this Department in 1983, but extending to a wider range of persons than our current procedures." (SNB-50394)

Comment

2.25 The recommendation made at paragraph 8.6 of the SWAG inspection report was correct in so far as it applied to volunteers visiting the home. It is inevitable, however, that volunteer visitors will form relationships with individual children, which may lead to them spending time alone with a child, either within the home and/or elsewhere.

2.26 I believe that management at Nazareth Lodge would have had no doubt as to the scope and significance of paragraph 8.6 of the inspection report, especially as the inspector had discussed with them the practice of student priests visiting the home.

2.27 Mother General had a clear understanding of the HSS Board requirement for the prior approval to every request for a child to be allowed out of the home, even for day visits.

General Comments

2.28 Nazareth Lodge appeared to be caught in a time-warp of institutional practice, while at the same time some other voluntary children's homes were actively promoting the professionalisation of residential child care, bringing it more into line with field social work standards of practice.

2.29 The inspectors did not, however, note evidence of complaint by children or their families, nor did the inspection report include any adverse comment or concern about the use of sanctions by the staff.

2.30 Subsequent reports of inspections by SSI a decade later portrayed a home that had been transformed by substantial investment in the fabric and layout of a still institutional style of building, and progress made in staffing arrangements and professional competence. The EHSSB, which had increased substantially the per capita payment, reported satisfaction with the standard of service being provided and both children and their families seemed content with the service.

3.0 Complaints reported by [NL 162] based on her observation of life in Nazareth Lodge children's home in 1984

3.1 [NL 162] had been on a short-term placement in Nazareth Lodge where she observed certain practices that caused her to make three complaints to EHSSB. (SNB 14679)
to be doing that.

A. Yes.

Q. If they didn't tell --

A. Uh-huh.

Q. -- the home that --

A. Uh-huh.

Q. -- is that not a disservice to them?

A. Well, I just wonder. I mean, I have explained that inspection was a collaborative process. I -- you were -- the 1983 whatever it was that has been described as a draft report, an aide-memoire, etc, I'm not sure of the extent to which that would have been agreed by the other colleague who was -- who was also present during the inspection. So to that extent I'm not sure what discussions took place after that, whether it was agreed that perhaps someone didn't experience the lack of competence as one inspector saw it in exactly the same way.

Q. Is that not so serious a thing that would you expect to find it on the file if it happened? If a discussion took place between them about the fact that one thought the lead member of staff in one unit was incompetent, and the other disagreed about that, and that, therefore, they weren't going to do something about it -- and I have to say Mr Chambers was not demurring at all from
Two matters may merit particular comment:

7. Our report commented on the fact that there was no record book for recording the events of importance connected with the home, as required under Regulation 5 (3) and Schedule 2 of the Children and Young Persons (Voluntary Homes) Regulations (Northern Ireland) 1975. Regulation 4 (2) requires the administering authority to make arrangements for monitoring visits to the home at least once in every month. From an inspector's perspective, evidence of such visits would be found in the record of events of importance. Since there was no record we did not have the evidence but we were informed that Mother Regional visited 3 or 4 times a year. Although we did comment on the lack of a record book for recording events of importance we should probably have made a stronger comment regarding what we perceived as the insufficient frequency of monitoring visits by Mother Regional. I understand that the Committee of Inquiry was informed that Mother Regional visited Nazareth Lodge 15/20 times a year in a monitoring capacity. I am sure we would not have recorded that Mother Regional's visits were only conducted 3 or 4 times a year unless we were so informed at the time. We did not see any record to show that there had been any more frequent visits by Mother Regional. We were informed she had appointed two "councillors" who met monthly to discuss the affairs of the home. However, this may not have provided adequate independent monitoring coverage to satisfy the objects of Regulation 4 (2). In any event the requisite record of events of importance, where such visits should have been recorded, did not exist. We should probably have made a stronger recommendation emphasising the administering authority's statutory obligation.

8. Regarding the visits of volunteers to work with the children we saw the potential for certain benefits from this. However, we did recommend, in our inspection report, that management should always make appropriate background enquiries regarding the credentials of persons offering to do voluntary work before linking them with the children. Although there may have been no statutory procedures dealing with the vetting of volunteers at the time I am now aware, from the Hughes Inquiry Report 1986 (paragraph 9.7 – HIA 909), that, by letter, dated July 1972, the Belfast Welfare Authority had asked the home to ensure that the Welfare Department was notified and couples or families approved before children in care were allowed out of the home, even for day visits. The sister in charge of the home gave evidence to the Hughes Inquiry that procedures had been laid down by the Boards that no child could receive a visitor nor could a visitor take a child away from the home without the proper approval of the field social worker responsible for the child. In light of this and its relevance to the position of volunteers within the home we should, perhaps, have made a more specific recommendation that clearance of volunteers should have been done by, or in close consultation with, the relevant HSS Board which had statutory responsibility for the children being visited.
2.13 The SWAG inspection report, paragraph 5.1, while noting the frequency of Mother Regional’s visits as 3-4 times a year, did not contain a recommendation aimed at informing the administering authority of its statutory obligation and requiring it to comply in spirit and in practice.

Other monitoring arrangements (SNB-50028)

2.14 Written evidence to the Committee of Inquiry, referred to the establishment in October 1984 of a monitoring team, comprising NL 123, NL 42 and NL 35.

2.15 The status of this monitoring team was uncertain. Firstly NL 123 was a Medical Officer for the home and as such could not be expected to monitor his own activities. Secondly, monitoring is a function of executive management and it is not clear whether the team’s functions were advisory or managerial.

2.16 Written evidence to the Inquiry stated that "The appropriate member of the team is shown any complaints or records of untoward events which may have arisen and signs the record to show that their attention has been drawn to the event. Equally the member is free to conduct such enquiries as they wish and to report to the Sister-in-Charge and the Mother Regional as they see fit. At six monthly intervals the Monitoring Team is asked to produce a report of their work and their observations...... and a copy (is) kept to be seen by the Department’s inspection team."

Comment

2.17 In retrospect, the SWAG inspection might have included a recommendation aimed at clarifying the monthly visiting and reporting requirements of the 1975 regulations and indicating the need for improved monitoring by the administering authority.

2.18 The subsequent introduction of a "monitoring team" in 1984 was commendable as it brought a relatively independent perspective to the running of the home and a potentially helpful point of contact for both children and staff. It was not clear how this initiative fitted in with the statutory function of the administering authority as required by Section 4.2, or indeed the managerial functions of the Sisters-in-Charge.

Vetting of visitors to the home

2.19 Paragraph 8.6 of the SWAG inspection report 1983 refers to visits to the home by volunteers. The report commends this practice, “There are benefits for the children and staff alike in such arrangements. It allows children access to male company in a home, which is run entirely by female staff.”
Social Services (CSS) in Northern Ireland, maintaining close links with the social work training establishments. I worked closely with the training branch in the DHSS and provided advice about a range of matters relating to the development and on-going provision of training for social workers and social care staff in the Boards and voluntary organisations.

5. From a distance of 30 + years I have very limited recall of detail about inspections which I carried out for DHSS and none at all of the inspection of Nazareth Lodge in 1983. Apart from the 1983 inspection I do not recall having undertaken any other work with the staff or management of Nazareth Lodge. I certainly have no recall of any reference to abuse of the children from the 1983 inspection and I think it likely that, had abuse of children come to our attention, it would have remained firmly in my memory. Had there been any such concerns we would certainly have referred to them in the inspection report.

6. I have had the opportunity to examine the Departmental file which contains the report of the inspection of Nazareth Lodge carried out between 10 and 12 October 1983 by Mr Norman Chambers and myself (SNB 14316). There was a number of concerns identified in the course of that inspection and these are covered in the inspection report. However, we did not come across any harsh treatment of the children or unacceptable methods of discipline. Later correspondence between Mr Chambers and the Eastern Board confirms that the children did not make any complaints regarding their treatment in Nazareth Lodge during the inspection visits (SNB 19053). The report resulted in 19 recommendations for actions to be taken to improve the running of the Home (SNB 50522). The Home’s response to each of the recommendations is contained in a letter to the Department from the Sister-in Charge of Nazareth Lodge at that time (SNB 50406). The concerns that were highlighted from the inspection related to matters such as fire safety, insufficient attention being given to individual work with the children by care staff, preoccupation with cleanliness and tidiness and the completion of a range of domestic duties allowing less time for care staff to respond to the emotional needs of the children, a sense of frustration amongst care staff at how they perceived the Home being managed by the Sisters in a rigid and authoritarian manner, staff being talked down to and treated as underlings, petty rules, lack of interaction between care staff and parents (restricted mainly to the Sisters), lack of attention to training and the development of staff etc. We also commented on what we regarded as inadequate staffing levels. In only one of the three groups did there appear to duties carried out which in the inspectors’ view resembled appropriate residential social work. Much, therefore, was required to be done to raise the standards of care in the Home. All in all, it could be concluded that there was room for much improvement in how the Home was being run. This inspection, of course, took place at a time when many children’s homes were operated by staff with limited qualifications.
11.0 CONCLUSION

11.1 At present the home is acting as a general purpose children's home accommodating 36 children and young persons between the ages of 3 and 16 years. Each of the groups has a number of children who have been in care for some time as well as some short-term children. One of the stated objectives of the home is "to ensure that opportunities are provided... for children to realise their full potential and gain a measure of independence - thus ensuring an early return to their own community". However, half the children in the home have been there for periods of 2 years or more and a quarter of them for 5 years or more. Few of the children present serious behavioural problems for staff. It is considered that more could be done in some of the units to prepare residents for independence and it is recommended that management give consideration to ways in which this can be achieved.

11.2 The future demands in residential care are likely to be different. It is expected that increasingly the demand will be for residential placements for adolescents who present difficult patterns of behaviour and require residential care for shorter periods. It is considered the home is not at present adequately prepared to meet such a demand and that changes will be needed if it is to retain its viability in the longer term. It is, therefore, recommended that management discuss with the Eastern Health and Social Services Board what sort of service is likely to be needed in future and make its plans accordingly.
1. A special book in which is entered the date and time of Fire Drills and also the date of visits from the Fire Authority is kept in the home. A file is also kept for reports of Routine Inspections carried out by Fire Officers. Two of these are outstanding and I have requested that they be forwarded to us.

2. Officers from the Fire Authority have visited the home on the 1/2/84; 8/10/84; 10/12/84; 8/3/85.

3. The regular Fire Drills were resumed when the Fire Precaution work was fully completed and the Fire Alarm System had been checked and tested.

4. Regular Fire Drills are now carried out and efforts are being made to vary the time.

5. Group Meetings are held weekly within each unit.

6. Consideration has been given to the possibility of appointing male staff. Three have already been engaged as vacancies occurred.

