In the context of Macedon and Sharonmore that often included caring for children who could no longer continue to live in other children's homes or might otherwise have been in training schools. Barnardo's was seen as the last resort to avoiding a Training School Order.

That is the context of the organisation that operated Macedon and Sharonmore that we are now going to turn to look at.

I want to look now first at Macedon, which was located at Whitehouse, 349 Shore Road in Belfast. Linda

Wilson on behalf of Barnardo's has described it to the Inquiry as "a traditional children's home".

We can see, if we go back, please, to the BAR and look at 25091, please, that it was opened in July 1950 by the then Prime Minister of Northern Ireland, Sir Basil Brooke, and he sets out over the course of a number of pages the speech that he gave at the opening. It runs through to 25093 with his recognition of the work done by Barnardo's. He received at 25094 a letter of thanks written on 12th July 1950 thanking him for attending at the opening and the words that he delivered. You can see the patrons to Barnardo's in 1950 are set out on the headed notepaper.

Macedon was registered by the Ministry of Home Affairs as a voluntary children's home on 29th June 1950, and if it is possible, if we could look at SND5654, please, we will see the register that was kept in respect of registration. Macedon is the fourth down. We can see the date it is registered, 29th June 1950, and then you will see on the right-hand side the formal cancellation of registration. Although the actual transfer of children was in June '81, the transfer formally for registration purposes was July '82, when Sharonmore was re-registered in its stead.

The fact of registration meant the home was subject

to the requirements of the Children and Young Persons Act (Northern Ireland) 1950. I am not going to open that, but the Panel is aware of it. It runs from HIA164 to HIA286. With that came the Children and Young Persons Voluntary Homes Regulations (Northern Ireland) 1952. They run from HIA287 to 291. During the time that most of the events we will look at occurred it was the replacement but virtually identical legislation of the Children and Young Person's Act (Northern Ireland) 1968, which can be found at HIA297 to 443, and its accompanying regulations, the Children and Young Persons Voluntary Homes Regulations (Northern Ireland) 1975. They run from HIA444 to 450.

Now we have looked at that legislative scheme in previous modules. Obviously we moved away to training schools in the last module. For context I am merely going to highlight the main elements of the regulatory regime.

For voluntary homes they required an administering authority, and the administering authority according to regulation 2 of the '75 regulations was the person or persons carrying on the voluntary home. We will see when we come to look at the Hughes Inquiry that that was deemed to be the Divisional Director in Northern Ireland, albeit there was a council to whom he

ultimately reported in London.

Secondly, the administering authority of the voluntary home had a mandatory obligation 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. That's regulation 4(1).

In addition and as the working out of regulation 4(1) the administering authority had a mandatory obligation to ensure that each home was visited at least once each month by a person whose obligation was to satisfy himself as to whether the home was being conducted in the interests of the well-being of the children.

"The visits shall be recorded in the events of importance log",

which was one of the documents Schedule 2 to the '75 regulations required to be kept, and importantly he would then report to the administering authority upon the monthly visit.

So there were three aspects to this. Someone was to be appointed to do it; they were to record the fact that they had done it; and they were to report on it to the administering authority.

One of the issues that we will look at is how that was complied with by Barnardo's, something I am going to

look further into.

On the issue of control or punishment, that was to be conducted in accordance with regulation 13. That had a mandatory obligation to avoid corporal punishment as far as possible and then the regulations set out how, if it was to be administered, that was to be done, with a punishment book being kept.

Schedule 2 to the regulations set out the records that were to be kept. This included at paragraph 2 of schedule 2 an obligation to keep an events of importance log, and I know in discussion with Mr Sayers Barnardo's believe it is likely that they did have an events of importance log, but simply through time it is something that's not available, because Macedon closed in 1981. We will look into that a little further.

The nature of the regulation. The Ministry of Home Affairs and post 1973 the Department of Health and Social Services had a power, but not a duty, to inspect a voluntary home. That's section 130 of the '68 Act. It can be found at HIA383.

The Ministry of Home Affairs and post '73 the Department of Health held the power to register and deregister voluntary homes. That's at section 127 of the '68 Act.

That's the framework of the scheme we have seen

before that these two voluntary homes fall to be looked at.

Macedon itself was located in a large, grand stately home in extensive grounds that were part of Hazelbank Park, Newtownabbey, overlooking Belfast Lough. The building has since been demolished following compulsory acquisition to facilitate motorway development. It was for school age children. In addition to the unit in the main house Barnardo's quickly built two chalet cottages on the site. One was called Wakehurst Cottage and I believe the other was called Granville Cottage.

Linda Wilson explains on behalf of Barnardo's in paragraph 3 of her statement of 13th November 2015 that this was part of a developing ethos in Barnardo's to move towards a more homely environment for children, which would replicate family life, and a less institutional model of care.

You will recall from earlier modules it was much later that other homes moved towards having the smaller cottage or chalet type facilities which were recommended in the 1950 Home Office Memorandum that we looked at in previous modules.

Barnardo's has explained to the Inquiry that there were generally thirty children resident. Again in comparison to the numbers we have seen from other homes

around the 1950s/'60s period that is a low number. Ten individuals resided in each of the three buildings, being the main house and then the two cottages.

I mentioned earlier Macedon had a feeder home in Ballycastle, as it were, where babies and toddlers were cared for and then they would move on to Macedon.

Importantly the Inquiry may consider Macedon did not have a school incorporated within it. The children went out to school. You may consider that relevant compared to other homes, voluntary homes, that we have looked at in relation to the opportunities to disclose any abuse said to be occurring in Macedon or indeed Sharonmore or which might be noticed by teachers in the schools that the children attended.

In addition, Barnardo's policy was to encourage family contact, and for those who did not have family, efforts were made to obtain befrienders for the children.

Macedon was registered initially for thirty-five places for boys and girls up to the age of 15. However, Linda Wilson has said to the Inquiry it was initially intended to be a single sex facility, although from the record that I have referred to it seemed to be registered for both boys and girls, but she points out that as focus moved towards maintaining family units,

both boys and girls were admitted.

While Macedon offered long, medium and short-term placements, the placements were predominantly long-term. This will become obvious when we come to look at the allegations that are made by individuals who resided in Macedon and subsequently Sharonmore. Most of them who are involved in the allegations resided in the care of Barnardo's for many years.

When on 28th April 1953 -- and with this I am going to look at the HIA bundle, if that's possible, please. It is HIA1462. On 28th April 1953 the one inspection report that, all being well, we do have is Kathleen Forrest's memorandum where she provided her summary of her impressions to the Ministry of Home Affairs about the condition of voluntary homes in Northern Ireland. It is HIA1462. I am grateful to my right hand who I am having to move between bundles this morning, but you will see that this is a document the Panel will recognise from previous modules when we have looked at other homes, but as far as Dr Barnardo's was concerned it is referenced as:

"A national organisation for school age children."

Macedon is described as:

"Well staffed, well equipped, excellent care and training. Children attend outside schools."

The reference to Manor House is not Manor House, Lisburn but Manor House, Ballycastle, which was described as being for babies and toddlers.

Now if we just scroll through, please, so we can show the date of the document, if we move on to the next page, and indeed one further page, 1464, you can see this is signed off by Ms Forrest on 20th April 1953. Obviously the Panel will be able to contrast what was being said about the provision in Macedon compared to Miss Forrest's remarks about some of the other homes, including the Nazareth homes that are recorded on the last page.

I am afraid for the reasons I explained earlier there are very few other documents of this kind that can be referred to which set out the regulator's position on the home and how it was operating.

What is available, however, is the policy of a Barnardo's home was set out at least from 1955 onwards in what was known as the Barnardo Book. We are going to go back now to the BAR bundle, please, and if we can look, please, at 19011 in the BAR bundle. That's 19011. So you can see the title of the book and then this is the second edition issued February 1955. I don't have a copy of the first edition. It is an English drafted text. It is not specific to Northern Ireland, but the

practice within the homes would be the same.

The index can be seen on 19012. You can see the issues that are covered as to how homes were to be run and what was expected of a Barnardo's home, which was described in the text as a branch home, was set out in detail in chapter 2. Chapter 2 runs from 19016 to 19023. I am not going to go through that now, but I want to refer the Panel to it, and I am going to look at the "Conclusions" section at paragraph 95, which is at 19023. If we just can maximise the left-hand side of the page, if that's possible, please. While that's happening:

"To the outside world the name Barnardo's conjures up the vision of a haven where a homeless child will be certain to receive something more than an institutional training; a place in which he or she is considered as an individual whose characteristics have to be studied and to whom real affection must be given; where unkindliness is left outside while inside perfect security is felt."

Reference is made to the ethos being faith-based:

"'For Christ is the head of the house.'

The responsibility of carrying out this ideal rests on each member of staff in the various homes. It must never be forgotten that the deep spiritual work of the

homes depends upon those with whom the children make their daily contact and that the developing boy or girl will be chiefly influenced by the attitude to life of the superintendent and staff, judging Christianity by their behaviour, not by their words.

Superintendents therefore must inspire their staff and do all in their power to assist them to fit themselves for this high service. Where it can be arranged, they should meet the staff regularly for prayer, discussion and planning. The more thought that is given to the everyday life of the home, the more active interest and vigorous purpose will be created, the senior and junior members of the staff each having his or her own contribution to offer. It would also help the staff to greater patience and more understanding if, as an outcome of their discussions, they undertook to remember special children in their private devotions, for the majority of our children have nobody but their friends in the homes to pray for them as individuals.

It should be the aim of superintendents and staff that by the time children are old enough to go out into the world they are equipped as far as possible to hold their own in their own chosen occupation, armed against the temptations which will have to be met and

sufficiently advanced in their religious life to have made the great decision to put God first throughout life."

So that is the ethos that is being described, but there are parts of this document which you may consider, Members of the Panel, in light of what we have heard in previous modules to be forward thinking in that there's a section on sex education in 1955. If we look at 19039, please, on the right-hand side of the page you can see:

"Every child has a right to proper education in regard to sex development and hygiene. This places upon the superintendent of homes a great responsibility.

The art of sex education depends on the outlook of the teacher and his comprehension of the needs of the child. A natural curiosity must be as naturally satisfied at the right time. Boys and girls should both come to see that true social and moral responsibility is inseparable from a right relationship between the sexes."

So it's a subject that's addressed in the 1955 Barnardo's Book.

Chapter 9 deals with maintenance of discipline in the home. If we can look, please, at 19040, and you can see on the left-hand side of the page:

"The guiding principle in all matters relating to the control of very young children should be to prevent a situation arising where punishment becomes necessary. It is more difficult obviously when dealing with groups than with individual children. Actual numbers give rise at once to possibilities of friction, but even so a very great deal can be done by diversion ..."

This is being written in 1955:

"... to prevent a difficult situation crystallising or a conflict of wills ever developing. Johnny is going to bang Charlie on the head. Johnny is diverted by an errand to be run, a job of work to be done. The moment of tension passes and Johnny is free from the necessity of punishment."

Then reference is made to the English equivalent, the Home Office Regulations, which laid down how corporal punishment was to be administered, and then at 362:

"Superintendents should apply the above rules in the following manner.

If a child is disobedient, it is best to stop him from playing with the other children. He can be made to sit on a chair and look on. He must never be put up in a room, be put in the dark, be confined alone anywhere."

