Historical Institutional Abuse Inquiry 1922-1995

Response to Witness Statement of BAR13 BAR – 044 to Bar – 050

1 BAR13 was appointed to the position of by Barnardos in with specific responsibility for the establishment of a . This was the first service of its kind The Northern Ireland and unique in that it was founded on the premise that:
- the long-term institutional care of children and young people in large groups is not in their best interests;
- children and young people should have experience of family life, if necessary in substitute families;
- the foster care of troubled children is a professional task for which foster carers should be trained and remunerated.

2 The first group of children to be considered for potential placement were residents from Macedon children's home. BAR 044

3 BAR13 states, "*It was my role to consider the wishes and suitability of young residents in Macedon as family placement candidates. This included familiarising myself with the young people and having contact with the staff at Macedon as appropriate". BAR 044.*

4 In she became with a team who supported a number of young people who were ex-Macedon residents. BAR 044. In BAR13 was appointed . Later the same year she was appointed .

5 It is therefore clear that BAR13 had an intimate knowledge of Macedon children's home from having direct access to a particular group of residents and their carers.

6 The closure of Macedon had been planned and progressed over a number of years, leading to the phased closure of the home from 1980 to 1981, with new services being developed on the Sharonmore residential sites and the associated Professional Fostering Service. BAR 045.

7 Following the conviction of two members of Macedon staff in September 2004 on charges of child abuse, Barnardos carried out a review of the presiding Judge's comments. This was presented as learning points from the Macedon experience and appears as BAR 051 to 059. The author presented a hypothesis as follows:
"My hypothesis is that the level of incidents, low staff morale, political environment (BAR24 letter 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" BAR 057

8 BAR13 BAR 048 paragraph 19 states that she agrees with that hypothesis. She continues, *" It appears that once the decision was taken to close Macedon there was a growing uncertainty amongst staff. At the same*

time management focus shifted to the development of the new service and consequently a diminishing robustness in the oversight of the service".

9 It may be helpful to HIA if I respond to Barnardo's witness statement which is presented in summary form as a hypothesis. (see paragraph 7 above)

10 A hypothesis is a supposition, or a proposed explanation that may be used as a starting point for further investigation. As such is must be capable of being tested. What is presented in the Barnardo review is not a supposition or proposed explanation, nor was it rigorously tested. It is a set of conclusions, based, it would appear, on a limited desk exercise, without reference to external and independent sources. There is no evidence that the author looked beyond Barnardo case files.

- The views and testimony of neither former residents nor staff members were elicited;
- The assessments of the relevant statutory authorities whose social workers visited children in Macedon were not sought;
- The assessment of Barnardos Headquarters team which annually received the required Divisional Plan setting out the Divisional Director's assessment of local services and proposals for development was not interrogated;
- Evidence gathered in the mid 1970s by Barnardo staff regarding young people's views about their experiences in residential care was not considered;
- There is no comparative analysis of experience in other children's homes that provided care for a similar population of young people.

11 While I do not dismiss all of what the author concludes, I am deeply concerned that the integrity of Barnardos and its senior managers may be discredited on the basis of an unsubstantiated and partial exercise.

I will consider briefly the main elements of the "hypothesis" as summarised by BAR13 , paragraph 19, BAR 048

The level of incidents

12 No information is provided as to the level or nature of incidents that had occurred at Macedon. It may be assumed that these were significant in nature and frequency. The author concludes, "*Having read the child care files and listened to the evidence in court, it is hard to see how the level of difficult*

behaviour, abusive practice or concerns about members of staff did not get linked together and addressed appropriately". BAR 056

13 The author here is conflating what was known in the 1970's, that is the facts about incidents at Macedon, and what was not known at the time, facts about abusive practices by two members of staff. Clearly it was not possible until much later for all of this information "*to get linked together and addressed appropriately".*

14 Any establishment that provides for a population of young people who include some of the most troubled in society, can expect to encounter a significant level of deviant and disruptive behaviour. [redacted] children's homes I came across many which were accustomed to disruption on a frequent basis. A high level of damage to property, aggression toward staff and other residents and absconding were commonplace. The author fails to elucidate in what way Macedon was exceptional in this respect.