7. The seconding of some staff to either the CSS course or the CQSW has received attention and the Department of Health and Social Services has been asked for financial assistance and to help with the placement of two staff on one or other of these professional training courses.

8. Whenever suitable Short training courses are advertised, the staff are invited and encouraged to attend them. At present with the assistance of the Department arrangements have been made with Rupert Stanley College to have in-service training given to all our caring staff in a course extending over a twelve week period. This training is given one day per week and commenced on the 13th. March.
9. We have changed over to straight shifts and this minimises the amount of domestic chores allocated to each individual staff member.

10. Primary worker system was already introduced into one group at the time of the Inspection. It is now working well in the other two groups.

II. Parents have always been made to feel welcome and are encouraged to visit the children. They are invited to involve themselves in the physical care of the children and when appropriate to partake of a meal with them. We are aware of the importance of the relationship between child and parent and we realise that any work undertaken with the child must of necessity include the parents.

I2. It has always been our policy to make appropriate enquiries about the character of persons offering to do voluntary work. Since our Inspection, however, we have asked for this information to be given in writing.

I3. The evening meal is now cooked in each of the three units on four evenings in the week. The menus for all meals were arranged by the head of unit after consultation with staff and children.

I4. Children are involved in the preparation of their own meals in the group kitchens but to date no decisions have been taken regarding the purchasing of food.

I5. In each of the three units there is a book set aside for recording events of importance.
I6. Copies of relevant court orders are obtained from Social Services on request.

I7. Delays still occur in receipt of reports - but demands are made of fieldworker to forward minutes of reviews as soon as possible.

I8. Opportunities are provided within each unit to help prepare children for independence. Consideration is being given to the possibility of using part of the top floor to further prepare residents for independent living.

I9. In forthcoming meetings with the Area Board issues will be raised concerning future trends in Child Care. We feel confident that Nazareth Lodge will make every effort to meet the required need and work in conjunction with the Eastern Health & Social Services Board.
COMPLAINTS PROCEDURE

1. Complaints form an important means by which practices which have to be rectified can be brought to our attention. They should be regarded in this light and, while it is not the intention to make children, or their parents, complaints conscious, there needs to be a procedure which is understood and operated within these guidelines.

The purpose of this document is to outline:
(a) what typically constitutes grounds for complaint;
(b) how complaints should be handled, investigated and monitored;
(c) how children and parents should be made aware of the Complaints Procedure.

2. Grounds for Complaint

The Department of Health and Social Services has given a useful guide about grounds for complaint. It is pointed out that a child may, on the basis of previous experience within his or her family, actually expect harsh treatment from staff and if the child does not realise that such treatment is contrary to good child care practice and in breach of the rules applying in the Residential Unit, he/she may accept the treatment without complaint. This fact must be borne in mind by all who have a responsibility for the care of children in our Homes.

3. Abuse and ill-treatment in Children's Homes can be said to fall into the following main categories:
   excessive physical punishment
   physical ill-treatment
   psychological ill-treatment
   sexual abuse
   bad institutional practices
   neglect or lack of care

4. What is required is a definition of ill-treatment which will be readily understood by children in care and their parents. It must also command widespread support and be workable. The definition of ill-treatment in residential care contained in the booklet given to children in care by Durham County Council is as follows:
   "(a) all forms of punishment to the body, for example, striking, slapping, smacking, shaking or kicking;
   (b) not letting you have meals;
   (c) stopping you visiting your parents when it has already been agreed;
   (d) actions by staff that make you look small, such as not talking to you; being blamed for everything, being made to wear second-hand clothes, or clothes that don't fit you; or being kept in pyjamas all day or being made a fool of, etc."
being locked up in a room;
(f) when the staff run down your parents to you or other children;
(g) being punished when you wet your pants or your bed;
(h) anything that takes away your dignity, or self-respect, in other words, makes you feel small."

5. The above list may not be totally comprehensive but does give an indication of the types of complaint which are likely to be a cause for concern.

6. Handling of Complaints
   (a) Receipt and Investigation
      The following procedures shall apply:
      (i) Written complaints should be acknowledged to the complainant and recorded in the Complaints Register.
      (ii) The complaint should be investigated promptly by either the Sister in Charge of the Home or by a person designated by her.
      (iii) If the complaint is made against a member of staff then he/she should be so informed. If the complainant alleges either physical ill-treatment or sex abuse then the member of staff should be suspended from duty, with pay, until an investigation can be carried out. In such cases Mother Regional must be contacted immediately and will advise on the form of investigation to be carried out.
      (iv) The complainant should be informed of the outcome of the investigation as soon as possible.
      (v) Serious complaints (i.e. such as those defined under paragraph 4.) made verbally must also be recorded in the Complaints Register and the same procedure followed as that laid down for written complaints.

7. Monitoring of Complaints
   The purpose of monitoring complaints is to satisfy those responsible for running the Home that there are no untoward practices being followed and also to establish if there are any trends in the types of complaints being received.
   The following procedure will be adopted for the monitoring of complaints:
   (a) The Complaints Register will be used as the basic reference point and, where available, the original of the written complaint should be kept in a file cross-indexed to the Complaints Register;
   (b) It will be the responsibility of the Head of the Home and the Mother Regional to review constantly the material entered into the Complaints Register. The Complaints Register will also be a prime record which it is understood will also be examined by officials from the Department of Health and Social Services and Social Workers from the Eastern Health and Social Services Board.
8. The Order intends to evaluate the use of an effective external committee to be established in Nazareth Lodge. The committee will comprise three persons who will not have a management role but will be encouraged to visit the Home; be made aware of the complaints received and make such enquiries and investigations as they believe appropriate. The arrangement will be established for the period of a year in the first instance and within this period a decision will be taken as to whether the practice should be extended to other Homes or is worthy of being continued.

9. How Children and Parents should be made aware of Procedure

Children coming into care will be seen by the Head of the Home and will be told how to make a complaint if this should be necessary. Parents will similarly be interviewed as soon as possible after the child's admission and will also be told of the Complaints Procedure.

Children will be encouraged to discuss matters with the Head of their section, the Head of the Home or the Social Workers visiting the Home. At this time it is not proposed to use cards as a means of communication to the Director of Social Services.
Q. Obviously there is the ultimate weapon of deregistration, but short of that were there any sanctions that you could apply or was it just a matter of advising?

A. I can't think of any sanctions other than encouraging, advising.

Q. And this would have been kept entirely between the Department and the home in question?

A. I guess so.

Q. Okay. Thank you very much.

A. Okay.

CHAIRMAN: Now, Victor, thank you very much for coming to speak to us today. That's all we need to ask you.

A. Thank you.

(Witness withdrew)

CHAIRMAN: We'll sit again not before 2.15, ladies and gentlemen.

(1.22 pm)

(Short break)

(2.15 pm)

CHAIRMAN: Ladies and gentlemen, I am sorry to have kept you waiting rather longer than we anticipated, but there were some administrative arrangements that we had to deal with before we could resume the hearings this
HISTORICAL INSTITUTIONAL ABUSE INQUIRY (HIAI)
STATEMENT BY FELICITY BEAGON

1) I am a former Inspector with the Social Services Inspectorate (SSI) now several years past retirement. I have been asked to provide information regarding my involvement with Nazareth House and Nazareth Lodge Homes to assist the HIAI. However, my personal circumstances are such that I have only recently been discharged from hospital, having suffered a significant back injury in a fall. I am in continuous pain to the extent that I have been referred to the pain clinic and am also trying to fulfil visiting responsibilities towards my sister who lived with me and was recently admitted to nursing home care. I have produced the information below only with some difficulty and would respectfully request that in view of this, I might be excused from providing oral testimony to the HIAI.

2) I was a member of the Social Services Inspectorate (SSI) from 1987 to 1994. My social work career commenced as a social worker in the Belfast Welfare Department. Following this, I held various senior positions prior to my appointment as a Principal Social Worker in the Northern Health and Social Care Board where I had responsibility for child care services and in particular child protection and fostering services. I held this post for 14 years before joining the Social Services Inspectorate (SSI) in 1987. I retired early from the Inspectorate in 1994.

3) During my employment with SSI, I had no involvement with Nazareth House Home which I understand closed in 1984. However, I inspected Nazareth Lodge Children’s Home on five occasions between 1988 and 1992. Each of the inspections considered:

- The Purpose of the home
- Children and Young People resident
- Staff
- The Premises
- Compliance with the regulations
- Monitoring arrangements
- Complaints procedure
- Financial position

4) With the passage of time, I have little memory of the detail of these inspections. However, I recall that the process was thorough, involving an intensive 3-day period spent in the home, interviewing staff, attending staff and other meetings scheduled during this period, reviewing files and other documentation as well as mingling informally with the children. On each occasion I discussed all issues relevant to the inspection with the Heads of
each of the three groups and in this respect, I particularly recall interviewing SR 18, SR 148 and SR 52. I also had discussions with staff and children's primary/key workers who were on duty while I was present in the home. The general practice of SSI Inspectors was to attend staff meetings. I believe I also met members of the administering authority, including the voluntary visitors. Although I did not meet with the home's medical officer, I sought written reports from him.

5) Whilst I did not formally interview children, I always took the opportunity to speak with those who were around during the day and in the evenings with a view to seeking to engage the children's interest, explaining the purpose of the inspection and offering them the opportunity to speak to me privately about any matter that they wished. I also inspected the menu, fire drill and important events books that the home was required to maintain under the children's homes regulations. Additionally homes, held a 'sanctions' or 'punishment book which I reviewed.

6) Departmental files evidence that I sought information from Health and Social Services Boards' Units of Management who had children placed in Nazareth Lodge, about their satisfaction with the care provided by the home.

7) During the periods of my inspections I found the home to be run satisfactorily with a good standard of care being provided to children. Despite a high turnover of staff there seemed to be a happy atmosphere in the home and the staff group appeared to be very committed to the children. The lists of untoward incidents during these times indicated that the home was caring for children with very unsettled backgrounds and who presented, at times, extremes of challenging behaviour. Staff appeared to be dealing well with these difficult situations and any child protection concerns were properly actioned by the home. Indeed, during one inspection, a Board was appropriately investigating complaints made on behalf of some of the children. However, relationships with Boards' staff appeared to be very good and social workers were visiting regularly. The Boards were generally content with the care the children were receiving. The reports of the medical officer for the home also did not reflect any concerns about the health or care of the children.