Now you may consider the implication of that is that

Barnardo's are aware that that is something that has been done presumably not in Barnardo's but has been done somewhere and is being specifically dealt with, or if it had been something done in Barnardo's, it is being prohibited.

"If the child is nervy or tired or out of sorts (factors which often are the cause of disobedience), he may be put to bed (this is applicable to small children only). It is not considered advisable for over 7s. If put to bed, he must not be left in a room alone. Arrange for someone to be occupied nearby.

Respect for other people's belongings must be inculcated. All small children are by nature inquisitive. Nursery school methods advocate that every child should leave his own locker where he may accumulate" -- sorry -- "should have his own locker where he may accumulate his store of treasures. This it is believed is the best way to teach a respect for private property. Never search or empty a little child's pockets at night. It only tempts him to make up losses from other people's belongings. Stealing a cake round about teatime may be punished by deprivation of cake at that meal, but threats of cakeless and jamless teas are deprecated. The little child cannot connect two separate incidents divided by a space of hours."

This type of attitude towards punishment I ask you to bear in mind when we look at some of the incidents that arise and how they were dealt with:

"The only way to combat noise in the nursery is for the teacher herself never to raise her voice or shout. It is highly infectious.

Persistent unkindness and bullying. If the methods indicated above fail, advice should be sought from the Chief Executive officer and Chief Medical Officer."

Barnardo's, as we will come to see, had this central facility of a Chief Medical Officer, who would also inspect the children, but would be available to provide advice.

Then paragraph 363 is something that the Panel may find in light of earlier modules interesting, given this is written in 1955:

"Never punish for enuresis, masturbation, nail-biting or other nervous affections. The physical or psychological root of the trouble must be sought. Encouragement here can work marvels and definite rewards should be given for 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 diversion, these and not a code of punishment are the essentials for the happy control of little children."

I am sure the Panel will take the opportunity to have a closer look at the book, but I am going to move through now to 19042 and draw attention to paragraph 370, which sets out the approach to punishment:

"On occasions when punishment is necessary it is permissible:

To withdraw temporarily some privilege.

To substitute a task of some useful type for a period of recreation.

In cases where children appear tired and factious ..."

send them to bed.

Then in 371 the policy in respect of corporal punishment:

"It is probably a good thing that the boys should know that there is a cane in the cupboard, but the more caning is used as a punishment, the more it loses its efficiency as a deterrent. A cane should only be used when it is quite clear in the mind of the head of the home that it is absolutely necessary."

Then a reference is made to how that must be done.

I am going to just mention chapter 12. If we look at 19051, please, the importance of staff training is set out in the Barnardo Book and what steps will be taken to assist the training of staff.

Then chapter 13 may also be of interest to the Panel if we move through on to 190... -- through to the next page, please. I am sorry. Go back up, please. Yes. It is the chapter on migration, which deals with the -- Barnardo's had a developed policy of children migrating to Canada. There is also a reference to Australia, although it is a reference to Australia House. You can see the reference in 476 to the opportunities which exist for enterprise and hard work in Australia.

So that's the Barnardo's Book that sets out the policy that was to operate in Macedon in terms of how children were to be looked after.

Linda Wilson has said to the Inquiry on behalf of Barnardo's that from the 1970s on there was an increasing emphasis from Barnardo's on therapeutic work, on trying to identify and meet the needs of the individual child. A reference for that is paragraph 3 of her statement at 607.

In paragraph 11 of her statement, if we go to 610, please, she explains the staffing arrangements. She

points out they would have varied, but:

"At the start of this period the model of care offered by Barnardo's was based upon a traditional family model and therefore Barnardo's sought to recruit a married couple to be in charge as superintendents of each home. Frequently the superintendents lived in the home itself. Staff who didn't live in worked in shift patterns and would have worked overtime where necessary. In the '50s and '60s staff members were selected for their personal qualities, character and temperament in addition to their affiliation with Barnardo's ethos and values. In the '70s this changed and a more formal process of recruitment ...",

and we will see some of that as we look specifically at some individuals:

"... was instigated, which included consideration of induction, secondment and ongoing professional training. Volunteers would also have been taken on to assist during holiday periods and to provide additional activities for children."

Then in the next passage she explains the staffing structure:

"Superintendents were appointed to be in overall charge of the home. There would have been a deputy superintendent, group leaders",

then in charge of the different units, if you like, the cottages and the main house. Then:

"... residential social workers. Staff may have been promoted to third in charge based on the level of responsibility they had."

We will see that in respect of one individual who will come to the Panel's attention:

"The home had a cook, a gardener, a seamstress, a domestic assistant and a secretary or administrative officer. In the '70s Barnardo's appointed its first attached social worker, who was appointed to support the children in Macedon. Barnardo's also employed a medical officer, who was based at Barnardo's headquarters."

We will see that shortly:

"The medical officer would have issued advice and circulars to staff and would also have made regular visits to homes to review the medical care and welfare of children."

So if I can pause there to observe that's a reference to an internal inspection mechanism broader than just the doing medical check-up of the children.

Then:

"Barnardo's would have met statutory requirements in relation to staff/children ratios. Over time it was recognised that higher levels of staff were required and

additional staff members would have been recruited. Volunteers were also engaged during school holidays and to provide additional activities."

So just stopping at the medical officer, I mentioned they appeared to carry out a wider function. It is evidenced by a 1971 inspection report. If we can look at, please, BAR-624, now this is from you can see in the top right-hand corner Dr Bywater, who was the Chief Medical Officer at Barnardo's headquarters. He said:

"Before my holiday in Northern Ireland ..."

This is from 1971:

"... I visited Mr Andrews in the new offices in Belfast ..."

So that's the main headquarters of Barnardo's:

"... and then made brief visits to both Macedon and the Manor House, Ballycastle."

He says this then:

"Macedon.

I did not do individual medical examinations of the children, since these are now fully covered by the local doctor, but I saw all the records in the home and spent much of the day with the staff and children, and had tea with the children in one of the cottages.

The records are all conscientiously kept. There are only three enuretic children, which is good for a home

of this size."

When he says size, he is talking about a home with thirty children:

"The diet appears to be of good quality and varied and there is a good cook, who has been at the home for many years. The children all stay at school for dinner. There are very adequate records of minor ailments and illnesses necessitating doctors' visits. The local doctor is integrated and reliable and the health of the children is generally good."

Then he makes reference to Dr Wilson being the doctor for the home.

Then 1971 he records this:

"Recently the consultant psychiatrist, Dr McAuley, has arranged to take his clinic staff to Macedon from time to time to help our staff with their management of difficult children, and I think his help could be very valuable. He seems willing to do this as an extension of his child guidance clinic work and is not being paid a sessional fee."

Then he says:

"The children at Macedon are divided into three groups, the main house and the two cottages. The children in the main house used to be divided into three separate groups, but this arrangement has now been

abandoned. explained that they prefer to have the children in one group and it gives the children the flexibility to attach themselves to a member of staff they prefer. I did not find this arrangement an improvement, however. I felt the large group of twenty plus children at meal times gave little opportunity for staff to have individual conversations with children. During the afternoon the children played in large bevies, some rather aimlessly. I was impressed with the warmth and good relationship which

BAR 6 obviously had with the children ..."

I will ask you to note that record as being relevant in due course when we deal with a particular witness:

"... in her cottage, and although the cottage as a whole was untidy, it was homely in that it was lived in. The other cottage was not only untidy but dirty and I think much help is needed here. It is a difficult time for staff in that because these buildings have a limited life, the usual maintenance work may not have been carried out, and it is naturally wise to wait until the new home is available before buying new furniture. Incidentally are we right in replacing the same numbers in the new home as there are at Macedon?"

He is recording 52. I think that's the number it was registered for:

"It does seem a large number of children to have on one site."

So even though there was the cottage format of different groups, Dr Bywater from headquarters is raising at that stage, "Is having fifty too many?" He is pointing out in '71 he is already on notice or Barnardo's are already planning for having a new home, which ultimately would be Sharonmore in 1981, and raising the issue of, "How many are we going to have in it?"

He then goes on to talk about Manor House. If we just scroll through, please, you can see they conduct the visits over August 14th and 15th and it is from 1971.

So the difficulty that arises, and again this is something Barnardo's are going to look into, as to whether if these were being carried out annually, obviously it would be very helpful if they were available. It may simply be they are no longer available, but this is one example of a mechanism that appears to have been in place where the Chief Medical Officer carried out an inspection. He's obviously at arm's length, being from London, coming over to inspect the Barnardo's homes in Northern Ireland.

If we look at 664, this is a memo again from

Dr Bywater. It is of 8th October 1975 and he is talking about the work of the Barnardo's medical officer up to reorganisation. So there's a reorganisation taking place which, if I have understood it correctly, involves the Chief Medical Officer not continuing to inspect and it being more divisional focused. So the Irish division was responsible. That's something we can clarify to be sure about, but you will see that the reference is made to the type of work that is being done, that he made a monthly report on the health of the children to the council at each of its meetings. Access to what council minutes there are relating to Macedon is an issue that I have raised with Mr Sayers. It's being looked into:

"This included any outbreaks of illnesses or serious accidents which had occurred, any deaths of children and observations on current health issues as affecting Barnardo's. He was responsible for the general medical policy on issues such as immunisation and also on less medical issues such as hours of sleep, children's diet, fire precautions. He did personal medical examinations of children emigrating to Australia or entrants to the printing school or the naval schools ... member of the planning committee."

Setting out plans for the new buildings:

"He was also directly responsible for all therapy and nursing staff in any establishment and for advising ..."

Then if you scroll down, please:

"Each of the other two medical officers was responsible for supervising the health and medical affairs of both residential care and foster care part of Barnardo's (ie part of the British Isles). The administration at that time was in three regions."

He makes reference to the Chief Medical Officer visited Scotland and Ireland.

He explains the region he was responsible for and then he explains what that involved. If we just scroll down:

"There were about fifty residential homes in my patch and I was expected to visit each home every year and write a comprehensive report about it. The nursery homes were similarly visited and reported on quarterly. These visits were frank inspections and recognised as such. The report was made in two parts: the first a general report on the state of health of the home, and the second part an individual medical report on every child in the home. Both reports were made to the Chief Medical Officer with a copy to the Regional Executive Officer and the second part only was sent to the

superintendent, with a copy for the local doctor."

So again if what he is describing was being carried out, then there would have been and potentially may be thirty-one reports on Macedon of this nature. Whether the '71 document is, in fact, one of those, given what he is describing the format as being, may not be the case, but that's a matter that can be looked into further by Barnardo's as to whether any of them are available.

"The visits were usually made in groups of three or four homes in a particular country. Superintendents were notified of the dates of the intended visits after clearance. Superintendents were asked to see that every child was present and to notify the local doctor and ask him to call to meet the Barnardo doctor if he wished to do so, or alternatively state a time when he would be free to be visited. The local doctor was always seen alone and his confidential report on the home and the children often proved valuable."

Then he sets out how it was to be conducted:

"The practice was for Barnardo's doctor to arrive in the afternoon by the time the children came back from school. Tea was always taken with the children and was an opportunity to see the way the meal was conducted, the reactions of the children to a visitor, the content

of the meal, including quantities of food served to the children."

Then it refers to the other parts of the inspection that he would have conducted.