Low staff morale

15 Unfortunately the author provides no qualitative information that might help one to form a view as to the causes of low staff morale. The author states that case files identify:

- *Regular reviews of children involving social work support staff and at times staff external to Barnardos.*

It was the case that Barnardos, in the 1970's, convened six monthly reviews of each child in the home, chaired each review meeting and documented the findings and recommendations. They encouraged social workers from the responsible authority to attend, though this did not always happen. This task should have been undertaken by the responsible authorities.

- Appropriate referral to psychiatric services.

Where appropriate psychiatrists or psychologists attended the home.

- Incidents were also recorded in detail

The author might have analysed these for the purpose of the report.

- There are examples of good work and staff working hard to understand and address identified difficult behaviour.

The author appears to acknowledge here that some constructive, analytical thinking and reflection did take place at Macedon.

16 BAR13 [redacted] BAR 048 paragraph 19 states, *" It appears that once the decision was taken to close Macedon there was a growing uncertainty amongst staff. At the same time management focus shifted to the development of the new service and consequently a diminishing robustness in the oversight of the service".*

17 It was true that staff experienced uncertainty once the closure of Macedon was known about and it is conceivable that there was some impact

on staff morale. It is entirely untrue to say that there was a diminishing robustness in the oversight of the service.

18 I recall clearly that in the late 1970's there was concern among some staff about where they would be placed in the new Sharonmore project. This was understandable. The process for appointing staff to the new project was explained to staff, but this did not reassure everyone. Some staff wanted to engage a trade union to represent their interests. At that time Barnardos did not recognise trade unions for the purpose of negotiating staff conditions of service, and this led to some friction.

19 It is my recollection that individual staff were invited to express an interest in specific positions in the new project and that this created opportunity for advancement for some. I do not recall any member of staff having to leave the service as a result of changes at that time. I do, however, recognise that staff confidence and therefore morale may have been adversely affected during the transitional period.

20 I also recognise that Barnardos at that time may not have been sufficiently cognisant of the possibility that potential abusers may exploit any lack of vigilance during a period of disruption, however it is caused.

Recruitment

21 Throughout the 1970's all children's homes experienced difficulty in recruiting experienced and professionally qualified staff. The reasons for this are elaborated in the report of the Hughes Inquiry, which made specific recommendations regarding the conditions of service for residential social workers. Barnardos had begun to offer to its residential staff, who were professionally qualified social workers, conditions of service comparable to those of field social workers some years before the Hughes Inquiry was announced.

22 In the 1970's Barnardos was committed to employing a fully qualified workforce in children's homes. At the time this was not achievable, despite the organisation having in place a programme of secondment to full-time qualifying courses. Nevertheless, Barnardo homes in Northern Ireland had a higher proportion of qualified staff than any other homes.

23 Locally Barnardos appointed a training officer to identify the training needs of its staff ; she arranged in-service and other training courses.

Political Environment

24 The author of the report of the Barnardo review appears to attribute to BAR24 a reference to "the political environment" in Northern Ireland.BAR 057. This was inaccurate and misleading and changes significantly the impact of BAR 24 judgment that "***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".***

25 I do not know what BAR24 had in mind in making this judgment, but I do not think that he was referring to the political climate or the troubles in Northern Ireland. It seems more likely that he had in mind the turmoil that existed amongst residential care staff as a result of the Kincora saga and the range of allegations and disclosures that were emerging at that time at a number of other homes. Residential staff felt under-valued and mistrusted and low morale was widespread.

26 Up until that time, and for a further two decades, Barnardos in Northern Ireland was untainted by allegations of abuse. It is conceivable that BAR24 simply tried to avoid implicating both staff and young people in the negative climate of mistrust that was prevalent in many organisations.