8) I recall that the home's management was trying to improve the level of staffing and the training needs of the staff. During this period the number of children was reduced to thirty children and the per capita rate agreed with the Eastern Health and Social Services Board was raised from £287 per week to £450 per week. This helped to increase staff levels and salaries. The Board had also agreed to second three members of staff on the CSS Course.
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Eastern Health and Social Services Board was raised from £287 per week to
£450 per week. This helped to increase staff levels and salaries. The Board
had also agreed to second three members of staff on the CSS Course.
9) Recommendations arising from the inspections concerned the organisation of children's file materials and fire drill records. It was also recommended that the three voluntary visitors should establish a routine pattern of visiting the same group so that children would become very familiar with them. There were also continuous concerns relating to the institutional character of the building in which the three children's groups were located and my recommendations included the need for the home to move to smaller units in the community.

10) Each home was required to return monitoring information annually to the Department. This information was passed to relevant inspectors and I commented on a number of returns made by Nazareth Lodge. The information within them gave me no cause for concern.

11) At no time during my inspections or involvement with the home did I receive any complaints from children or staff regarding any issues to do with the care of children nor did I have reason to believe that the care regime within the home left children in any way vulnerable to physical, sexual or emotional abuse.

Felicity Beagon  
09/03/2015
NAZARETH LODGE CHILDREN’S HOME, BELFAST


2. I undertook the annual inspection of Nazareth Lodge Children’s Home, Belfast, between the 4th and 11th January 1993. Mr N J Chambers, Assistant Chief Inspector, was the Inspection Manager. At the time of this inspection no Departmental Medical Officer was involved in children’s homes inspections.

3. In total the inspection took 58 hours to complete, excluding preparation time and the writing of the Inspection Report. At the time of the inspection 24 were resident although the home was registered for 30 children.

4. I have no recall of the inspection or the concerns expressed to me by [NL 269] on the 26th January 1993. The following comments are, therefore, based on a review of the inspection file prepared by me in 1993, the Witness Statement prepared by [NHB 137] dated 25th January 2015 (SNB-6092) and his Oral Evidence to the Panel on 25th March 2015.

   (i) Issues emerging from the Inspection

5. From a review of the Inspection Report the key issues which were of concern to me in 1993 were:

   - the plan to establish 4 units with a specialist remit without addressing the issue of short-term placements or the care needs of pre-adolescent children; (Para 2.5)
   
   - the plan that each of the specialist units would retain an intake function and the potential for this to “place some children at considerable risk”; (Para 2.5)
   
   - doubts regarding the advisability during 1992 of having admitted children aged 8, 7 and 6 years on a short term basis to Units 1 and 2 given “the behavioural difficulties of the resident adolescents and the pattern of long-term provision; (Para 2.5)
   
   - the adequacy of the staffing complement, examples include:
and another large children's home all on the one campus, so that would have been not my expectation of a children's home, but having said that, once you got into the homes the Sisters had made considerable effort to personalise the homes, to make them domestic in nature, and they had done that as much as they could, given the structure of the buildings and the premises that they had, but I felt that because of where policy was going, that these homes were in the transition. They had been very large. They were reducing in size, and to me it was inevitable at some stage in the future these homes would no longer have a function, but in the meantime that they should operate in a way which was as domestic as they could make them, and I do think that considerable effort was put into making them as domestic as they could within each of the units.

Q. Yes. So the unit itself did reasonably resemble what a small children's home would look like, albeit when you went out that double door, you were into something that obviously wasn't a small children's home?

A. That's right.

Q. I'm going to use a colloquial phrase. Cutting to the chase, because there is 29 pages of your report and I am not going to pour over it, but you will probably tell me understandably you don't have an acute memory of the
complaints, because if they dealt with something informally, they didn't view it as a complaint. So I did notice that, but I would have gone through the children's records and the daybooks. So if there were behaviours that I thought were untoward that hadn't been recorded, I would have picked that up, because I did check those.

Q. That's very helpful. That's a helpful clarification for me. Can I just ask in terms -- and this is the final one you will be glad to hear -- in relation to the hierarchy you have obviously got Dr McCoy above Mr Chambers.

A. Uh-huh.

Q. Was there the potential within the Inspectorate, if you and Mr Chambers had a different view about something, to go forward and escalate it up to Dr McCoy or would that not just have been the thing to do?

A. It wouldn't have been the thing to do.

Q. Okay. Thanks very much.

MR LANE: When you were discussing the staffing and you said that the staffing wasn't ideal, it was a bit thin in the event of problems, were you making this observation just simply on what people had said to you and your own reading of the situation or did you actually apply any sort of formulae or guidance that there was on the
staffing levels for residential homes?

A. Well, we always looked at the levels using the Castle Priory measures.

Q. Right.

A. So they were within the requirements, but it didn't -- there was no -- because of the size of the home, it didn't give them any margin of error. That was basically the problem, particularly at school holiday times, where you've staff going on leave and you've children at home, so those sorts of things, but once you get the voluntary visitors' reports, you will see that over the summer holiday period that the team leaders did use considerable imagination to keep the children occupied during the day outside of the home. So that probably helped them to cope with not having a staffing level that I would have thought would have given them a bit more ...

Q. What sort of assumption was made about the number of hours that the Sisters would work?

A. The Sisters seemed to work all hours. They did -- they were on -- they manned the roster during the day and then they did sleeping. So it just seemed to be that the slack was taken up by the Sisters. They didn't have a set working week from what I could gather.

Q. I appreciate they may have actually worked all hours,
13. **RECOMMENDATIONS**

The following recommendations are made on the basis of the Inspection.

1. In Bethlehem House more lighting should be available in the bedroom corridors. Consideration should also be given to the relocation of light switches to children’s bedrooms in unit 2. (Sections 3.3 and 3.4.)

2. Recording practices should be afforded higher priority. (Sections 4.3 and 12.2(k).)

3. The keyworker role should be reviewed to ensure uniformity of work practice across units. (Section 4.7.)

4. The Medical Record Card should record all relevant family and personal medical history and all contact with the doctor. (Section 5.4.)

5. Each unit should maintain a drug administration book. Medicines and drugs should be stored in a locked medicine cabinet. (Section 5.5.)

6. Children’s house-meetings should be promoted. (Section 7.4.)

7. Care information and details of the complaints procedure should be readily available to children and their parents on admission. All complaints should be recorded in the complaints register. (Section 8.2 and 8.3.)

8. Clothing monies should be used as designated. (Section 8.5.)

9. Greater variety in the menu is recommended. Consideration should also be given to rescheduling the main meal to tea time, during week days. (Section 8.6.)

10. Children should have ready and private access to a pay telephone. The number and location of pay telephones should, therefore, be reviewed. (Section 8.8.)

11. Admission criteria should be established for each of the units to ensure the appropriate placement of new residents. (Section 9.2.)

12. The current sleep-in arrangements should be reviewed. (Section 9.6.)

13. The work practices of the Team Leaders should be reviewed to ensure priority is afforded their managerial duties. (Section 11.8.)

14. Consideration should be given to establishing a pool of relief workers to provide a back-up system of temporary workers. (Section 11.10.)
15. Staff should be regularly support through formal system of supervision and team meetings. (Section 11.11(ii) & (iii)).

16. The time and day of fire drills should be varied. Children should be encouraged to use their nearest exit point when vacating the building. There should also be adherence to fire door regulations. (Section 12.2(f)).

17. The religious and cultural practices of non-Catholic children should be respected and promoted by the care practices within the home. (Section 12.2(g)).
Q. Marion, I also -- just for completeness, I did say to you and you agreed that you would look in what remains of your archive to see what other departmental material you might have that would assist the Inquiry, and you will come back to me on what you find in addition to whatever version of the manual you have. We may need to ask your assistance further and I hope you will be prepared to do that.

A. Thank you.

Q. I am not going to ask you any further questions now, Marion. The Panel Members may want to ask you something. So if you just bear with us for a short time, please.

Questions from THE PANEL

CHAIRMAN: Marion, I would like to pursue, if I can, two quite distinct matters with you. In your report, if I have noted it correctly, you noted that the staff during the inspection of Nazareth Lodge were on the low side. So there was a lack of -- there was over-reliance on the Sisters to step into the gap if there was a gap created by a sickness or holiday leave or resignation or whatever. So the picture, as I understand it, from what you found at the time was the staffing level was just about adequate.

A. (Nods.)
Q. It couldn't be condemned as inadequate, but it wasn't ideal. Is that a fair summary?

A. That would be fair, yes.

Q. Another aspect of the staff attitude was that -- we have heard ten years before was they felt they weren't -- their views weren't even asked, let alone given any weight at all. Did you get any impression that was the position as far as the staff vis-a-vis the Sisters were concerned?

A. Well, there was different views expressed by staff, and in the report I mention that some staff did feel that their views were of secondary importance. Now as part of the inspection I would have spoken to as many staff and children, visiting social workers and if there were parents visiting as possible. So by my action I sought to give staff the impression and the view and the acknowledgment that their points of view and their comments were as important to me as the managers of the home.

Q. But some of the staff, but not all, therefore, indicated a degree of unhappiness with the position. Is that what you picked up?

A. Yes. Some of them obviously felt they weren't being given enough freedom to act or their views weren't taken into account --
13. At the conclusion of the telephone conversation I prepared a note of concern for Mr N J Chambers, the Inspection Manager and my line manager. Mr Chamber's response of 2nd February 1993 stated:

"While expression of concern confirms your own findings I don't think it can be used, unless he makes specific complaints in writing."

14. My practice prior to this date (January 1993) and subsequently would have been to make no distinction between either a written or verbal complaint or an anonymous or known source of concern regarding children's well being and protection. It is apparent from Paragraph 3 of my notes of my telephone conversation with dated 26th January 1993 that I planned to follow up his comments with the Administering Authority.

15. I am, however, unable to recall what further discussions or action occurred following receipt of the note from Mr Chambers, dated 2nd February 1993, in respect of the handling of concerns.

16. A letter on the Inspection file dated 29th March 1993 shows that I was seeking to acquire written confirmation from in respect of the matters raised by him on 26th January 1993.

17. On 8th June 1993 Mr Chambers (Inspection Manager) and I met with the Management Committee. The concerns raised by were at that time recent and had been raised in the context of the Inspection. I would have expected that an agenda for the meeting would have been discussed by Mr Chambers and me prior to meeting with the Management Committee, an expectation which is apparent from my memorandum to Mr Chambers dated 5th May 1993. I have no recollection whether concerns were shared with the Management Committee during this meeting. I note that they were not reflected in my handwritten notes prepared after the meeting.

18. It is clear, however, from the Inspection file that the content and recommendations of the Inspection Report caused concern within Nazareth Lodge's Management Committee and that particular concerns were expressed at the costs associated with addressing sleep-in arrangements within the home as recommended.

Marion Reynolds
03.04.15
"It works on a one to one basis, trying to nurture and stretch children to the best of their ability".

"Nazareth Lodge provides high standards of physical and emotional care for children - it emphasises treating children as individuals".