Now the reorganisation seems to have taken place based on another document as being 1st July 1972. So if that's right, these type of reports would have carried on up to 1972. The reference for that is at 673. We will try and clarify that a little more with Barnardo's and I will return to that with you, Members of the Panel.

Whether after reorganisation in 1972 there is some equivalent type system is something that we need to look at further.

The arrangements for recording of relevant information within the home are set out by Linda Wilson in paragraph 21 of her statement. If we look at 613, please, she describes in paragraph 21 the service user files that were kept on each individual and then references to an admissions book, a visitors' book, an accident book, a punishment book, a menu or diet book and a petty cash book. Now there is not a reference to the events of importance log. It may be that was seen as being kept through a combination of the other books in terms of the visitors' book recording people who

visited and then the individual children's files recording particular events that related to them as opposed to an actual book called the events of importance log, but that's something that can be clarified.

They also had, Barnardo's, a practice of what were called branch home reviews. If we look at paragraph 6, please, of the statement at 608, these appear to have been similar to the six-monthly case reviews that were conducted in the statutory sector. If we just scroll down a little further, please:

"Branch home reviews", in the second part of the paragraph, "were undertaken in relation to the welfare of children."

They give an example of the branch home review. I think you will see reference in some of the statements to Barnardo's encouraging the statutory sector to improve their approach in this area, and one issue that the Panel will want to take into account is that for these children, they are placed in care by the Eastern Health & Social Services Board. So there is an external social worker. Now we will see when we look at some of the individuals, the extent of the involvement of the external social worker, but in addition to going out to school you have the external social worker from the --

from the Board involved in the life of the child in addition to the Barnardo's staff, and you have the reviews that take place then as part of that statutory mechanism.

In addition, Barnardo's then operated an aftercare service, if we look at paragraph 19, please, at 613, and, as I touched on previously, it will become apparent when you consider the disclosure of allegations that long-lasting contact was maintained between members of the Barnardo's staff and many of the children they cared for in Macedon and Sharonmore as an example. It is those staff from Barnardo's who take the disclosures.

I want to say something about the management structure then within the organisation. You start with the Barnardo's council in London. Then in London is a Director of Childcare, who reports to the council. Then you move down into what by the '70s was divisions, and you had the Irish Division. The Irish Division reported to that Director of Childcare in London, who then reported on to the council. The reference for that is at paragraph 22 of the statement at 614.

Now within the Irish Division -- so if I can move from the structure in London of the council, the Director and then to the Irish Division -- within the Irish Division you had what was initially known as the

Divisional Children's Officer, the Assistant Divisional Children's Officer, a residential -- sorry -- a senior residential officer, who provides support to the superintendents running the homes. There was then a senior social worker with responsibility for fieldwork policies, a divisional administrative officer, who dealt with the administrative affairs within the division, and then you had a superintendent in charge of each home. Macedon always had its own superintendent. So you have in the headquarters that layer of senior staff to whom the superintendent, as it were, was answerable. Their direct liaison was with the Assistant Divisional Children's Officer, but we will see from various documents that the Divisional Children's Officer had contact as well.

CHAIRMAN: Can I just ask at this stage is this an all-Ireland organisation?

MR AIKEN: It did have some services in Eire. In fact, we will see if we look at the chart on 678 -- the extent of those services I am not able to say at the moment, Chairman, but you will see this is -- the DCO is the Divisional Children's Officer. Then you have on the left the senior residential officer, in the middle the Assistant Divisional Children's Officer, and you can see the one in the middle is for Northern Ireland and then

the one on the right is for Eire. This is the proposed staff structure that's being described in 1977. Then you can see underneath the Assistant Children's Officer you have the senior social worker, who is involved in the fieldwork policies.

Now by the time of the Hughes Inquiry in 1985 the management structure had altered at least in name. It is not entirely clear, and it is something Mr Sayers is going to look into for me, at what point the alterations occurred, but we move from having what were described as Divisional Children's Officer to the Divisional Director Childcare and the Deputy Divisional Director Childcare. As I say, it is not clear at what point that change occurred, but it certainly was the case by -- and we will see from various documents that we will look at -- by the time of the Hughes Inquiry those were the descriptors being used for the posts.

Now at no stage was there a management committee or local board of management in the way that there was in other homes that we have looked at. So you had a superintendent running the home, reporting into the headquarters structure, with the liaison with the Assistant Children's Officer or the Deputy Director of Childcare, and then the headquarters feeding into London to the Director of Childcare in London and the council.

We have some work to do with the -- that process and the records that might exist that would touch on Macedon.

It is also clear at least at the time of the submission in April 1985 to the Hughes Inquiry that Barnardo's, if we just look, please, at 22079, regarded the regulation 4(2) -- this is the cover page of the Barnardo's submission to The Hughes Inquiry, and you can see in the bottom left it is dated April 1985. It's a very detailed document, but Barnardo's regarded the regulation 4(2) monthly visitor obligation as being met through the visits to the home of the Assistant Divisional Director of Childcare. Now that we can see, please, on 22087. You can see it's described:

"The Assistant Divisional Director (Childcare) is responsible for setting objectives for monitoring and evaluating the work of each project."

By this stage homes are described as projects:

"He is also responsible for discharging the statutory visiting and reporting requirements and fulfilling statutory and organisational requirements in respect of each child, including six monthly reviews."

Appended to the submission is an example of the monthly pro forma that the Assistant Divisional Director was to complete. If we look, please, at 22207, you can see the type of information that's being requested on

the monthly record. If you just scroll down a little further, please. Just scroll down a little further. So that's a single page pro forma.

What I can say about that is that the Social Work Advisory Group inspected Sharonmore once the inspection process became the norm in November 1983. Now the report can be found at BAR-26533 to 26608. I draw attention to the fact it is looking at Sharonmore, not at Macedon. If we look at the index, please, at 26535, you can see the matters that it covers. It made some 22 recommendations, but in paragraph 7.2, BAR-26558, the Social Work Advisory Group inspectors expressed their view on the adequacy of the monthly visiting reports, where it is said:

"In Ireland the ", who at this time -- BAR 79 , he took over, as I said, in , replacing BAR 14 , "has overall control of the childcare services. There are three Assistant Divisional Directors, one of whom is based in Dublin and the other two in Belfast. BAR111 is the responsible for all the residential services for children other than those who are handicapped. He regularly visits the units in the project and prepares monthly reports on them for BAR 79 . The reports are submitted on a pro forma,

and while they satisfy the legal requirements, the advisers do not think that they contain sufficient detail to enable senior management to effectively monitor the operation of the project. It is recommended that in future some -- more detailed monthly reports should be submitted."

Now this inspection is taking place in November 1983. So what I can say to the Panel is that by November 1983 this was the mechanism that was in operation for complying with the monthly visitor requirement in the regulation. We don't at this point have any of the forms that would have been completed for Sharonmore and we don't have any for Macedon. Whether they exist or not Barnardo's will have to check and confirm, but it's not possible to say at this point -- as I say, it is not clear at what point the structure changed to be referring to directors rather than children's officers, or indeed at what point this pro forma process that's definitely operating in November '83 was introduced, and I don't at this point believe we have received any monthly reports on either of the homes we are looking at. It may be they don't exist now. Whether it will be possible to establish when the systems were introduced, whether the council minutes would explain that perhaps in a wider UK basis and

therefore it would be of some relevance, that's something that perhaps can be looked at, and whether there was any other system to comply with the monthly visiting regulations prior to this method we have to try and work out.

In addition to this mechanism, which was about the monthly visiting mechanism under the regulation, Hughes was also given an example of a quarterly report that was also compiled by the Assistant Divisional Director. It was referred to in the submission as something that was done, and again if we look at 22209, please, you can see this is one in respect of Sharonmore from May 1984, and it records the number of visits that were made to the project. You can see they appear to be either -- mostly every fortnight but sometimes every week, and then there's eighteen children in Sharonmore at the time. Then if we scroll further down, please, it's the same type of questions are asked as per the last document. Keep going down, please. Then more detail is being recorded on questions such as:

"Are all the records being kept in a satisfactory and up-to-date manner?"

Move on to the next page, please. We can see there's reference to subjects being discussed, decisions being taken, summary of action and decisions. Obviously

none of the names that appear on the screen should be mentioned beyond the Inquiry chamber.

Then if we ...

"What are your current objectives in relation to the management of the project?"

If we scroll down a little further, please, reference to staffing issues, number of referrals coming in. It certainly was the case at this point in time that there were serious issues arising, as you saw, for other institutions and for Barnardo's about the under use of places and what impact that was going to have, and at one stage quite early on in the development of Sharonmore one of the two units -- there were two units, Ravelston and Ballyduff, but I'll confirm the right way of it -- I think Ballyduff -- and one of those was very quickly closed. So there was just the Ravelston unit plus the two satellite units that operated in Ballysillan and Rathcoole.

If we scroll a little further down, please:

"Are you concerned about any aspect of the project's economy?"

"General comments -- future planning."

Then it's signed off by the Assistant Divisional Director and then discussed and signed off by the Director. So BAR 79 and BAR111 talking about the

outcome of the quarterly review that's being conducted.

Now again it is not possible at the moment to say when did this mechanism begin to operate, and I am not aware that Barnardo's would be in a position to provide any of these reports. This happened to be one that was exhibited at the time of the Hughes Inquiry, and obviously if there are any in particular that relate to Macedon, that would be something that would be very helpful.

Chairman, I notice the ...

CHAIRMAN: Well, I see we are going on to another topic. This I think is appropriate. It's the time to adjourn and start again at 2 o'clock.

(1.00 pm)

(Lunch break)

(2.00 pm)

CHAIRMAN: Mr Aiken.

MR AIKEN: Chairman, Members of the Panel, just before we broke for lunch we were looking at some of the governance type arrangements and material that might otherwise be available in terms of when the monthly visiting mechanism performed by the Divisional Director began and when the quarterly more detailed reports began and in the context of annual reports that we already touched on, and I know those are matters from speaking

to Mr Sayers that Barnardo's are actively pursuing, but what I am going to do now is turn to a different issue, and as and when we progress on those records matters, I will bring that to your attention, but going back to Macedon, Linda Wilson had explained in her statement that from 1975 -- although in discussions from other material it seems like it was probably an earlier date, possibly as early as '67 -- Barnardo's was aware that Macedon would close ultimately as part of the motorway development around Newtonabbey, and that would provide Barnardo's with the opportunity to develop a residential childcare project based on small, bespoke units. She refers to that in paragraph 4 of her statement at BAR-608. That ultimately would become the Sharonmore project, which was a purpose-built residential facility for children.

Barnardo's point to that decision. If we look at 616, please, BAR-616, paragraph 27, this is referring to the section in Martin Ruddock's 2004 review post the original trial from the Macedon Inquiry, and she says this:

"The hypothesis which Martin Ruddock formed was that the level of incidents" -- that's matters happening in Macedon between really to -- "the level of incidents, low staff morale, political environment",

which I take to be a wider issue than just within Barnardo's, "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. I agree with this hypothesis", Linda Wilson says. "It appears that once the decision was taken to close Macedon there was a growing uncertainty amongst staff. At the same time the management focus shifted to the development of the new service and consequently a diminishing robustness in the oversight of the existing service."