27 I knew BAR24 very well and respected and valued his professional and moral integrity. For many years he had been a leading figure in the , which was a national organisation committed to the development of the residential care of children. Most of his working life was spent working with troubled children in training schools and in both statutory and voluntary sector organisations. He was one of the longest serving male residential staff in the Province.

28 Having read his File Note BAR 4242 for the first time within the last few weeks, I cannot fully understand how he came to the conclusion that he did. Nor do I understand why he did not make me aware of what had been brought to his attention regarding BAR3 . I am content that he made his decision in good faith, motivated by his desire to do what he felt at that time was in the best interests of a young person.

Management failure

29 Judge Weir's comments about management competence refer specifically to the appointment and subsequent deployment and supervision of BAR1 . In total, she was employed in residential services for about . After she was promoted to the position of in the new Sharonmore Project. BAR 046 (paragraph 19). Approximately years later she was demoted, and within a few months she was disciplined. Later the same year she was again disciplined and moved to another Barnardo unit. There she was again disciplined, leading to her resignation in .

30 This limited synopsis of her employment history indicates that for a period after her appointment BAR1 performed well enough to be promoted to one level above that of basic grade residential social worker. In the position of she would have had limited autonomy in day-to-day decision making regarding individual children. Her position involved a significant level of trust and discretion, which clearly she abused.

31 Effective residential care practice is predicated on consistent teamwork and sound leadership. At the risk of generalisation and in the absence of access to Barnardo records covering the relevant period, it seems that in the late 1970's there were weaknesses and tensions in the management of

Macedon children's home. This was compounded by recruitment problems and to some extent by uncertainty about the positions of staff once the home closed.

32 It is established fact that children are mostly abused by those who know them well, that a process of grooming leads to secretive encounters, when patterns of abuse become established. It is also the case that children who have been abused are confused, they feel guilty about their participation and they do not readily confide in anyone. The history of abuse at Macedon followed that pattern. The question raised by the Court was how could this have gone on without BAR 1 colleagues realising that something was not right? Was this the result of management failure?

33 I am unable to answer these perplexing questions, other than to observe, on the basis of my limited recollection, that a combination of factors was at play, and that, with hindsight, two members of staff were able to exploit the situation with impunity. It was also the case that a number of external personnel were regular visitors to the home at this time. These included an attached social worker employed by Barnardos, who was the confidante of many of the children, members of the Professional Fostering Team, social workers responsible for individual children, as well as senior managers.

Strategic leadership

34 This refers to the planning and management of organisational change. Throughout the 1970's Bardardos in Northern Ireland pioneered new services and models of delivery in a number of areas. In particular, the need to replace Macedon as a result of the site being vested by the Department of the Environment was associated with a major change in the way the organisation provided residential care services. Care arrangements changed in favour of provision for young people with more challenging behaviours, replacing the longer-term care of sibling groups. The Sharonmore Project was a significant departure from the traditional children's home model of care. Small homes for 3-4 children were opened in the community settings in recognition of the fact that their care in large-groups was not appropriate.

35 During this period some Health and Social Services Boards were building homes for thirty children. In 1974 Barnardos had abandoned plans to build a home of this size despite the proposed Ballyhanwood project being at final stage of development. It was recognised that professionally and strategically it would have been unwise to proceed with a building project that was already out of date.

36 Professional foster care services were developed; the first small home for children who had previously been in long-term care in Muckamore Abbey Hospital was opened; following the closure of a home in Belfast, the resource was developed to offer respite care of very young children suffering from profound and complex disabilities. All of this happened some 20 years ahead of the commencement of the Children (NI) Order 1995. Barnardos at that time was proactive and innovative in the development of a number of new services. Whatever the perceived failings at Macedon, Barnardos cannot be accused of a lack of strategic leadership during this period.

I trust that these comments and observations are helpful.

BAR 14

BAR 14

13 December 2015