"It delivers a high level of primary care and work in social and personal development despite the adverse structure and layout of the building".
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APPENDICES

Appendix 1 Brief for the Inspection
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Appendix 3 Health and Safety and Fire Risk Assessment Report by Assessor from Management Executive Estate Services Directorate
1995. I was not the Inspection Manager for this inspection and can only comment in general terms based on the information supplied.

What the Department did when it was made aware of complaints from a number of individuals in the home about how a member of staff was behaving.

7. Nazareth Lodge was inspected in October/November 1995. The Brief for the Inspection is set out in Appendix 1 to the Inspection Report [SNB 14240] and this included an examination of the monitoring system and the operation of the complaints procedure. As part of the methodology for the Inspection the Directors of Social Services and Trust Managers were informed by letter that the Inspection was to be conducted. This would have provided the HSS Boards with an opportunity to convey any specific complaints they had received about the care of children for whom they were responsible in the home. There is no indication in the Inspection Report that any HSS Board informed the Inspector that they had concerns about the care and treatment of children in the home.

8. Paragraph 6.4 of the Inspection Report [SNB 14219] refers to the identification of complaints through discussion with children and the completion of questionnaires by children. As a result the Inspector wrote to the management of Nazareth Lodge and the HSS Trusts responsible for the children involved. See Miss Chaddock’s letter of December 1995 [SNB 17967].

How the complaints detailed in the documents presently available would have been viewed by the regulator and its inspectors at that time.

9. The complaints that were identified by the Inspector were deemed to be very serious. The Inspector had examined the monitoring report for 1994-95 prior to the Inspection and commented [see SNB- 14230] that the type of incidents of importance recorded varied from minor accidents to more serious incidents such as aggressive behaviour and self-mutilation.
Ministry of Home Affairs, Northern Ireland.

Mr. Sec H.

As directed by the Ministry, I made a complete inspection of Argrett House Industrial School on the 17th inst. and a copy of my report thereto is attached.

As regards the boy NL 161, I found that he was not under detention, so that the W.I. is not directly responsible for him. This case is mainly important as indicating the treatment to which the Industrial children might be liable under similar circumstances. In any case he ran away again, and is now in the crin who has been at present Hospital (for children) at the Belfast Union Workhouse.

I questioned [REDACTED], who said that she had stricken him on the hands with a stick (not a slapper) on the morning before he first ran away, as he had not only wet but soiled his bed, and that the latter does seem likely to be wilful. She denied having beaten him again on the following morning, when he says he was stricken on the legs. It would appear that he ran away three times altogether: first on the day his hands were slapped, second on the following day when the alleged beating of his legs is said to have occurred, and lastly after his return by the police, when he was not sent back. Both [REDACTED] and [REDACTED] say that the boy is a liar and generally unsatisfactory. They seemed to think, however, that punishment is the right way to deal with unruly boys, pointed out to them with some care the acknowledged fact that
punishment is not the proper way to deal with these cases, but on the contrary is liable to make them worse. They informed me that the wetting took place not only at night with but sometimes in the day also, so that he had to be sent from class. He would not impress one as a cruel person.

On the following day, 15th inst., I visited the boy at the Bufferi Hospital, where he was in bed, being treated for various small sores, which seem to be healing. One on his knee he said was caused by scrubbing floors, one on his left hip by being unable to lie on the wire mattress without a hair mattress over it after the latter had been wet. He persisted in saying that he had been beaten on the legs on the day he ran away the second time. [I should mention that the Manager informed me that though not beaten on this occasion the boy had had a girl's paddicat put on him as a punishment]. He also said that other boys who offended in the same way were also beaten, but this caused gave me the impression that he believed that he was telling the truth. He is a well-nourished, rosy-faced child, of above average mental ability, and he said he had reached the fourth school standard, which is not bad for a boy of 12 years. Beyond bed-wetting he has given me no trouble at the hospital, which I find myself unable to judge between his statements and those of others, but undoubtedly would be accepted in court. It is admitted, however, that the children at the school are punished for bed-wetting, though should be stopped, whatever the form of punishment.

W.D. 
9/5/27
On 4.5.27. I was asked to see a boy named [redacted] at the Nazareth by Dr. E. McSorley. I obtained the following history:

That the boy ran away from the Home on Monday and was brought back on Monday night; ran away again on Tuesday; a policeman brought him back on Tuesday night; he was found by a man in University Street on Tuesday who took him to the Donegall Pass barracks. He thinks he was seen by a doctor at the barracks.

On questioning the boy as to whether he had any pain or made any complaints he said that he had pain in the right side and also in the left side; that he had some trouble there since before Easter; in fact, he admitted that the pain had been there for a very long time. He also said that he had chilblains on both hands; that he had a sore on his right knee and that he had also bruised his left knee by a fall on the ground.

On examination:

1. There is right hand is swollen. Many chilblains occur on the fingers; on the back of the wrist there is a tiny mark about 1" long like a crack in the superficial layers of the skin. Above this mark there are two smaller marks which resemble pustules which had healed up.

2. The left hand. There is a small pustule in the middle of a chilblain on the index finger. The little finger shows an ulcerated chilblain. The whole hand is considerably swollen.

3. Right thigh. Over the great trochanter there is an ulcer in a healing condition and several smaller healed scars in this neighbourhood.

4. Right buttock. There is an almost healed ulcer over the buttock.
5. Left thigh. Over the great trochanter there is an ulcerating patch with some purulent secretions dried up over it.

6. Genital organs. The foreskin is very long and cannot be drawn back. Both testicles are undescended.

7. Feet. Both feet are somewhat flat and there is evidence of old chilblains on several of the toes. There is no sign of either leg having been beaten.

8. Knees. The right knee shows a bruised area as if he had fallen. There are also abrasions on the left knee.

The boy is well nourished and warmly clad. 

I obtained the history that he frequently wets the bed and I enquired from the boy himself and he made the remark that only once or twice has he remained dry at night.

I came to the following conclusions:—

1. There is no evidence of any unusual injuries to this boy with the possible exception of the very tiny crack on the back of the right wrist.

2. The condition of the hands are strongly suggestive of the sores that occur in cases of chilblain. This view is supported by the condition of the feet. The sores on the hips are unquestionably the result of nocturnal enuresis.
Alleged corruity to Nazareth Lodge

City of Belfast

The Constable

Before taking any further steps in this case I beg to ask for a direction in the matter.

I agree with the report of Sergt. Taylor and am of the opinion that the evidence would scarcely sustain a prosecution for corruity.

There is no doubt but that the boy got beaten rather severely, but in the circumstances it was justifiable to a certain extent.

On the morning the boy left the home it was very cold, and this, in my opinion, had the effect of causing the marks after the beating.

Immediate

Inspector

Submitted for Laura's information.

Please understand these papers are
In fact it seems at the present 2
Home Affairs.
Whilst this may undoubtedly
appear to have been severely
punished, I doubt if in the circum-
stances, if a prosecution for cruelty
would be likely to succeed.

URGENT.

Submitted... it is
doubtful if a prosecution
would be successful
in this case.

S. Williams
S. J. for S.J.
Alleged cruelty to NL 161, Nazareth Lodge.

City of Belfast

Don gull Pass,
5th May 1927.

I beg to report that at 9-30am on the 3rd inst, Belfast, brought to this barracks, a boy known as NL 161, Illy, inmate of the Nazareth Lodge, Ravenhill Road, whom he found wandering on the Rugby Road in his bare feet in a very scantily dressed condition.

I was not in barracks when he was brought in but arrived ten minutes later. On interrogating NL 161, he informed me that he had been severely beaten in the Nazareth Lodge on the previous morning the 2nd inst by Sister SR 206, who he alleged beat him severely on both hands, back and front, with a stick for wetting his bed. He also alleged that on that morning the 3rd inst she beat him severely about the legs with a strap for wetting his bed.

I examined NL 161 and found his hands and fingers bearing traces of Chilblains some of which appeared to have been broken, both hands and fingers were greatly swollen and there were distinct strap marks on both wrists.

His legs from the thighs down to his feet bore distinct traces of severe strapping and appeared to be in a very bad condition as when I pressed my fingers on marked portions he complained that his legs were very sore.

I immediately telephoned for Dr Dixon, who arrived about 10-15am and after examining the boy gave as attached certificate.

I detained the boy in barracks and telephoned to the Nazareth Lodge for his clothes which were sent down later.

In company with Sergt Stanley of Ballynafeigh barracks I visited the Nazareth Lodge at 9-30am same day where I interviewed Sister SR 206, who brought in the Revd Mother and another Sister of the Home to the interview.

I informed SR 206 of the serious allegations made against her by the child NL 161, relative to the mornings of the 2nd and 3rd inst, she admitted slapping him on the hands on the 2nd for wetting and mending his bed but she denied interfering with him on the morning of the 3rd.

I then informed her that he had been examined by a Doctor and read the certificate and asked her if she could account for the injuries to the boy's legs; she replied that she could not unless he had been fighting with some of the other boys in the Home. She also said that the boy was not under her control on the morning of the 3rd but under that of the other Sister who was present at the interview, the latter supported this statement and said that XXX he was under her care that morning and that he disappeared from the Home about 8-30am. She said that she did not beat him or see any other person beat him that morning.

Dr Edward McSorley, called with me.
at 9p on the 4th inst and informed me that he had examined
the boy that morning at 10-15a and showed me a certificate
that he had prepared in connection with the matter, this
certificate goes to show that there were no traces of the
alleged illtreatment. I asked him about the boy's hands
and he admitted that they were in a bad way from Chilblains,
I asked him was the Sister justified in slapping him on the
hands with a stick and his hands in such a condition and he
replied "She was not". He also informed me that Professor
Irwin of examined the boy at 5p same date
4th inst and would sub it a certificate later, this certificate
was produced to me this morning by Dr McSorley and he says Dr
McSorley's views i.e. that there were no traces of the
alleged illtreatment.

On the evening of the 3rd inst on receiving a promise
from the Revd Mother that the boy would not be punished for
what had taken place and would be properly treated I had him
sent back to the Home.

There are upwards of 200 children in this Home, all of
who appear to be well cared for and I have not heard any
complaints of illtreatment previously.

I learned from the Revd Mother at my interview that the boy is a filthy boy who wets
diarrhea his bed clothes every night and under these
circumstances. I believe that he did receive the beatings complained of by him, at the same time if a prosecution for
crimility was instituted I have no doubt that the evidence of
the Sisters and the Revd Mother would be believed before that
of the boy, a copy of whose statement I attach.

B. [Signature]
Sr. I.254.
3.5.21

This is to certify that Jane Doe this morning examined

There is evidence of severe bruising

on both thighs and calves; also on

both wrists. Her hands are swollen,

but states they are swollen every minute.

Several serpice spots on buttocks

do not appear to be finger or left

hand. His appearance is consistent

with having been beaten with a

strap.