She talks about that elsewhere in the statements that she has provided, that it is now known that when an organisation is bringing onstream a new facility, there is a danger that the eye is taken off the old one, which increases the risk to children as a result, and it's this decision that is one of the factors in any event that Barnardo's point to to explain the problems that thereafter arose in Macedon, given, subject to the particular matters I drew to your attention this morning, that there doesn't seem to have been a high level of difficulty prior to this point in time.

The policies that it appears were to be operated in Macedon from at least 1st April 1979 -- so this morning we looked at the Barnardo Book, which set out 1955

procedures. 1st April 1979, if there weren't any intervening ones, there is a document entitled -- if we can just bring up 627, please. If we can move back a page to begin with, please, and if possible, if we can turn that on its side. Thank you. This is a text called the "Barnardo's Assisted Community Homes Handbook for Managers and Staff". It runs from BAR-626 to 663.

If we move on to the next page, which is the "Contents" page, and again if we can rotate it round, please, you can see it's dated April of '79 and then you have the "Contents" section with the managers, the responsible organisation, the staff of the home, the children, including dealing with discipline in chapter V, and then reference to the local authority. So again it is an English text. The local authority mechanism of boards of management that had some local authority representatives as well as some from the voluntary sector was not replicated in Northern Ireland. Therefore this is not a direct read across. There was no bespoke text that I am aware of particular to Northern Ireland.

Then in the appendices you have various documents, the care and control circular, which is the punishment circular, which we will look at shortly. Then instruments of management. Each home -- local authority

utilised home in England had to have an instrument of management, and then various regulations that applied in England.

But the appendices to this document demonstrate -- and I will leave the Panel to read the document itself -- that Barnardo's issued a circular in July 1977. Given most the matters we are going to look at relate to the to period, that's a particularly relevant document, and that, if we look at 632, please, the circular in July 1977 set out -- again if we can just rotate that, please -- the circular sets out what the policy was to be in respect of care and control in residential establishments. The circular says this:

"During the past few months there has been a considerable amount of discussion about issues of care and control within Barnardo establishments. This circular draws together many of the view points and comments received and it is now being issued:

(i) to give general guidance to staff and

(ii) to inform staff of the support they can expect from Barnardo's if problems relating to the care and control of children do occur.

Positive methods of control.

When a child is received into care and placed in a residential home, he may experience for the first time

in his life a stable and consistent relationship with an adult. This consistency and dependability within an atmosphere of open discussion and understanding of problems may be all that most children will need to help them to maturity. It is this treatment of each child as a valued individual which will help adults and children understand and appreciate each other. Praise and encouragement for good behaviour and for real effort are more important and offer a greater return than ingeniously devised punishments which fit the crime. We tend to take good behaviour for granted and only react when our peace is disturbed."

Then under a section called "Undesirable methods of control":

"It is neither practical nor appropriate to list all undesirable methods of control. The following examples are intended to be illustrative of the type of practice which should be avoided. They are not exhaustive. If a child needs to spend some time alone ..."

Then we are going to have to rotate again:

"... for the sake of himself and", I think that's, "the other members of the community, this should be for a relatively short period and there should be an adult within easy call."

There is further references to food shouldn't be

withheld as if it were a privilege.

Pocket -- bring that back -- the child is entitled to the appropriate rate of pocket money.

"The use of sarcasm and bitter tongue can be as harmful and wounding as physical violence."

Then:

"Mouth washing for the use of bad language is an obsolete practice and should not be used."

Then as far as corporal punishment is concerned this is said about circular DCC/77/9/DCO:

"Sets out Barnardo's instructions to staff on the use of corporal punishment and limits physical punishment to an occasional smack for non-handicapped children under ten years of age. Staff should ensure that they are fully conversant with the Barnardo rules. The rules have been drawn up in this way for several reasons."

They say:

"The use of corporal punishment within Barnardo's appears to have diminished considerably in recent years and in some divisions it has been discontinued entirely."

They set out two further detailed reasons. What I would like to draw your attention to then is the section that begins at the bottom right of the page, "Staff vulnerability and necessary precautions".

So this is not the corporal punishment, because what we have just looked at is contained within the circular. DCC/77/8/DOC is simply referring to the DCC/77/9/DCO and in DCC/77/8/DCO it says this about staff vulnerability and necessary precautions:

"As Barnardo's become increasingly specialised in its residential care, we are admitting more disturbed, difficult and troublesome children. From time to time the behaviour of these children may tax the patience and", if we can rotate again, "[something] that they hit out in anger and frustration."

I think that's potentially a staff member might hit out in anger and frustration at some of the incidents:

"Such incident should be reported immediately to the senior member of staff on duty and recorded on the child's file. The head of the establishment should ensure that the incident is brought to the attention of the supervising officer on his next visit and the supervising officer will decide on an appropriate course of action. In the event of a serious incident the senior member on duty at the time should report immediately to the supervising officer. If the incident were of such a nature as to warrant the attention of the Director of Childcare ..."

He makes reference to a 1974 complaints policy,

which I think is available:

"... the staff member would be told so that the record on his personal file at headquarters could also record his comments and point of view.

Field and residential staff are equally vulnerable in some ways, but staff working in residential units have many more hazardous situations to face each day. Men are probably at greater risk from accusations about their behaviour made by both girls and boys, but the women are also at risk. To enter upon many situations which could appear quite natural may have dangers when they are shared by disturbed youngsters. It is, therefore, part of the duty and responsibility of each member of staff to watch out for these and avoid them or minimise the risks if at all possible."

Then these examples are given:

"For example:

Car journeys, especially fairly long ones, taken by a man alone with a disturbed sexually aware girl -- or a young woman driving alone with a teenage boy. Accusations made by the girl are exceedingly hard for the man successfully to refute. Advances made by the boy might be hard for the woman to deal with.

Staff should not make a habit of wandering about the house or go into children's bedrooms to say goodnight or

to get them up in the morning when dressed in pyjamas and dressing gown.

It is natural and desirable for staff to become very fond of many of the children for whom they care. It is important not to show favouritism for one child over another, and we accept that without question and discipline ourselves not to show it. It is equally important that we are circumspect about the amount of physical affection we offer to children. Other children who perhaps feel left out or who wish to make trouble and do harm can easily put a false construction on innocent acts. Staff should be careful to safeguard their interests in situations in which they are in close physical proximity to children. For example, it is unwise for a male member of staff to have a 10 or 11-year-old boy on his knee with the lad dressed only in pyjamas.

Staff should be aware of their own situation and a child's age, sex, needs and problems when having them alone in their own accommodation for prolonged periods."

So it is not, as perhaps happens nowadays, setting down hard and fast rules saying, "Two members of staff must travel in a car with a child". It is not saying, "You must not do this or must not do that", but it is offing guidance on the identified risks that seem to

have been known of in 1977 as far as the authors of this text are concerned.

That was the circular DCC/77/8/DCO that we are looking at, and then reproduced from the bottom right of this page is the corporal punishment circular, DCC/77/9/DCO. You can see that in paragraph 1 of that circular it is saying:

"The only form of corporal punishment provided 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 personnel file -- personal file. No child suffering from a mental or physical disability should be smacked."

If we can move on to the next page and just rotate it, please:

"The term ..."

I am afraid we are missing again -- there is something that is -- I think it is saying that the following things are forbidden:

"The term 'corporal punishment' includes striking, cuffing, shaking, the use of a cane, strap, slipper, tongs or other implement or any form of physical violence."

So Barnardo's are saying those things are not acceptable:

"It is sometimes" -- then in paragraph 3 -- "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 such an incident should be made on the child's file."

Then paragraph 4:

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

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

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

So the circular is indicating for a child under 10

a slap on the hand with your hand and that's it, and making explicitly clear what's not acceptable, which are other forms that we have seen in some of the earlier modules in terms of how corporal punishment was implemented.

Now having looked at that corporal punishment policy and noting it is from 1977, I am going to pause here to look at a specific issue that arose in , which is fully recorded contemporaneously. It relates to an applicant to the Inquiry, but I am going to go through the documents now so it is much easier for the witness when he gives evidence. That relates to HIA 101 . Again his name shouldn't be used beyond the chamber.

If we can look, please, at 143, first, the incident is summarised in a memo from BAR 7 , who is then at this point in time . She had previously been head of one of the groups, but at this point in time she is ndent. It is initially of and she says:

"At approximately 4.00 pm on

BAR 35 ..."

That's another member of staff, all who worked I think in cottage :

"... reported to me that £30 had been stolen from

BAR 1 's handbag, which was in the staff bedroom.

HIA 101 had admitted stealing the money and BAR 35 smacked him on the hand with a wooden spoon. HIA 101 said he did not think he would have been punished if he had been caught.

I went over to the cottage to see HIA 101. He was in the staff bedroom with BAR 1 . I spoke to him about stealing the money and he said he had taken it and given it to friends. I explained to him that if he had taken the money, he would have to pay it back. I had my doubts about HIA 101 stealing the money and I spoke to him about it again after tea. HIA 101 told me that he had given 30p to one boy, 20p to another, etc. I got annoyed with him at this stage and he started to cry and said he didn't take the money. I had heard at this point that he had been smacked by and BAR 76 as well as BAR 35 . I spoke to my -- I spoke to BAR 35 about my concern about punishments.

I went off duty explaining to HIA 101 that he would not be going to his grandmother's for the weekend as I wanted to get things sorted."

Then on 9th February BAR 7 records:

"I spoke to HIA 101 again about the money and he said he had taken it and given it to a ..."

This has been redacted. Perhaps, if possible, if Barnardo's can get us a copy that's unredacted so we can see what's under that:

"I showed him his savings book and told him we have to lift his savings to pay BAR 1 back. I also told him his grandmother was very annoyed because he had not got home for the weekend. He said he would tell his grandmother the truth and I asked him what the truth was and he said he did not take the money. HIA 101 kept changing his story and I just did not know what to believe. I told him I was going to tell the police.

HIA 101 went back to the cottage and ten minutes later came back to tell me he had taken the money. I spoke to BAR 1 after this and explained about punishment, and I asked BAR 35 , BAR 1 and BAR 76 to fill in the punishment book.

I reported the stolen money to the police (Youth Liaison Department) and a member of this department visited HIA 101, who again said he had given the stolen money to ..."

an as yet unclear individual.

Now -- so pausing there, money has been stolen. The three members of staff who work in house 2 -- and I think at that stage BAR 35 was the person in charge of House and the other two worked under her

-- each of them have punished physically the boy for stealing the money, but the grandmother is involved. The theft issue is going to be reported to the police.

If we leave that memo at this point, and we will come back to it, but if we can move to 132, please, the matter is then brought to the attention of the -- to -- I thought this was from BAR 14 . Just scroll down a moment, please, on to the next page. Yes, it is from BAR 14 . Sorry. If we can go back, please, to the first page, 132. So what's happening here, BAR 14 , who is the is writing to -- there is a file note and he seems to have cc'd in BAR 24 , who at this point -- you will recall he was between and but then was promoted into performing the role of in head office before, as we will see shortly, in he comes back to be for a period after BAR 7 has been and before the transfer to Sharonmore. The incident is brought to BAR 14 attention:

"Discussed an incident which took place three weeks ago at Macedon with BAR 24 and BAR 7 ."

This memo is of 20th February. So the incident that had happened was some -- perhaps at the end of January and the punishment for it happened on 6th February.

That was a week later.