Edwin MB.
LILY, states I have been in the Nazareth Lodge, Ravenhill Road, Belfast, since I was a baby. Miss [redacted] is in charge of the boys in the Home.

Yesterday morning the 2nd inst I wet my bed and came to me when I was dressed before Mass, she had a stick in her hand, she called me out to the passage, caught me by each hand and beat me severely with the stick on both back and front of each hand.

She then sent me to my class and I got ready for Mass.

I wet my bed this morning and came in to where I got my breakfast, she called me out and then sent [redacted] who was in the room with me out, she ordered me to stand up and she then beat me severely about the legs with a strap. She then ordered me to go scrubbing and I went down a field and ran away by the River Lagan. No other person in the Nazareth Lodge or elsewhere beat me.

I am afraid to go back to the Home.

Signed.

[LILY]
to leave Nazareth Lodge. In October 1976 it was suggested to [HIA 41] that he move to Rubane where his older brother [DL 87] resided, see exhibit two. He did not wish to move as he did not have a good relationship with [DL 87] but had a close relationship with his younger siblings [NL 57] and [NL 56] who were resident in Nazareth Lodge.

4. In March 1977 [HIA 41]'s behaviour became very unsettled, truanting from school and absconding from the home as described in exhibit one. [HIA 41] told me that he wanted to move to Rubane, and that he behaved in this way hoping he would be moved to Rubane as a result. He also told me that he missed [SR 30] who had left the home to take up a full time teaching post. His unsettled behaviour continued and in May 1977 [HIA 41] told me that he did not like Nazareth Lodge because [SR 46] and [_____] treated him like a child. My records indicate that [SR 46] and [_____] found it difficult to cope with [HIA 41]'s behaviour. A place was available for him in Rubane and my records indicate that when I advised him of this he was 'delighted'.

5. I transferred [HIA 41] from Nazareth Lodge to Rubane on 6 May 1977. The records indicate that he was upset leaving Nazareth Lodge but 'cheered up' on the way to Kircubbin. Social Services records indicate that [HIA 41] settled well in Rubane.

6. During this time [HIA 41]'s sister [NL 57] born [_____] told me that she was unhappy in Nazareth Lodge. In June 1976 she told me that [SR 62] had hit her shortly before my arrival at the home. She was not upset at the time. She told me that she had been disobedient and I thought that she may have said this to deflect from her behaviour as she had not previously reported Sister [SR 62] hitting her. I recorded this and advise my line manager. I had not recorded advising my line manager but can recall doing so. On reflecting on this incident I realise that this would now be dealt with in a very different manner. At the time, however, I did not believe that [SR 62] would have hit [NL 57] and thought that she had a good relationship with her.
OUTLINE OF CASE*

(Give salient facts in chronological order with clarity and brevity. Do not merely repeat witness statements. Where more than one person reported summarise the case against each.

Whilst the aim should be to summarise the facts on one page, a continuation page may be used if it is necessary for the inclusion of all the salient facts.)

This file concerns the alleged assault of a number of persons while they were detained at Nazareth Lodge Children's Home in Belfast between 1971 and 1981.

The subject of this report is Sister [redacted] (formerly known as [redacted]) who was at the home between 1964 and 1981.

She now resides at [redacted].

The complainants were traced and interviewed by police after an investigation was launched into Nazareth Lodge Children's Home, Belfast following a number of complaints from children who were resident there and these are the subject of separate files.

Allegations

1 NL 57 [redacted] was a resident of Nazareth Lodge Children's Home in Belfast from March 1971 until 1981. When interviewed on 22.1.96 she stated that she had been assaulted a number of times within the home by nurse [redacted] for smoking and not doing her duties.

She further stated that when she asked why she was in the home she was told by Sister [redacted] that she wasn't wanted by her mother, that she was a 'drunken whore'. She alleges that on one occasion she was smoking in one of the staff bathrooms when she was discovered by nurse [redacted]. Sister [redacted] lashed out at her punching her on the eye and mouth. Her lip was cut and it started to bleed.

The following day NL 57 [redacted] eye had blackened and she had a cut to her lip. Nurse [redacted] observed NL 57 injuries, she told her if she knew what was good for her she should say that she fell. NL 57 states that she told none of the children within the home what had happened to her and that none of the staff asked her how she got her injuries. NL 57 did not receive any medical attention for her injuries. (Part II, pages 1-2 refer).

I certify that all witness statements taken by police in connection with this investigation are included in this file.
- 'cos we're going from records which are recollection of the children's instance -

**SR 62**

Yes.

- although you may have better records than us.

**SR 62**

Yes.

OK. Right, the first ah, allegation that we wish to deal with ahm, is made by a girl called **NL 57**

**SR 62**

Yes.

Now have you any recollection of that names.

**SR 62**

Yes I know her very well, I knew her very well.

You knew her.

**SR 62**

Yes.

And she would have been, according to her recollection been in the home around 1971.
Yes I should imagine so yes.

Right OK. Now ah, she came with her brother actually to the home.

That's right.

And subsequently ah, 2 other brothers also came to the, the home and then subsequently went to Kircubbin.

Yes.

Right, what she says is that ah, as her time in the home passed by and she got older she began obviously to question the reasons for her being -

Yes.

- here in the first place. And she specifically mentions that she questioned you -

Yes.

- about why am, why am I here.
SR 62

Yes.

What she says that oh, you, you said to her that oh, she wasn't wanted by her mother and that she was nothing but a drunken whore, that's referring to her mother obviously -

SR 62

Well.

- ahm, now, I'll ah, she said that distressed her. Ahm, have you any recollection of any such conversations.

SR 62

I think that's a, a lie.

You would think that's a lie.

SR 62

Yes I do indeed, she never questioned it.

She never questioned why she was in the home.

SR 62

No, no.

Right. Right. Now she further goes on to say that oh, she was assaulted by you on a number of occasions for very very minor things, maybe not doing her duties in the
home and I believe the children maybe had some task to perform would that be correct, to your recollection.

No it's quite incorrect, because I had a good staff in the home and they looked after the children very well.

Yes. Now what I, what I mean is actually the children themselves, would the children have had any duties within the home.

Ah, what do you mean now.

Well say maybe washing the floor or.

Oh no, no way because the place was carpeted from wall to wall.

Well I use that as an example Sister as ah.

Yes.

I would say obviously minor duties what I'm talking about.

No, no, no.
Children would have absolutely nothing to do.

No domestic help at all.

No domestic duties whatsoever.

No.

Ahm, would any of the children smoked?

Well actually did smoke but I didn't know it, but she didn't ever smoke in front of me in the home.

Yes did you ever catch her smoking.

No I never did.

Right.

But I knew she smoked because ah, one of the staff gave her a cigarette.

One of the staff gave her a cigarette.

Em.

Ahm, what actually she says that ah, you
assaulted her on one occasions for smoking.

No I've never seen her smoking.

OK.

She never smoked in my presence.

Right ahm, do you remember a child called

Yes, yes.

Now can I ask you why you remember him, to
make sure we know we're talking about the
same person.

Yes I do know I know him very well, he calls in quite frequently to see me.

Right.

And talks to me on the phone.

Right. And is distinguished from
the other children for a certain reason.

Yes.
- is that right.

Yes.

Because

Yes.

Right, that's we're, we're talking about the same person.

Yes.

Ahm, what ah, this girl says in relation to DL 40 and herself is that ah, she was made to bathe together with DL 40, so obviously -

That's ridiculous.

- she was concerned that she was made to bath with a child and she was saying around this time she would have been 13 years of age, that kind of age group.

Oh no, she never, they had separate ladies toilets and separate boys -
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Yes.

- bathrooms you know, they bathed them separately.

Em hm.

Yeah.

Ahm, she specifically remembers in that, an incident when she was in the staff bathroom and she was smoking and ah, she turned on the hot water to try and create steam so that ah, the smell of smoke wouldn't be apparent and ah, you walked in and ah, you said I'll box the ears off you and ah, you punched her in the eye -

(inaudible)

- ah, she was obviously standing in the bath because she says that when she was punched she fell, says she cut her lip, started to bleed, and you said you shouldn't have been smoking and ah, you shouldn't have been in the staff quarters. Have you any recollection of this incident.
No recollection whatever. No.

No. Ahm, she said that her eye, as a result of this had been blackened, that there was a cut to her lip and the next morning when you get her up, got her up for school the obviously the injuries were apparent from the blackened eye and the cut lip, and ah, you warned her to say that if she was questioned that she had fallen.

I did no such thing and I've never seen her with a black eye or a cut lip in my life.

Right. Ahm, she said that ah, one of the ah, punishments that you would is that you would hit them with a hair brush.

Oh not at all I never.

Not at all.

Not at all, right. - Did you ever have cause to punish any children for misbehaviour.

Yes I did have cause ah to punish one child
and I can recollect that (inaudible)

In your whole time. In your, sorry for
interrupting you. In your whole time just one
child or one in particular.

Yes just one child, well I never punished

Well what was the procedure if you were going
to punish a child.

The procedure was ahm, it would come within
the case if you would like to wait.

It would.

It would come up in the case, the family.

The when it comes to the.

Yes. Well the. A little ahm, his mother ah came in one Sunday and she'd
had the family home, you know, for the day
and ah, she reported to the Mother Superior
that was immoral at home and that he was
getting all these habits in the house. So
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DOCUMENT D1002

the Superior of course naturally came and told me.

Em hm.

And after, the following week, within days of that ah, ah you know, he touched a little girl and put her hand, his hands on her personally you know.

Em hm.

A very private place.

Yes.

And ahm, she roared and I said what's wrong, and she said has sticking his finger right up inside me. Well I said, well come along and I took him into the ah, the changing place, and it was a small little stick like that, and ah, I spanked him on the trousers twice and put (inaudible) but I didn't do it (inaudible)

With your hand.

No with a small little stick that was there
A stick.

- It was for a little game you know, so I spanked him twice. Anyhow his sister was very upset and when she went home she complained to the mother about it.

Em hm.

And they enlarged on it, and ah, they accused me of beating him with the snooker stick, and the (inaudible) came and then again went up to the Superior and after she went to the Superior she complained about that and ah, any, anyhow, I didn't know that all this was going on and came down with the children and I, she looked upset and I said you're very upset. She said oh nothing Sister. And I said would you like a cup of tea and she said oh no thank you. So after that she went off home and Mother came down to me later on and she said you know Sister, the police have been in and I said why. And she said because of the way you smacked little [NL 97] and ah, his, they said that [NL 229] had been in to complain but she was making no charges.
Em hm.

That's (inaudible) and I rang up the Social Worker and I told her and she came in the next day to investigate.

Well, now is that the only one you ever punished or is that the only one that.

Yes the only physical punishment -

Right.

- because we had a very very happy group, and we were very, they were young and there was necessity to punish them really. Except for misbehaviour maybe to stand in the passage.

So (inaudible)

Or (inaudible) deprive them of television.

(inaudible)

I never never, never punished (inaudible)

What was the guidelines in ah, on punishment for instance. What ah, what was the
procedure.

To slap them on the hand, the younger ones you know. But I mean, I never hardly ever punished them but that was the procedure (inaudible) 2 spanks.

That was, that was the only one that you can recall as (inaudible) any way severe.

Oh no no no.

No, but I mean in terms of ah, of actually hitting, that’s the only one you can remember.

That’s the only one -

Yeah, OK.

- I’ve ever done because I didn’t believe very much in spanking.

OK. Right. - Right ahm, well we will come, well you’ve already covered most of it about the but -

Yes.
- we, we'll come to them in a wee minute, as
  I say we're actually dealing with ah -

- NL 57 yes. Ahm, and what we, just to cover
that again, it's just to say in relation to
the, the alleged assault is that ah, she was
smoking in the staff bedroom -

Yeah.

- or bath, bathroom.

Yeah.

And you came in, caught her and ah.

The staff bathroom wasn't near us at all.
The staff bathroom was away in other quarters
and I would have never gone into the staff
bathroom.

You wouldn't, well actually she said that ah,
you, you gave off to her for being in an area
that she shouldn't have been anyway for a
start. Ah, but, she says that the main point
is that ah, she had a black eye and a cut
lip -

No.

- and ah, you say that's absolutely false.

It absolutely false -

Absolutely false.

- there was no way and I would surely remember a black eye and a cut lip.

Well yes, indeed. Right. Now, ahm, actually what we have now is ah, statement of a

you were referring to there.

Yes that's right.

Was, do you remember

Yes well and the other little boy (inaudible) another group, I only had ah, and and

Right.
Ahm. So are you saying that ah, you would have absolutely no contact with NL 68

No, NL 68 ah, NL 68 was ahm, out of the He's the eldest boy isn't he.

Ah, well I can't, I can't just say now to be honest with you.

Well ah, NL 68 yes, NL 68 is the eldest and he wasn't in the house actually for very long, he was out with another lady you know, wherever he was, he wasn't under, in my group.

Right ahm, what ah, NL 68 would say ah, that he was only in the home a short time when he became aware of a nun called Sister SR 62 That might suggest that he wasn't actually with you.

Yes.

But it doesn't say that. And now, what, one of the things that he says, what really makes it stick out in his mind about the place is
that ah, as a punishment ah, he was made to
eat soap by you.

That's a good joke. (inaudible)

Well it's, it's an allegation made by a
person who has a child then.

I know, I know but sure how would they make
anyone eat soap.

Well it, it may, people have been familiar
with the term washing your mouth out with
soap and water.

Oh no.

Maybe this was a literal interpretation of
it.

(inaudible) never, never, never. Children
had their own toothpaste and tooth brushes.

But you certainly didn't make them eat a bar
of soap or -

Not at all.
- any part of a bar of soap.

I wouldn't think of it.

Or even suggest it.

No.

No.

I didn't have anything to do with

Right and ah, he also says that ah, he was beaten across the back, shoulder, sides with a pair of clothes tongs. I think that's the old clothes tongs, wooden ones he's referring to.

Wall ah, he wasn't with me at all

Right so that's, that couldn't have happened, never.

No, wasn't in my group at all.

No right. - But he was (inaudible)

She had a twin brother, what's this his name
is, it wasn't

would it be.

No no. Are you on the case, the case
the.

Yes (inaudible)

(inaudible) yeah.

I'm talking about ah, who
would be

Oh I thought you were on the case.

No no we've moved on from that.

No I'm sorry but was never made to eat soap.

Yes, yes we've been. We're talking about

Yeah. I thought you were talking about (inaudible) the brother or who's up in the other group.
Complaint 1

3.2 The complaint was that a child, NL 157 had been harshly treated by a residential social worker NL 163 who had told another child, NL 18 to put soap in his mouth in response to his swearing.

3.3 NL 162 stated that the soap broke into pieces in NL 157's mouth and that he wretched and was sick. She also alleged that SR 52 had said: "the only way to cure swearing was to put soap in a child's mouth."

3.4 SWAG and the EHSSB collaborated in approaching the investigation of this complaint. When interviewed by a Social Worker, NL 157 gave a coherent account of what had taken place and confirmed that this had happened only once to him. He said that two other children had been punished in the same way. He acknowledged that his behaviour had been wrong, but he felt that he had not been punished appropriately, given that the home had in place a range of sanctions that were acceptable to the children. He could not remember whether pieces of soap had been put in his mouth, or only one piece.

3.5 NL 157 said that he got on well with the offending member of staff. His reason for wishing to make a complaint, when given the opportunity of doing so, was that he did not wish other children to be treated similarly.

3.6 SR 143 of Nazareth Lodge carried out an internal investigation, which included interviewing inter alia NL 163 and SR 52. SR 143 admitted that the incident had happened but alleged that it had been a 'playful' episode. She stated, however, that she had seen SR 52 rub shampoo across NL 157's mouth after he had been swearing. In her report of her interview with SR 52, SR 143 stated: "I confirmed that it took place. Sister stated that when NL 163 was washing NL 157's hair he resorted to swearing and using foul language and she took the opportunity to rub the shampoo across his mouth. Sister states that she did not injure him, nor was he sick and her actions were entirely spontaneous, without much thought. Sister very much regrets the incident and has confirmed that this type of thing is not a practice in her Unit."(SNB-19006)

3.7 SR 52 and NL 163 were reprimanded by SR 143.

3.8 On 18 September 1984 Mr R Bunting, EHSSB, in reply to a letter of 4 September from Dr K McCoy (SWAG) stated "It is proposed to take no further action in relation to the complaint concerning NL 157... NL 157 is doing well in Nazareth Lodge and has a good relationship with his primary worker... and his parents are satisfied
that the complaint has been properly dealt with and do not wish to pursue the matter further." (SNB 14765)

3.9 The Departmental file does not indicate whether Mr Bunting obtained legal advice on this case. The EHSSB decided not to interview other children and were content not to take any further action.

Comment

3.10 This episode was handled properly by SWAG, the EHSSB and Nazareth Lodge. The complainant was vindicated, the child’s right to make a complaint and to be listened to, was upheld, and Nazareth Lodge accepted responsibility.

The EHSSB did not consider it necessary to have other children accommodated in Nazareth Lodge interviewed regarding their experience of life there, or the use of sanctions.

Complaint 2

3.11 NL 162 alleged that children who misbehaved were on occasions placed in a cloakroom as a means of punishment. She claimed that the cloakroom so used was infested and frightening for children.

3.12 The Head of the home admitted that on occasions children were placed in a cloakroom because of their misbehaviour, but stated that this was for the purpose of “time out” and generally for not more that 10 minutes. The cloakroom was adjacent to a television room on the ground floor, it was well ventilated and subject to supervision by care staff. She said that a number of rooms on the ground floor had been treated for infestation.

The cloakroom was examined by Mr C Walker (SWAG) who reported, “it proved to be a light and airy room on the opposite side of the corridor from the children’s living room, which makes supervision of any child placed there easy. It is rather bleak having a tiled floor and walls and lacking furniture except for a chair. It was, however, clean and there were no signs of cockroaches......I told the Head that in my opinion the boot room was not unsuitable but since there is a small, fully furnished sitting room which is used for homework next to it, it might be better to use that for “time out”, when it is not otherwise occupied. She accepted the suggestion.” (SNB-19003)

Comment

3.13 I agree with Mr Walker’s suggestion that the sitting room was a more suitable place to send a child for the purpose of “time out”. The apparent bleakness of the other room could suggest punitive intent,
as outlined in the 1985 Circular is to:-

- be informed of any complaints alleging criminal activity which are referred to the police
- be assured that the Boards and Voluntary Organisations have in place adequate arrangements to investigate complaints
- undertake, at regular intervals, a review of complaints made regarding a voluntary children’s home

1.12 In paragraph 2.20 of his statement, dated 25th March 2015, Robert Bunting indicates that there were issues in relation to the implementation of this circular which were not fully resolved until 1991/92. However, it seems appropriate to use the 1985 Circular as the descriptor of the arrangements that should have been in place during the time periods under consideration.

2.0 Events which took place in 1985/86

2.1 In March 1985 a number of allegations were referred to DHSS by the Eastern Health and Social Services Board about the care provided in Nazareth Lodge (the “Home”). These allegations consisted of putting soap in a child’s mouth as a punishment for swearing, using a room infested with cockroaches as an isolation room, and using out of date food. The DHSS worked alongside the management of the Home to investigate these complaints and no further action was taken.

2.2 Also in March 1985, a Senior Social Worker reported that a former resident of the Home, [HIA-210] had made statements about the care he received whilst he was living in the Home. These included allegations that:

- he was regularly beaten by [SR 62]
- he was placed in a cold bath as punishment for informing his social worker about the beatings
- he was locked in a bathroom overnight without lights; and he was locked in a cupboard

2.3 The North & West Belfast Unit of Management conducted a partial investigation into these allegations to establish the detail as outlined in the statements of [NL 223] and Mr Robert Bunting, and the file records.

2.4 In the relevant file records there was also a series of correspondence between the Director of Social Services at the Eastern Health & Social Services Board and the Chief Social Work Advisor at DHSS regarding the conduct of an investigation into the allegations. An internal DHSS report by Mr K McCoy to Mr P Armstrong dated June 1986 [SNB 6957-SNB 6961] summarises the events from the Department’s perspective, whilst in his statement of 25 March 2015 Mr Robert Bunting outlines the view seemingly held by the Eastern Health and Social Services Board.

2.5 A letter dated 3rd July 1986 to Mr Armstrong from [SR 143] of the Order [SNB 6952] provides details of the investigation undertaken by the Home into the allegations.
April 1984 with a follow-up in March 1985
January 1986
January 1987
January 1988
January 1989
January 1990
January 1991
January 1992
January 1993
January 1994
November 1995

The investigation of and correspondence relating to complaints in respect of Nazareth Lodge's care of children made by the Eastern Health and Social Services Board (EHSSB) to Mr P J Armstrong, Chief Social Work Adviser (CSWA), March 1984–September 1984.

27. In March 1984 the Eastern HSSB referred a report to SWAG setting out a number of complaints in relation to the running of Nazareth Lodge [SNB 14677]. These were:

- Putting soap into children's mouths as punishment for swearing;

- Using a room infested with cockroaches as an isolation room for disruptive children; and

- The use of surplus food from Marks and Spencers.