"About three weeks ago ..."

The allegation is then set out about the money. Questioning HIA 101 about the incident. Reference is made to the punishment with the wooden spoon by the three members of staff in the second paragraph and then reference to the changing story. Claimed he took the money to give it to another boy who was bullying him.

If we scroll down, please, on to the next page, reference to the punishment of not letting him go to the grandmother's. Then BAR 8 , another member of staff -- you can see at some time HIA 101 had been given a bicycle. References to the conflict over him having access to the bicycle and having stolen as he had done.

Then:

"When HIA 101 next went to his grandmother's, he related the experience to her and she was very angry. When BAR 7 was collecting HIA 101 from his grandmother, referred to the episode. BAR 7 explained to her to the best of her information what had happened."

Then:

"On a visit by -- on a visit to the same grandmother by BAR 8 she expressed her deep concern about the incident and said that she wanted to speak to someone in authority. She said that she would speak to Roy Blair

in the Eastern Health Board or to BAR 14 ."

So what that shows is that over the course of that period of time there is regular contact with the family member, which would have been part of Barnardo's standard practice, as they have set it out to the Inquiry.

Then he defines the issue:

"The reason for the use of physical punishment in this incident is unclear. While a slap with the hand on a younger child may be allowed ..."

So that's referring back to the corporal punishment policy that we have looked at:

"... 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 are experienced residential social workers and one was personally involved in the incident, BAR 1 . Their response to HIA 101 did not arise out of any sustained provocation and is completely

indefensible.

Another measure was suggested by BAR 7 , that there was £10 in his bank account and could be used to reinstate -- refund BAR 1 .

Because of her own doubts about HIA 101 s guilt BAR 7 has not implemented that measure and until such times as it could be proved that he had, in fact, done it.

It seems to me that this was the only form of punishment which HIA 101 was liable for and in the circumstances it was the only sensible one."

Then reference to:

"In view of the fact that HIA 101 goes to his grandmother on a regular basis, this incident should have been discussed with her by a member of staff, as I have little doubt that she could have obtained the truth from HIA 101 and made a positive contribution to resolving the matter in a way that HIA 101 would have understood. It appears it was not discussed until she raised the matter", the granny.

Then:

"Petty thieving is a pretty regular occurrence in most children's homes and I would expect that staff and children should have a common understanding of how incidents are dealt with. They should not be dealt with impulsively by the staff. On the contrary, the

implications for the individual and the members of the group if responsible individual does not own up should be worked out with the children so that they know where they stand. Any form of punishment must carry real meaning for the children and this can only be achieved if the rules of the group are worked out between staff and children."

Then under a section of "Action to be taken":

"The details of this episode should be set out in a report prepared by the superintendent and this must be discussed by BAR 24 with the staff directly concerned in the incident."

So what he is setting up is BAR 7 as will provide a report to BAR 24 , the , who will then meet with the staff concerned to discuss the incident. You can see the reference:

"Initially other members of staff should not be included in the discussion, as those involved are in breach of discipline and the discussions with the staff must have some formality.

Staff must understand that not only were their actions unprofessional but that they were in breach of Barnardo policy, that this is unacceptable.

A note should be made in each member of staff's file

to the effect that the incident occurred and that it has been discussed formally with them by a senior member of staff.

It is not the intention to discipline the staff beyond this, but it is important that they are made aware that in the type of situation outlined above they cannot expect the support of senior staff."

Move on to the next page, please:

"On BAR 8 contacted me by telephone, as BAR 77 wished to see a senior member of staff in order to discuss the incident in which HIA 101 was involved. It appears that she is looking for the opportunity to express her concern about what happened rather than seek any form of retribution."

He has arranged to go and see her.

Now what I would ask the Panel to note about this document, especially when we come on to look at the Macedon Inquiry, this is . You might consider the level of concern being interacted with over -- I don't want to diminish it by saying only someone getting hit with a wooden spoon on the hand, but when one considers the gravity of some of the allegations that we are going to deal with that are said to have happened before as well as during this period of time, it is something the Panel will want to reflect on

that here this is how this incident was dealt with, which might be considered towards the lower end of the scale of some of the abusive activities that the Panel has to take into account.

If we can look, please, then at 144, this again is BAR 14 then explaining. So he as the goes and meets HIA 101 grandmother, BAR 77 , in her home along with BAR 8 , her having previously complained to BAR 8 about the matter. You can see in the second paragraph:

"When I met BAR 77 , the burden of her concern was not so much that HIA 101 had been punished but that another boy", who is presently unidentified, "to whom HIA 101 had given the £30 or allegedly given the £30 had not been traced and was getting away unpunished. She said if no-one else was prepared to approach his family that she would do it.

She also expressed concern that staff should leave large amounts of money in an unlocked room as it presented a temptation to any child. She said she did not know of the incident until BAR 7 came to collect HIA 101. She had known about it earlier -- if she had known about it earlier, she could have talked to HIA 101 and she felt she could have got the truth from him. However, she has now had the opportunity to talk

to HIA 101 and she is completely satisfied in her mind that he did take £30 and gave it to a boy known as ... She wondered whether HIA 101 had been under any pressure to do this, though for the moment there is no evidence that he was. She emphasised that HIA 101 had not spent any of the money on himself nor told any of the other children at Macedon about his actions."

Scroll down, please:

"Unidentified people have told BAR 77 that HIA 101 was beaten with a wooden spoon by three members of staff. When I questioned her about this, she did not know whether he had been smacked on the hand, the wrists, the legs or elsewhere. It has been suggested by [two names] that HIA 101 was smacked on the wrists. It is important that we ascertain how HIA 101 was punished with a wooden spoon, as I am in no doubt that his father sooner or later will raise this with the area board."

Now that's a reference to an individual called BAR 30 . We will hear more about him as we go. One of the patterns that flow through the documents amongst the -- those dealing with the BAR 30 children was the propensity of the father to be making complaints about how the children were being looked after and there are references on repeated occasions about the difficulties staff had dealing with him and that's no doubt what that

is a reference to. So that's BAR 14 having met with the grandmother to deal with the issue on 21st February.

Then if we go to 143, please, the bottom of the memo of BAR 7 , we can see what happened then the next day, 22nd February:

"Policeman Hamill from the Youth Liaison section of the police called in at Macedon regarding the money HIA 101 was supposed to have given to", whoever that it. "He had visited somebody's home and spoke to him and his parents. They categorically denied receiving the money."

Reference to the very poor condition that the house is in, and then apparently the policeman said there was nothing more he could do, but felt that, reading between the lines and his own instinct, that the boy had, in fact, received money, but he couldn't produce any evidence to substantiate that.

Now on 7th March then, 146, please, the meeting that BAR 14 had required to take place by the and the members of staff. So that's BAR 24 meeting BAR 35 , BAR 1 and BAR 76 takes place along with BAR 7 . The reference to physical punishment in paragraph 2:

"A wooden spoon was used to slap HIA 101 on the hand.

The reason for my visit to Macedon", paragraph 3, "was to express senior staff concern for the handling of the incident in general and the punishment administered to HIA 101 in particular."

There is then reference to what was done with the money. Then the final paragraph:

"I expressed some concern that three members of staff punished the boy for the same offence, that it was administered three weeks after the money had been stolen and that a wooden spoon was used -- which was a breach of Barnardo's policy. The three members of staff admitted using a wooden spoon to punish HIA 101 in a final bid to defer him from stealing ..."

In the documents there were previous incidents that had come to light:

"... and they suggest it was done in a retributive manner.

All staff agreed that it may have been beneficial to seek the aid of HIA 101's grandmother in this issue. It is hoped that HIA 101's grandmother can be encouraged to visit Macedon and become familiar with the staff and the problems that the BAR 30 children present.

No definite date could be given as to when the bicycle had been withdrawn from HIA 101, but all agreed that it was not for this incident but for two previous

bouts of stealing in the first cottage.

BAR 8 had not informed the staff that she had presented HIA 101 with a bicycle. They learned this from HIA 101 himself.

Staff completely denied HIA 101 being deprived of cereal was punishment for this incident. The only time HIA 101 was stopped from taking another dish of cereal was after he had already had three dishfuls.

Concerning the withdrawal of £10 from HIA 101's bank account as part of his repayment, BAR 1 told the group that she did not want the £30 replaced. I told her she could hardly expect to have it replaced in view of her delay in reporting the stolen money and also in leaving such a large sum of money in an unlocked room, especially in view of the fact that staff have indicated that regular stealing is taking place at Macedon. I believe BAR 1 should bear the consequences for leaving such an amount of money unguarded and I was not pleased at her involvement in the physical punishment of HIA 101.

After the formal meeting was over we continued to discuss children's and young people's acting out behaviour, in particular stealing and lying, which seems to be a major problem for some time at Macedon. Staff went on to recall very vividly their experience during

the summer holidays with their group in Donegal and how their morale was very low. This was due to the spate of stealing by the children from the local stores and having to deal with the complaining shopkeepers."

Now you saw in BAR 7 's memo of 6th February that she insisted it be recorded in the punishment book. If we can look, please, at BAR-148, if we just scroll a little further down, please, so you can see BAR 35 signing:

"I slapped HIA 101 on each hand with a spoon for stealing cash from a member of staff."

Then BAR 76 signs:

"I slapped HIA 101 on the legs for stealing money out of my pockets and out of my purse over a period of some" -- I think it's "eight weeks".

Then BAR 1 signs:

"I spanked HIA 101 with the wooden spoon on his bottom with his pants on. He stole £30 out of my handbag. He admits this."

So according to the punishment book the striking was in three different areas. One was on the hand, one was on the legs, one was on the bottom for effectively two individuals who believed they had had money stolen by the boy and then the third, who was the senior member in the house or in the cottage, for the fact that that had

happened.

Now obviously you can see how this incident was dealt with by both the superintendent in the home and then by the senior staff in headquarters. We will shortly look at what occurred in Macedon in terms of the allegations in more detail, but just to allow me to bring this sequence to an end, all the children were transferred from Macedon to its replacement, Sharonmore, by 29th June 1981 -- the reference for that is at BAR-4239; it is contained in a police report -- bar two small groups of children and staff, who went to satellite units of Sharonmore at Derrycoole Way in Rathcoole and Ballysillan Road in Belfast. So the Sharonmore project had two units, Ravelston and Ballyduff, on its own site and then it had two satellite units that provided specialist care to particular families. One was in Rathcoole, living in the community, as it were, and the other was in Ballysillan.

Macedon was ultimately deregistered -- and we saw the memo from the registration file earlier -- deregistered on 7th July 1982, at which point Sharonmore was registered, although the de facto operation appears to have been from June 1981.

Now Barnardo's have said to the Inquiry that it believes 598 children passed through Macedon during its

existence between 1950 and 1981. That's in paragraph 9 of Linda Wilson's statement at BAR-610. Now based on those who have come forward to the Inquiry about their time in Macedon and taking into account the material received by the Inquiry that identifies others who make allegations, some of whom I have opened to you this morning, it would appear that fifteen children who resided in Macedon have made allegations of abuse in some form. That would mean -- you probably know what's coming next from previous modules -- that the percentage of children making complaints about their time in Macedon may be as low as 2.5%.

Now into that bald figure -- and, of course, that should not in any way be seen as any minimising of the abuse of any particular individual -- but into that figure I will ask you to bear in mind that there are obviously issues over some of the allegations, as we will come to see, that would make up part of that 2.5%, and it obviously doesn't take account of the wider -- as you saw earlier, Barnardo's have dealt with 3500 children through the residential homes that they have had. The third contextualising of it is this particular unit was the recipient of particularly difficult families with problems residing in other children's homes.

I am now going to turn to look at some of the allegations of abuse involved in the module, what they are, how and when it came to light and what was done about them. I am going to look at them in the order in which they came to light, because given the evidential issues in the Macedon Inquiry, this is likely in my view to be the best way that I can to assist the Panel to consider what is said to have occurred.

I am going to begin -- we have looked at this issue from . That's documented and dealt with at the time. I am now going to deal with a matter that arose in the early part of . It relates to a boy in Macedon called BAR 46 and a staff member who worked there between and -- we will come to that shortly -- called BAR 3 . His is a name that we will return to on a number of occasions, but in early BAR 46 disclosed to Barnardo's staff that he had been abused sexually by a member of staff and that was said to be BAR 3 .

BAR 46 was born on . He was at the time of his disclosure. He had resided in Barnardo's Macedon from aged , and continued to reside there after these events until and into Sharonmore on , when he was aged . The references for that are at 4290 to 4294.

Now BAR 3 was born on . That's at 4237. He commenced nine months of employment in Macedon on , then aged He resigned on , aged . We will look at him in further detail, as I say, but he died aged on . The death certificate can be found at 8651.

The relevant sequence of events to which this relates is recorded in a file note of from at the time, BAR 24 , who had come back to take over a role he had previously had. He had been from to . Then he had been in HQ before taking on a staff development and training officer role and then returning to perform this task again.

If we can look, please, at BAR-4242, he says:

"This note is a recording of a conversation with BAR 8 on the morning of at Macedon.

BAR 8 reported to me that some months ago staff member BAR 2 had said to her that BAR 46 told him in general conversation that former member of staff BAR 3 while in charge of BAR 46 tried to put his arms around him and also on

occasions had tried to kiss him.

As these reported incidents took place some months ago, the member of staff concerned has now left our employment."

He had resigned on

"On considering the situation, in my judgment any well-intentioned cross-examination at this late stage might do damage to all concerned, especially in view of the climate in the province at present."

If we just scroll down a little further, please, so we can see. Dated . BAR 24 ,

. So at this point the language had changed from " " to " ".

Now the sequence of events that this document either demonstrates or implies is, if we just scroll up so the Panel can see the text again, BAR 46 had disclosed to BAR 2 in general conversation after BAR 3 had already left the employment in Macedon that he, BAR 3 , had tried to kiss him on occasions.

Now BAR 2 was a staff member between and . He -- and obviously what I draw attention to at this point, if I may, Members of the Panel, you will wish to note the involvement of BAR 2 at least as far as this

boy is concerned as someone who was both trusted to receive the disclosure and who passed the information on to BAR 8 . So BAR 2 informs BAR 8 , another staff member, who was more experienced is a fair description and older than BAR 2 . She had begun working for Barnardo's in and continued to work in Barnardo's until and it appears, having told her that, she then tells BAR 24 , , after some months. So it's unclear at what point it was first told to BAR 2 and then to BAR 8 , but at this later stage BAR 8 has told BAR 24 about what had been said.

In her police statement -- if we can look, please, at 8502, in her police statement of 25th April 2001 as part of the Macedon Inquiry BAR 8 sets out her recollection about this.

"The first time" -- this is about eight lines down -- "I became aware of an allegation of sexual abuse was in when I spoke with one of the children in Macedon named BAR 46 . At that time there were rumours going around the children that one of the staff members named BAR 3 was a homosexual. I spoke to BAR 46 as the result of a conversation with BAR 2 . I remember that BAR 46 told

me that he had been on a weekend trip with BAR 3 I believe to Dublin. He explained that BAR 3 had got into BAR 46 's bed beside him to comfort him after terrifying him by talking to him about spirits. He explained he'd started to cry and was terrified and that he'd got out of bed. BAR 46 was very agitated when I spoke to him and had difficulty in talking to me about this. When I asked if anything further had happened, BAR 46 told me that he didn't want to talk about it further and he wouldn't talk about it further.

I passed this information to BAR 24 , who was at the time. BAR 3 had left Macedon shortly before this incident. BAR 24 didn't come back to me about the incident. I had other concerns about BAR 3 , including that he had borrowed money from staff, including me, and that he was dishonest."

Then she says:

"I went to the , BAR 14 , and voiced my concerns to him, explaining to him that I thought BAR 3 should never work with children again."

Now BAR 24 , having considered -- if we go back, please, to 4242, because obviously what BAR 8

is recording in her statement does not quite match what's recorded in the memo at the time in terms of what the abuse was said to consist of, but we will see in the third paragraph , having considered what should be done, concludes that in view of the time that has passed since the incidents, the fact that BAR 3 has since left the employment of Barnardo's, then conducting any well-intentioned cross-examination about the matters at this point in might do damage to all concerned, especially in view of what was described as "the climate in the province at present".

It may be, Members of the Panel, you may feel there are many questions that come out of that paragraph as to what is intended. You will recall that the Kincora scandal broke in the media in and there was already a police investigation underway.

Now this memo came to the attention of the subsequent police inquiry, the Macedon Inquiry, which culminated in a very substantial police report from Detective Constable Boyce in April 2001. That's a subject that I will return to, but during that investigation BAR 24 made a statement to police on 23rd April 2001.

That begins at 4524, please. Now it runs through

4527 and I am simply going to summarise. He explained he had been from to 6, when he was promoted. He did continue to visit Macedon in a supervisory role and support of the then superintendent. He was involved in developing what would become the Sharonmore project because of the impact the M5 motorway was going to have. Then he explains how he returns to work as in and tendered his resignation on . So that's a few weeks before he is writing the memo. So he clearly may well be working his notice at the time that this happens, but he does address the memo if we move through to 4525, please. He says:

"I can recall that BAR 3 came to work in Macedon. He seemed good at his job and could talk through problems. I can remember that he had a . That's all I really remember about him.

I have been shown an incident report dated ."

He can't recall what that's about. He is then shown a file note dated . That's the note we have been looking at:

"I can confirm that I also wrote this report. I vaguely remember BAR 8 coming to me. At that

point in time I dealt with the incident and I felt that it was the right decision at that time. Kincora was on the go at that time. I felt that it was important to record the incident. I would have thought that when I made the decision, that that was the end of the matter. I have no recollection of informing the , BAR 14 , or the police."

Now BAR 14 made a statement to police on 25th April 2001. It is at 4522, 4523. He was not asked specifically about whether he was ever told about BAR 46 disclosures about BAR 3 , though he did recollect having his own what appears to be separate concerns that he sets out in the police statement, and he also wrote a memo of , which pre-dates the memo that we have just been looking at by some four days.

If we can look, please, at 5924, he says:

" BAR 3 was employed at Macedon from until . Immediately prior to his resignation it had come to light that he owed money to both the petty cash account and to certain children's pocket money. On investigation it transpired that loans had been made by supervisory staff, but at no time had he been authorised to take money from children's pocket

money. When these matters were discussed with him, he acknowledged his responsibility and agreed to repay the outstanding amounts. Having repaid the loans, he resigned.

Since his resignation BAR 3 has indicated a willingness to return to Barnardo's and it does appear to be his wish to continue in childcare. In addition to the matter referred to above, there were a number of other matters of concern and we would not be prepared to re-employ BAR 3 in any position. BAR 3 has an effeminate manner and one is inclined to the view that he is most certainly homosexual. However, this was never a problem as far as his work was concerned except that children made reference. Following his resignation there was some evidence that he brought alcohol to the premises, though most of his colleagues were of the opinion that he did not drink. In addition to borrowing money as referred to above, it is known that he borrowed a large number of money from one member of staff and that this was not repaid. BAR 3 had the ability to work through difficult experiences with the children and there was never any doubt as to his childcare ability. He appeared to be supportive to staff, but tended to become involved in their personal lives and seemed to have the skill to identify their vulnerable

points. Having done this, he tended to work on these for the purpose of gaining their confidence.

I have great doubts as to BAR 3 's reliability and certainly would not recommend him for a position of trust or for any post in a social work setting."

So he has, looking at the documents in his police statement, not been told about the disclosures made to BAR 24 , but has expressed to the police in 2001 his own concerns about BAR 3 through various other incidents that had come to light, but he says and said to the police, if we go back to 4523, please, on 25th April 2001 -- he says:

"During my time as Director I had no concerns that children in Macedon were being abused by staff."

Now I take that to mean in the context of the Macedon Inquiry. So that was about sexual abuse. We will be able to clarify with BAR 14 what he meant by that.

Now I mentioned when we looked at BAR 8 's police statement of 25th April 2001 her recollection at that time was she went to BAR 14 and voiced what she describes as her concerns, explaining that she thought BAR 3 should never work with children again.

BAR 14 , if we look at 1022, please,

addresses this in his statement to the Inquiry, where he says about BAR 24 's statement -- he draws attention to the fact there were criminal proceedings:

" BAR 24 states that he has no recollection of his having informed me of the matter dealt with in his written report. I do not have any recollection of having read BAR 24 's report or of the question of referral to the RUC having been discussed with me."

He refers to the file note and says his view of it, which may or may not be right, but what he then says is in paragraph 11:

"I cannot say with certainty what my view would have been had this matter been reported to me at that time. At the very least I think I would have taken advice from Barnardo's headquarters and I think that I would have instructed my colleagues to report the matter to the responsible statutory authority."

That's what he, looking back, is saying as the he would have done or believes he would have done if the matter had been brought to his attention.

I mentioned Detective Constable Boyce. He commented on the handling of this particular document. If we can look, please, at 4241, which is in his police report of April 2001. If we scroll down, please -- scroll down,

please. He expresses the view:

"I personally find the report a graphic ignorance of BAR 24 's responsibilities to the care of the children in Macedon and of the implications for other children who in the future would come into contact with BAR 3 ."

If we scroll down, please, we have then the file note. If we move on to the next page, please, he says:

"The final paragraph in BAR 24 's confidential report I believe relates to the huge investigation being conducted by police at that time known as the Kincora enquiry ... The media attention was huge and caused huge political implications.

I believe that BAR 24 made a decision not to inform police at that time in order to avoid an investigation by the Kincora enquiry team into Macedon and to protect Barnardo's from media attention."

Now he expresses his belief. Ultimately it is a matter for the Panel to reflect on and, as necessary, decide upon as to whether that was the purpose of the decision not to disclose it. BAR 24 obviously expressed the view in his statement he felt it important that it be recorded, although he didn't inform those above him in Barnardo's. It would appear there is nothing in the documents that suggests he informed the

Eastern Health & Social Services Board who was responsible for the boy in question and nothing suggests he informed the police at the time.

Now in October 2004 Martin Ruddock, the principal officer of Barnardo's, in his paper reviewing the outcome of the Macedon Inquiry trial recognised the relevance of BAR 24 's comment about Kincora. If we look, please, at BAR-054 and two-thirds of the way down -- and this is an issue I am just going to flag up and I will come back to it -- he draws attention to the link between member of staff BAR 1 's personal link with BAR 85 , the who was convicted in 1981 of sexual offences against boys there, and he said -- Martin Ruddock says:

"We have to date been unable to identify evidence of how Barnardo's addressed the issues arising from the investigation into or whether there were any risks to children in the care of Barnardo's. It is my view that this issue is of greater importance because of BAR 24 's letter", or file note, "which talks about the climate in Northern Ireland and leads to his decision not to address the allegation about BAR 3 ."