28. The complaints were investigated by two Social Work Advisers. Mr Norman Chambers, Social Work Adviser, met with Mr Robert Bunting, EHSSB, on 4 April 1984 [SNB 18982] and no further action was taken by the Department or the Board in relation to the child named in respect of the use of soap. In July 1984 the Chief Social Work Adviser, Mr P J Armstrong, advised the EHSSB that the Department would not be taking any further action and that the resolution of complaints by children in the Board's care should be pursued by it [SNB 19009].
rather than opportunity for the child to calm down, or reflect on his/her behaviour.

Complaint 3

3.14 A major retailer donated foods not sold at the end of the day to Nazareth Lodge and this was given to the children.

3.15 The Head of the home defended the practice of the limited use of food donated to Nazareth Lodge by a major retailer at the end of trading on certain days. She stated that the home was scrupulous in ensuring that the food was not past its sell-by date. This food was not part of the children's normal diet but was in addition to their meals and they were not required to eat it.

3.16 The retailer confirmed that some items of unsold food were made available free to Nazareth Lodge. It was not out of date and was entirely safe if eaten within 24 hours of delivery.

Comment

3.17 It may have been expedient for Nazareth Lodge to make limited use of certain foods, which did not comply with the sales policy of the retailer. There was no reason to doubt the assurances of the Head of the home that these items were used responsibly and that food that became out of date was discarded. There is no record in any inspection report examined that children suffered from food poisoning as a result of food provided by the home. Indeed the high quality food items in question may have amounted to treats for the children whose meals were criticised by some staff as being dull and unappetising.

4.0 Complaints received from a former member of staff in January 1993

4.1 The Social Work Advisory Group was renamed the Social Services Inspectorate (SSI) in 1986. In January 1993, Miss M Reynolds, an SSI Inspector received information by telephone from who had been employed at Nazareth Lodge between September and November 1992. He alleged that because of the response of his Team Leader and Sister Superior, when he expressed a number of concerns regarding staffing and other matters, which he believed had a bearing on the wellbeing of the children, he had no alternative but to resign.

4.2 The inspector recorded comments and read back to him her notes to assure their accuracy.(SNB 19070)

4.3 She informed him that some of the points raised by him had been covered in the draft inspection report, which had already been written;
The purpose of this visit was to discuss further certain allegations concerning Nazareth Lodge Children's Home, Ravenhill Road, that [REDACTED] had made to me informally on Thursday, 1 March 1984.

We began by clarifying what these allegations were. Firstly, that Fairy Liquid soap had been used as a punishment for swearing; secondly, that the children were put into a room known as the "boot room" as a disciplinary measure; and, thirdly, that it was the practice of this particular unit to use out of date food.

NL 162 [REDACTED] has worked in Nazareth Lodge as part of a Manpower Services scheme from 9 January 1984. Her duties were those of a child care assistant. We began by discussing the first of these allegations. This occurred in the unit supervised by SR 2 [REDACTED] and this was the unit in which NL 162 [REDACTED] was working.

NL 162 cannot remember the exact date of the incident which she witnessed herself but from going over her rota she would say that it was probably on Sunday, 5 February 1984 in the afternoon. Exactly one week later NL 162 had to take a child from the unit, [REDACTED] to the City Hospital with a split finger so if it could be checked against records when that date was, she would then know the date exactly. The incident involved NL 18 [REDACTED], a child who lives in the unit. He had been wearing and one of the staff, NL 163 [REDACTED], held the child while another one of the children, NL 163 [REDACTED], went and got a bar of Fairy soap. On instruction from NL 163 [REDACTED], NL 18 then put the soap in NL 162 [REDACTED] mouth. The soap was then broken up into pieces in his mouth causing NL 157 [REDACTED] to be sick and wretch. This whole incident had been witnessed by NL 162 [REDACTED] commented that she had heard SR 2 [REDACTED] say that the only way to cure swearing was to put Fairy soap in the child's mouth and would therefore take it that this type of treatment was accepted policy within the unit.

The second allegation was concerning a room known as the "boot room" that the staff used for disciplinary purposes. The room is about the size of a large sitting room and contains lockers and stands for coats - there is nothing else in the room. Generally the unit has been having trouble with pests and this boot room is known to contain dead cockroaches. It is the accepted policy of SR 2 [REDACTED] unit, and NL 162 [REDACTED] herself has in fact done this, that any child who is cheeky or disobedient or has been fighting or who lies on the floor when they want to watch t.v. is put in the boot room as a disciplinary measure. They are usually left there for about 10 minutes, the light is left on and they are not locked in, however, Karen expresses concern that the children should be put into this room knowing that there are dead cockroaches about. She had discussed this with her parents who had felt a more appropriate punishment would have been to send the child to its room. All members of staff were encouraged to use this form of discipline according to NL 162.

The third allegation concerned the practice of using out of date food for the children's meals. NL 162 [REDACTED] has seen herself packets of biscuits dated "not to be used after 12 November 1983" still being in the larder in the unit in March. She has also seen yoghurt in February still being kept in the fridge even though the yoghurt should have been used by January. NL 162 also commented that the meat generally was not of a very good standard - pork and sausages especially tended to taste sour and on two occasions the meat that was to be used for a salad had to be thrown out.

I then asked the [REDACTED] about the meeting they had told me about previously between themselves and SR 2 [REDACTED] and the Mother Superior. Contrary to my understanding this meeting had not been about these allegations but had been mainly concerning NL 162's placement. The [REDACTED] had discussed with the Mother Superior NL 162's hours of work, her duties and the fact that this was a learning situation for NL 162 and she was not to be used merely as a domestic. During the initial part of NL 162's placement had told NL 162 that she was telling her parents too much about the
children in the unit. NL 162 denies this but generally told her parents about how the unit worked and felt the fact that they were approved foster parents should show that they could handle confidential information. The parents had been reluctant to bring these allegations to the attention of the authorities for the following reasons. Firstly, the fact that NL 162 is on a 6 months placement there and has another 4 months of that placement to go. Secondly, the parents are very anxious to foster the children who are presently living in Nazareth Lodge and they felt that anything they said about Nazareth Lodge might affect their fostering application. Thirdly, [personal info] has always had a very high regard for nuns and it took her a long time to come to terms with the fact that they could treat the children in this manner. Fourthly, they felt that these allegations might be viewed as them being vindictive having had difficulties with [personal info] concerning hours of employment, duties, etc. This had led to their reluctance to make a fuss even though they had mentioned it informally to both myself and the other two social workers who visit the house. However now they are glad that these allegations are being investigated and feel the overriding concern should be the children who are being treated in this manner and that any difficulties or hostility they personally experience will have to be dealt with in that light. I assured the parents that these allegations would not affect their application to foster the children.

Conclusion

The [personal info] are a very committed, child-centred couple who have been genuinely shocked by the treatment of children that their daughter has told them about. Even though they experienced some difficulties between themselves and [personal info] due to working conditions, they have managed to separate these from the allegations they are making concerning the care of the children. I feel confident that these allegations are made out of a genuine concern for the welfare of these children and are not being made unreasonably or vindictively.

NL 181

Senior Social Worker

8.3.84
9th March 1984

Re: Complaint from NL 162

Please find attached a report setting out a number of complaints in relation to the running of Nazareth Lodge Children's Home.

The [redacted] family are at present being considered as foster-parents for the [redacted] children who are at present in Nazareth Lodge. This report has not been passed to any other district or agency.

[Signature]
District Social Services Officer
Eastern Health and Social Services Board

CONFIDENTIAL
The Chief Social Work Adviser,
Department of Health & Social Services,
Dundonald House,
Upper Newtownards Road,
Belfast,
BT4 3S7.

Dear Mr. Armstrong,

I attach copies of correspondence I have received from the District Social Services Officer in the North and West Belfast District dealing with a number of alleged complaints in relation to the running of Nazareth Lodge Children's Home.

In the circumstances and because the Home is registered with the Department of Health and Social Services, I thought that it was appropriate that we should mutually agree how these should be processed.

If you think it would be helpful, I would be happy to meet with you and agree the way forward.

Yours sincerely,

[Signature]

Director of Social Services.
IN CONFIDENCE

28 March 1984

Mr E S Gilliland
Director of Social Services
Eastern Health and Social Services Board
65 University Street
BELFAST
BT7 1BN

Dear Mr Gilliland,

NAZARETH LODGE CHILDREN'S HOME - COMPLAINT BY NL 162

Thank you for your letter of 15 March and enclosures.

I have considered NL 181's report with Mr McCoy. A number of points arise from it which, we feel, would be best discussed with Mr Bunting and I have asked Mr Chambers to arrange to meet him to do so.

Yours sincerely,

P J ARMSTRONG
Chief Social Work Adviser

[Signature]

[Signature]
Mr K F McCoy
Re: Nazareth Lodge Children's Home

On 4 April 1984 I met Mr R Bunting and NL 181 (SSW - [redacted]) to consider the allegations as described in NL 181 report of 8 March 1984, and to agree the way forward.

1. The Department to forward NL 181 report to the Sisters of Nazareth requesting clarification of current policy regarding methods of discipline and SR 143's response to the specific allegations.

2. In the light of the home's response Mr Bunting will brief supervising social workers to interview all children in the care of the Eastern Health and Social Services Board regarding their experience of discipline while in the home.

NL 187 will be interviewed regarding the specific incident of alleged mouth washing and the decision will then be taken by the Board whether to ask the boy's parents if they wish to make a complaint.

3. A copy of social workers' reports of interviews with children will be forwarded to the Department by Mr Bunting.

4. Mr Bunting will obtain legal advice regarding the first allegation in order to determine whether it constitutes personal assault. If it does the Police will be notified.

5. The Department will notify the Northern and Southern Boards that allegations have been made so that their supervising social workers may interview children at the appropriate time.

6. Mr N J Chambers has made Mr Bunting aware of the major concerns about the home following the SWAG inspection of October 1983. These do not include unacceptable methods of discipline, nor did children make any complaints regarding their care and treatment in the home.

cc Mrs D Brown
Mr R Bunting
9.4.84

Mr. Chambers telephoned and informed me that a letter and copy of the report from North and West Belfast District was being posted to [redacted] that day. She should have received the report on 11th April, 1984 at the latest.

I confirmed that arrangements would be made to interview [redacted] either on 11th April, 1984 or as soon as possible after the 11th.

I telephoned Mrs. McCrea, Principal Social Worker, North & West Belfast District, who confirmed that [redacted] was their responsibility and that arrangements would be made to interview him. I suggested that the Senior Social Worker (Team Leader) should be present with the Social Worker when [redacted] was being interviewed.

...........

R.J. Bunting,
Assistant Director of Social Services

12th April, 1984
Dear SR 143,

Certain allegations have been made to the Eastern Health and Social Services Board regarding Nazareth Lodge Children's Home and these are outlined in the enclosed report which has been prepared by NL 181, Senior Social Worker. I should be grateful if you would let me have, as soon as possible, your response to the 3 allegations.