So there is two issues that arise there. The first is the decision not to deal with the allegation, not to

investigate it, not to report it on, but Martin Ruddock is also recognising the second issue to its side, which is well, Kincora is recognised. The relationship between BAR 1 and BAR 85 is known. What steps, if any, were taken to see whether that had any implications or none for any of the children in care of Barnardo's?

Now speaking of how BAR 24 dealt with this disclosure, in her first witness statement to the Inquiry, if we look, please, at paragraph 18 at 048, Linda Wilson on behalf of Barnardo's says this:

"Particular concerns were identified in respect of the response to the report that BAR 3 had on occasion tried to kiss a male resident. Martin Ruddock concluded that the report was inadequately addressed and did not lead to any investigation. In accordance with Barnardo's policy at the time on how to deal with allegations of 'interference' the first task of the superintendent was to find out facts. This did not happen and as a result Barnardo's failed to address potential child abuse."

In his 2004 report Martin Ruddock said this, if we can go back, please, to 055. Sorry. I will come back to you with the page numbers, Members of the Panel, but if I can -- what he said:

"If there is a crucial moment when Barnardo's failed to address potential child abuse, this is it."

Just before we perhaps, Chairman, take another short break if I can ask you, Members of the Panel, to note this. The nature of the complaint that was made in was one of attempts to kiss or, if BAR 8 's recollection in 2001 is more reliable than the memo written at the time, some effort to get into bed that was resisted. If I can ask you to bear those in mind, because, like each of the matters that are dealt with in the , they return again by the time of the Macedon Inquiry and you will have to look at the difference between what is said then and what was said at this particular juncture.

Before I move on to the next matter perhaps if we take a short break.

CHAIRMAN: Yes. We will rise for ten minutes.

(3.20 pm)

(Short break)

(3.30 pm)

MR AIKEN: Chairman, Members of the Panel, just before the break we were concluding the first occasion looking at BAR 46 's allegations against BAR 3 . I said I would give you a reference. If we can bring up, please, BAR-056, we should find the quotation from

Martin Ruddock as part of his work. Yes. It is that first paragraph on the page, the second sentence that we can see he is referring to this complaint being inadequately addressed. So BAR-056.

The disclosures themselves that BAR 46 made, as I mentioned, will arise again further along this chronology and --

CHAIRMAN: Well, I think before we just leave this it is worth just setting out why Mr Ruddock took the view there may have been failure. He points out the first task of a superintendent is to find out the facts --

MR AIKEN: Yes.

CHAIRMAN: -- which they clearly didn't seek to do, because they just let this man disappear off into another world.

MR AIKEN: Yes.

CHAIRMAN: Nobody knew where he was, what he was doing, whether he was working with other children.

MR AIKEN: Yes.

CHAIRMAN: Then:

"Potential failures in the recruitment of other staff, befrienders and volunteers."

MR AIKEN: Yes.

CHAIRMAN: So those elements appear to be what led him to that conclusion.

MR AIKEN: Yes. Indeed, that first point you make is the

point that Detective Constable Boyce was making in 2001. It was not only, "What about the children in Barnardo's?" It was, "Where did this man go?"

In fairness to Barnardo's we will see as we move through the chronology the exact opposite approach being taken, where very proactive steps are taken to alert statutory authorities to investigate particular individuals that Barnardo's become aware of and it's a complete contrast to this particular event that we're looking at.

The next matter that I am going to move on to -- I should say I will be coming over the course of the rest of today and tomorrow and whatever other occasions I need to complete this task and in dealing with the witnesses that there is a family in Barnardo's at this time that we are looking at, , and that is the BAR 30 family. There are , , . They feature through a lot of the material that we are going to look at.

I am going to begin now by looking at a particular incident on . Now the Panel will recall that at this point Macedon is still operational until . On BAR 8 made a statement to police about a disclosure made to her by

BAR 47 , the older sister of HIA 516 and HIA 101 , about what occurred when they were on a home visit to their father, BAR 30 .

Now I want to be clear, Members of the Panel. I am going to look at this matter not because the Inquiry is investigating incidents of abuse that may have occurred outside the institution that the Inquiry is investigating, which, of course, is not to in any way undermine the effect those incidents may have had on someone, but rather because of what other relevant matters can be gleaned from this series of events, including the approach of Barnardo's to matters of this kind and the relevance of these disclosures to subsequent allegations made about staff in Barnardo's during the later Macedon Inquiry. So in layman's terms if I can say sometimes what's not said is also as relevant as what is said.

So in that context I am going to set this out. BAR 47 was born on , came to live in Macedon on , aged , transferred to Sharonmore in and remained there until , when she left at age . The references for that are at 8731, 4275, 4289.

If we can look, then, please, at 149, BAR 8 recounts in this -- you can see the document is headed

"Statement made to Police Woman Constable Ann Campbell, Lisburn Road RUC Station. BAR 8 , over 21, social worker. ". She says:

"On at approximately 9.30 pm I was discussing parental contact and home visits with BAR 47 . During our conversation BAR 47 became agitated and very emotional and broke down several times crying. BAR 47 told me that she wanted to see her mammy on her own. She stated several times that she hated her father and never wanted to see him again.

I questioned BAR 47 as to her reasons for stating that she hated her father and never wished to see him again. BAR 47 told me that during home visits when she visited with her brothers HIA 516 and HIA 101 her father had 'done things to her -- done things on her'."

So if I can pause there just to observe that the events that BAR 47 is speaking of to BAR 8 are happening while she is resident in Barnardo's, going out on a home visit to her father:

" BAR 47 also told me that the incidents which she referred to occurred whilst her father and mother were living apart and she had visited him along with her two brothers at his home ..."

at a particular address:

"She added that during these times he was under the

influence of alcohol. The following account is an incident which BAR 47 states took place during a visit to her father's home."

She then refers to her father asking her to go upstairs, as he had something nice to show her in the bedroom. They both entered. She describes what took place. If we just scroll down a little, please, you can see the reference to him lying on top of her, about his weight. If we scroll down further, please, what he then tried to do, but she struggled and he was unable to remove her underwear. This will become important for other reasons that you will see in due course. So she is saying he put his hands underneath her sweater and touched her chest.

While this was happening she was shouting for help and shouting for her father to let her up. Her father told her to keep quiet and released her when he heard one of the boys running up the stairs apparently to BAR 47's cries for help. He then let her up and opened the bedroom door.

We will see that was HIA 101 , because on BAR 8 also spoke to BAR 47's brother , who was born on -- so he is aged -- about what he could recall happening on the home visit. Yes. He is aged at the time of

these events where BAR 47 would have been at the time of these events.

If we can look, please, at 153, BAR 8 is recording an interview with HIA 101 and I am just going to let you read that document. So a discussion is taking place about how the home visits are going and who is involved in them and the nature of the home relationship.

Then if we scroll down, please, you can see at the very last line:

"At this point I asked HIA 101 if he could remember an incident when ..."

That will have been -- we will have to get an unredacted copy. Perhaps if that can be dealt with.

"... BAR 47 had been upstairs and she had shouted for him."

If we scroll down, please:

" HIA 101 said he did remember BAR 47 shouting for him and told me she had scared him. According to HIA 101 daddy and BAR 47 were upstairs. HIA 516 was either outside in the street or at the shops. He", as in HIA 101, "was downstairs playing. He told me he heard BAR 47 shouting 'HIA 101, HIA 101, help, help'. He ran upstairs to see what was wrong with BAR 47. She was in the back bedroom. He could hear her shouting, 'Help, HIA 101', but he said he

couldn't get the bedroom door open. HIA 101 told me he stayed outside the bedroom door and in a wee while BAR 47 and his daddy came out of the back room. BAR 47 was crying."

Now BAR 47 made a statement to the police -- if we look, please, at 151 -- on 3rd March. This is a report of the police interview that happens on , but if I could ask you to note in the end of the first paragraph you will see reference to her having made a statement to police on . We don't presently have that statement nor indeed the police file to which this investigation relates. So this story is capable of being told through the documents that Barnardo's kept as opposed to material we have received from the police, but she made that statement to police on 3rd March. However, BAR 8 then attends with her when different police officers interview her on at which point she is years of age.

The officer explains he is taking over the investigation and initially BAR 47 is anxious then.

"The police officers endeavoured to put her at her ease and chatted informally to her for quite some time. They talked of her interests, school, boyfriends, etc."

If we scroll down, please:

"Detective McKnight explained to BAR 47 why he had

visited Macedon to see her. He told her that the police officer Ms Campbell was leaving and he had been allocated some of her work, that he knew her family. After some questioning and gentle persuasion from Detective McKnight BAR 47 recounted her story of the incident."

You can see again she indicates in response to the questions that the incident had taken place in the back bedroom. He held her down with his right leg as she struggled to get free. Again you can see the extent to which it is said these events reached.

You can see then in the next paragraph the personal distress BAR 47 exhibited when being spoken to and then how that was dealt with in the third paragraph down. Then in the fourth paragraph she left the room and it was evident she was sobbing and crying from her bedroom.

"He also said" -- this is Detective Constable McKnight -- "that in the event of this case being brought before the court BAR 47 would, he felt, be unable to face the trauma that this would entail."

So that is the judgment that he made based on the way BAR 47 had presented to him at the interview.

If we look at 155, please, you will see that BAR 8 attended with HIA 101 being spoken to by the same officer who had came up to Macedon on the same

date. He then recounted again what he could recollect had taken place. Just scroll down so the Panel can see the rest of the document. Again signed off by BAR 8 .

Now, Members of the Panel, what I would like to do then is say this. It is not at this point clear what became of the police investigation, though I note from the criminal record of BAR 30 that there was a conviction for indecent assault on a child at Belfast Magistrates' Court on . The reference for that is on his record at BAR-8167 at the bottom. Whether that relates to this or not --

CHAIRMAN: Does the record not give the date of the offence?

MR AIKEN: Sadly not. If we look at 8167, it's --

CHAIRMAN: Well, it should be possible to get a copy of the entry in the magistrate's order book --

MR AIKEN: Yes.

CHAIRMAN: -- and the summons would give the date of the offence.

MR AIKEN: Yes. We are also trying to get -- if we scroll down, please -- we're trying to get -- to the bottom entry on the page -- we're trying to get the police to find, if they can, the file from their side, as it were, of this investigation. That's the indecent assault being recorded and the court date where a conviction

takes place, but if we scroll down a little further, please, unfortunately none of the entries have a date connected to them. It is something we can look into further.

CHAIRMAN: Well, we see there at the bottom we do get the date for another offence.

MR AIKEN: Yes. It just seems to be missing for that particular entry unfortunately.

CHAIRMAN: Well, we should be able to get that from the court files, even if the police don't have it.

MR AIKEN: There are some matters then that I want to highlight at this point, reflecting on that series of documents that we have looked at.

The first is the victim was prepared to and felt able to as a -year-old disclose the matters that concerned her to a member of Barnardo's staff. Barnardo's brought the matter to the attention of the police and supported the victim and the witness indeed through their involvement with the police. Separately, but perhaps importantly, BAR 47 and HIA 101 were both speaking to police about abuse. The nature of the allegations themselves of indecent assault, and then the timing. This is , just a few months before Macedon would close and services and therefore the children transferred to Sharonmore.

I would ask you to bear this incident in mind and its sequence and chronology when we come to look at the Macedon Inquiry, as two of the complainants of the ten residents I refer to in the Macedon Inquiry are BAR 47 and HIA 101 , because by now in the abuse said to have been perpetrated by BAR 1 and BAR 2 , when we come to look at the Macedon Inquiry, would have been occurring and would have reached its end by June 1981, because as far as HIA 101 was concerned and the same for BAR 47 , save for involvement with BAR 2 , when they transferred to Sharonmore, the abuse did not continue.

Obviously what flows from that is that neither of the individuals who were either speaking to BAR 8 about what happened and then thereafter speaking to the police about what happened in relation to the father make any reference to either of the two members of staff that feature front and centre in the Macedon Inquiry.

I am then going to move into an event in involving a different boy who was residing in Barnardo's called BAR 44 . This relates to an adult in the community called David Jarvis. It is what resulted in Barnardo's being before The Hughes Inquiry.

On -- so you will immediately note this is now Sharonmore that we have moved to, Macedon

having closed in June 1981 -- on a -year-old boy BAR 44 , who had been admitted to the care in Barnardo's Sharonmore from Rathgael two months before -- in was when he arrived in Barnardo's -- was the subject of a sexual assault by a man called David Jarvis. BAR 44 had truanted from school and was picked up by Jarvis, a then delivery driver and also a convicted sex offender, in Belfast city centre and taken on Jarvis' delivery rounds. Jarvis indecently assaulted him during that time, and a co of days later BAR 44 informed his uncle about what had occurred. His uncle informed Barnardo's, who prepared an incident report.

If we can look, please, at 9... -- 932 -- that's a wrong reference. If we can look at HIA932, please, if that's possible. If we can move to the HIA bundle, that would be super. While that's being done -- there we are. Yes. You can see the police were informed immediately about the indecent assault of BAR 44 , who is A4 as far as the publication of the Hughes Inquiry report is concerned. He made a statement the following day. The incident report was copied to the Southern Board.

His statement of , BAR 44 's statement to the police, what had occurred, if we can

look at 22318, please, I am not going to look at what he describes occurring, but what I want to show you is he is again accompanied by a member of Barnardo's staff, the group leader, BAR 9 or . If we just scroll down to the bottom, please -- just scroll a little further -- you can see in the bottom right-hand corner BAR 9 , in Sharonmore.

Then if we look, please, at 22330, the social worker, residential social worker in Barnardo's, BAR 80 , who dealt with this incident along with BAR 9 -- sorry. 22330. 22330. That's great. Thank you. He records the incident.

" BAR 44 had been at his grandmother's, was brought back later in the evening by BAR 75 ."

He was another member of staff in Sharonmore, .

" BAR 75 reported to BAR 9 and myself that BAR 44 's grandmother had been greatly alarmed and upset by what BAR 44 had told her re being followed and picked up by a man in the Ballyduff area.

BAR 9 and I both spoke to BAR 44 . He reported having been picked up on a number of occasions and also having seen this man in the area on other occasions. He said also that the man had made a number of suggestions to BAR 44 of a sexual nature. BAR 44 had been careful

not to oblige the man, and although he reported the incidents eventually, he said that he had been too frightened to say anything earlier.

I immediately contacted the police, who came to Sharonmore and questioned BAR 44 in the presence of BAR 9 . They also made arrangements to have BAR 44 call at the station the following evening. BAR 9 accompanied him on this occasion also.

On Monday evening BAR 44 was taken to the police station and later in the week the police reported having picked up and questioned the suspect. He appeared in court and admitted his offences. Later he was released on bail. BAR 44 was asked to report any more sightings."

The police investigation -- Mr Jarvis admitted at interview five days later when he was picked up that he had indecently assaulted the boy and that investigation formed police file C642382, which can be found in the bundle at 7252 through to 7283. Jarvis was convicted of the offences in December 1992. The reference for that is at HIA931.

Now the behaviour of David Jarvis, his conviction and his access to children in care resulted in the inclusion of Barnardo's Sharonmore and Manor House, Lisburn, because he had done the same thing with a boy

from there, in the Committee of Inquiry into Children's Homes and Hostels, The Hughes Inquiry. Barnardo's provided a detailed submission to the Hughes Inquiry, albeit its focus was the 1982 Jarvis incident that affected Sharonmore. That 33-page submission can be found at BAR-22079 to 22113 with appendices then at 22114 to 22315. The Panel will want to take the opportunity to read the 33 pages in any event of the submission. It will be of general assistance to the Panel, although, as I indicated this morning, I've discussed with Mr Sayers the need to clarify when certain procedures that are referred to in the submission began to operate, ie were they operating in Macedon between and , or just from Sharonmore began to operate in , or just from , whenever the matters before the Hughes Inquiry are being dealt with?

Now BAR 79 , who became the Barnardo's

of Barnardo's in , replacing BAR 14 , gave evidence to the Hughes Inquiry on behalf of Barnardo's on Day 58 of its public hearings, which was 19th April 1985. I think it had 60 days of hearings in total. So it was towards the end of its public hearings. The transcript of that evidence can be found

at BAR-22020 to 22076. Again it will be of interest to the Panel.

The Hughes Inquiry reported on 31st December 1985 and the report can be found in the bundle -- it is in the HIA bundle at 656 to 1000. Chapter 11 of The Hughes Inquiry report dealt with Barnardo's Sharonmore in the context of the Jarvis incident and it can be found at HIA931 to 937.

Now I am going to -- if we can bring up 931, please, I am going to draw this short chapter to the Panel's attention, and it may be that's something that the Panel having the opportunity to read would be easier than me reading it, but I will draw attention to some matters, because it will assist with context and also be of wider interest as the Panel reflect on the evidence relating to Barnardo's over the coming days.

At 11 -- if we just scroll down, please, we can see the different facts of the matter are set out as far as dealing with David Jarvis is concerned and the particular issue involving BAR 44 , but if we can move through to 11.7, please, and obviously it's a matter for this Inquiry looking at these matters, but what is said by The Hughes Inquiry:

"We find that the staff of the project acted promptly and correctly in recording the allegations and

referring them to the police for investigation and to the Board for information. We note that the boy chose to make his disclosure to his uncle rather than a member of staff, but this is by no means surprising, since he had only been at Sharonmore since . We also noted the discrepancy between his police statement, which dealt with a single occasion, and the incident report, which indicated that he had been picked up on a number of occasions. BAR 80 made a statement to us to the effect that the police were given all available information at the time. We are satisfied that the Barnardo's staff took all necessary steps to assist the police fully in relation to the matter."

Then they look at various other incidents involving this particular boy, and of more general interest if we move down to 11.9, please:

" BAR 79 gave evidence that BAR 44 was boy with a record of truancy since the age of 9."

He then goes on to describe how this indecent assault occurs when he was a boy playing truant:

"But we could conceive of no continuous precautions which the Sharonmore staff could have taken to prevent his truanting. There are clearly limits to the amount of direct supervision which can be provided for children

who are not in enclosed institutions."

Then they make this point:

"The various incidents involving this particular boy demonstrate the difficulty of supervising disturbed and difficult children and we make no criticism of the Sharonmore staff in this respect. The history continued to present difficulties, however, and raised the broader question of whether he should have been kept at the project rather than returned to a more secure environment."

They then talk about the particular matters that are on the file and recognise the issue of judgment in placing of someone.

Then in paragraph 11.12 they examine the issue of files and supervision that was being operated and the interaction with the Southern Board. If we scroll down, please, to -- if we just keep going, this is all about this particular boy. If we just stop there at 11.14:

"The general management and monitoring ... not directly material",

but looked at to some extent.

If I can draw attention to 11.16 -- you can see in 15 a reference to a sophisticated system of annual staff appraisals, but:

"In one respect Barnardo's is in advance of the

statutory sector in that since 1979 it has paid its residential staff on a par with field social workers. 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."

Then you can see at 11.18 reference to the administering authority, the Divisional Director being the de facto administering authority as far as this assessment was concerned:

"The statutory monthly visits were deputed to the , BAR111 We scrutinised the records from mid '81 until the end of '82 and found that visits were reported on pro formas as having been made to Sharonmore for each month from July to December 1981."

Then you can see:

"During '82 reports were only completed for visits in January, March, June, August and October."

So it seems that at the time of The Hughes Inquiry report at least there was evidence before it, although it was looking at a very specific time, of these monthly pro formas being completed during 1981 and 1982, with the occasional blip in terms of timing.

Then you can see reference:

"Often more than one visit was made in a month and 25 visits were made during 1982."

Then reference is made to something I drew your attention to earlier, the SWAG report referring to how these were being conducted, the SWAG point about meeting legal requirements but not being sufficient:

" BAR 79 accepted this and gave evidence that a quarterly report", which I touched on earlier, "had been introduced since then, which gave much fuller information."

So that would imply that the quarterly report mechanism only came in post the SWAG report in 1983, which means it won't have applied in Macedon, and to what extent the monthly version did we will have to work on a bit more.

"But he also drew attention to and placed the statutory visiting and reporting activity in the broader context of Barnardo's monitoring of the project, involving three-weekly supervision meetings between the

Divisional Director and Assistant Divisional Director."

You can see then in 11.20 the point is made:

"Nevertheless we consider Barnardo's record on reporting to have been less than entirely satisfactory insofar as it fell short of full compliance with the letter of the '75 regulations."

This didn't have any relevance to the isolated matter with which they were dealing.

Then he refer to the SWAG inspections and the first time this happens is November 1983:

"Inspections carried out by two of the social worker advisers and extended over four days ran to some 50 pages plus appendices and made 22 recommendations."

I gave you the reference for it earlier. If we scroll down, it's -- this is what is said:

"We consider that it was reasonable for SWAG to allow the project to function for two years before undertaking a full inspection. The project was to a degree experimental and was bound to take time to settle into a pattern."

They say:

"The report was comprehensive and detailed, although BAR 79 suggested that it had some presentational defects in that it dealt with a number of incidents without presenting them chronologically."

That relates to in the body of the report reference is made to a series of very serious acting out behaviours by children that are referred to by the SWAG inspectors, but they don't precisely identify who and when they're talking about when they're referring to them. They express their view. It should be a matter for this Panel as to whether they agree about that on the standard of the reporting.

Then reference is made then to the issue with the Black Report and how it was arising for organisations such as Barnardo's in the context of what was the future role of training schools. You can see that the suggestion was being made which was recommended.

So that's again a particular matter in and it is not possible to leave aside the fact it was dealt with at a Public Inquiry, but stripping back to the core issue that this Panel may regard as relevant, again it comes to the attention of Barnardo's staff. They report the matter to the police and Social Services immediately. They accompany the child. The person then is convicted.

Subject to the Chairman and Members of the Panel, I will resume at another incident in in the morning.

CHAIRMAN: Well, I think this is a suitable point at which

to stop for today and resume tomorrow morning.

(4.20 pm)

(Inquiry adjourned until 10 o'clock tomorrow morning)

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