You will appreciate that the allegation in respect of the treatment of NL 157 may constitute cause for formal complaint by the child or his parents. For this reason it would be necessary for the child's supervising social worker to talk to him about the incident and I expect that that will happen within the next few days.

When the Department has received your response to the allegations and the social worker's report following her interview with the child a meeting will be arranged with you to consider the matters fully.

Yours sincerely,

P J ARMSTRONG
Chief Social Work Adviser
Mrs D Brown  
Child Care Branch  

RE: NAZARETH LODGE CHILDREN'S HOME  

I enclose herewith a copy of Mr Gilliland's letter of 15 March, together with [181] and [157]'s report of allegations made regarding the treatment of children in the above home.  

I have discussed with Mr Bunting arrangements for investigating the matter and my minute of 5 April to Mr McCoy outlines these.  

Mr Armstrong's letter of [NL 181] to Mr Gilliland confirms that, in the first instance the specific allegation relating to [NL 157] should be investigated, before other children are interviewed.  

In the meantime the home will be asked to respond to the 3 allegations referred to in the above report.  

Copies of subsequent correspondence will be forwarded to you.  

Please let me know if you consider the above arrangements should be amended in any way.  

N CHAMBERS  

April 1984  

CC Mr P J Armstrong  

[181]  

[157]
Not if a meeting with Mr. N. Chambers, Social Work Advisor and
Senior Social Worker, North & West Belfast District to discuss the processing of
the complaints regarding Nazareth Lodge Children's Home.


Mr. Chambers confirmed that the Department of Health and Social Services had recently
conducted an inspection of Nazareth Lodge but had not identified any of the practices
outlined in the report from North and West Belfast District. It was agreed that the
following action should be taken in regard to the complaints:

1. The Department of Health and Social Services will forward a copy of the report from
North and West Belfast District regarding the complaints to Mr. Chambers and a colleague, probably Mr. Walker, will discuss the complaints with
SR 143's Unit will be investigated by the Department of Health and Social Services.

2. Mr. Chambers will inform that it is likely that Board Social Workers
will have to discuss with individual children the care they are receiving and whether
they have any complaints to make.

3. Mr. Chambers will notify the Southern Board as that Board has children in the Unit.

4. Mr. Bunting will discuss with legal department whether the forcing of soap into
mouth causing him to be sick amounts to a criminal offence of assault.

5. Mr. Bunting will liaise with South Belfast District to ascertain which Districts in the
Eastern Board have children in Nazareth Lodge as these Districts will have to be notified
of the proposed action in regard to the complaints. Board staff will have to be briefed
prior to interviewing the children.

6. NL 157 will be interviewed by the appropriate Social Worker as soon as possible after
SR 143 has been notified of the complaints. It will be ascertained whether he
confirms account of events and whether he wishes to make a formal complaint.
His parents will have to be notified as soon as possible after NL 157 has been interviewed.
Regardless of whether NL 157 wishes any action to be taken the complaint will have to be
pursued.

R.J. Bunting,
Assistant Director of Social Services

12th April, 1984
Reference

MR N CHAMBERS

NAZARETH LODGE CHILDREN'S HOMES

Thank you for sending me the papers relating to the allegations made regarding the treatment of children in Nazareth Lodge.

I am content with the line of action prepared.

Yours sincerely

[Signature]

Director

13. 4. 84
Mr. P.J. Armstrong,
Chief Social Work Adviser,
Dundonald House,
Upper Newtownards Road,
Belfast BT4 3SF.

Dear Mr. Armstrong,

Thank you for your letter of the 9th. April.

On the morning of April 11, I interviewed in connection with the first allegation in the report prepared by Senior Social Worker. admits to the incident involving but disagrees with the manner in which it is described in the report. I quote her exact words: "The way the statement is written sounds awful but it was not like that at the time. It was a joke that day and was standing by laughing. The soap used was not a bar of fairy soap but a small piece of soap. did not break the soap in mouth and was not sick. spat out the soap and went off in a huff, but later returned and apologised to me for using the bad language. did not feel sorry for. She thought it served him right for using such bad language. She was in no way disgusted."

assured me that this was the one and only occasion that she had recourse to this form of deterrent and readily acknowledges the inappropriateness of her actions. She has been reprimanded for this and I would confirm that her actions are unacceptable and that no such practice will be permitted in the Home.

The room referred to as the boot room in the second allegation is actually a cloak room, the door of which is directly opposite the sitting room door. It is a bright airy room with plenty of window ventilation. It has been used for "time out" as a disciplinary measure as it is convenient to the sitting room for supervisory purposes and the child does not feel isolated. As the bedrooms in this unit are on the first floor we consider it inadvisable to send children to their bedrooms as a form of punishment. Cockroaches have been seen in a few places on the ground floor of this unit and in an effort to eradicate these pests Rentokil is engaged on continuous contract. A representative visits regularly.

I totally reject the allegation regarding the food and in particular the meat which is supplied by the local butcher and is always examined by our catering personnel on delivery. Our resident social worker has attested that the dinners served to the children at week-ends and during holiday periods are always tastefully presented and are relished by them. As regards the meat which was to have been used for salads but had to be thrown out, our caterer informs me that on these two occasions and only in this particular unit the dish had been left in a place exposed to the sunlight and although covered with cling wrap the ham discoloured. It was therefore decided not to use it and an alternative dish was provided.

It is the practice of Marks & Spencer to give supplies of yoghurt and biscuits from time to time which although fresh when received do not meet with their sales policy which requires sale by a certain date. These items are not given to the children as part of their daily diet but are available to them for use. It is our usual practice to throw the food out after a few days and it may be that allegations are based on this arrangement. I wish to emphasise, however, that it is not either our policy or practice to ask children to take such food and we try rigorously to ensure that the surplus is removed.

Trusting this response is explanatory and adequate.

Yours sincerely,

SR 143
IN CONFIDENCE

19 April 1984

Mr E S Gilliland
Director of Social Services
Eastern Health and Social Services Board
65 University Street
BELFAST
BT7 1HN

Dear Mr Gilliland

NAZARETH LODGE CHILDREN'S HOME

Further to my letter of 9 April regarding allegations about the treatment of children at Nazareth Lodge I enclose a copy of the letter I received from [SR 143], whom I asked to comment on [NL 181]'s report.

I would be grateful to receive copies of the reports being prepared by [NL 157]'s social worker and the social workers of other children in the home. When these are to hand Mr Walker will contact Mr Bunting to discuss what further action, if any, needs to be taken in the matter.

Yours sincerely

P J ARMSTRONG
Chief Social Work Adviser
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Dundonald House Upper Newtownards Road Belfast BT4 3SF
Telex 74578 Telephone 0232 (Belfast) 650111 ext

Mr E S Gilliland
Director of Social Services
Eastern Health and Social Services
Board, 65 University Street
BELFAST

Please reply to The Secretary
Your reference
Our reference
Date 19th April 1984

Dear Mr Gilliland

RE: NAZARETH LODGE CHILDREN'S HOME

Thank you for your letter of 15 March 1984 and NL 181's report of 8 March regarding allegations in relation to the treatment of children at Nazareth Lodge Children's Home. I enclose a copy of Mr Chamber's minute of 5 April outlining arrangements for dealing with this matter, which were agreed with Mr Bunting on 4 April.

May I suggest that, in the first instance the allegation relating to NL 157 be investigated and when the outcome of that is known a decision be made regarding other children in the Board's care. Perhaps you would arrange for the supervising social worker to interview the child as soon as possible.

In the meantime, we have written to SR 143 asking for her response to the 3 allegations referred to in NL 181 report. I shall let you have a copy of her reply.

Yours sincerely

P J ARMSTRONG
CHIEF SOCIAL WORK ADVISER
IN CONFIDENCE

19 April 1984

SR 143

Nazareth Lodge
516 Ravenhill Road
BELFAST
BT6 2EX

Dear SR 143

Thank you for your prompt reply of 14 April covering the points raised in NL 181’s report. I understand that the Eastern Board was arranged for a social worker to interview NL 157 about the incident and the report will be forwarded to me. When I receive it I shall send you a copy. I shall contact you again if I consider that any further action is necessary.

Thank you for your co-operation in the matter.

Yours sincerely

[Signature]

F. ARMSTRONG
Chief Social Work Adviser
Dee K. Gillican
Director of Social Services,
Eastern Health and Social Services Board,
City University of.
Belfast.

Nagashell Lodge Childrens' Home

Dear Mr Gillican,

Thank you for your letter of 15th March by
seq and enc report of 3rd March regarding
allegations in relation to the treatment of children
at Nagashell Lodge Children's Home. I enclose
a copy of the Chamber's minutes of 5th April,
setting arrangements for dealing with this matter,
which were agreed on with the Secretary on 15th April.

May I confirm that, on the first
instance, the allegation relating to the

be investigated and when
the outcome of that is known, a decision to
make regarding other children in the Board's care.
Perhaps you would arrange for the supervising social
worker to interview the child as soon as possible.

In the meantime, written to
asking for his response to
the three allegations referred to in

SR 143

NL 181
I shall let you have a copy of his reply.

I trust that the arrangements for today with the matter are clear.

Yours sincerely,

P. J. Armstrong.
Senior Colleagues,

Please accept my apologies for the tardiness of my response to your letter of 11 March. It's important that I receive all your correspondence in a timely manner.

As you are aware, the election is scheduled to take place on the 7th of April. I have discussed this matter with Mr. Minister and we have decided to proceed with the arrangements for investigatory ballots and the meeting.

I have forwarded copies of all relevant documents regarding the investigation to the respective members of the committee.

I look forward to hearing your thoughts on how we can proceed.

Best regards,

[Name]
Nazareth House Children's Home.

On 14th April 1984 I met Mr. Bunting and (S.S.W.-) to examine the allegations as described in the 8th March 84 report and to agree the way forward.

1. The Department forward report to the Sisters of Nazareth requesting clarification of current policy regarding methods of discipline and is response to the specific allegations.

2. In the light of the Home’s response Mr. Bunting will brief supervising social workers to interview all children in the care of the E.H. 135. Bd regarding their experience of discipline while in the home.

3. The interviewee regarding the specific incident of alleged mouth washing and a decision will then be taken by the Board whether to ask the boy’s parents if they wish to make a complaint.

4. A copy of social workers’ reports of interviews
with children will be forwarded to the Dept. by
Mrs. Bunting.

4. Mrs. Bunting will obtain legal advice regarding
the first allegation in order to determine whether
it constitutes personal assault. If it does,
the police will be notified.

5. The Dept. will notify the N. S. M. S. RD
and the S. A. N. S. RD that allegations have
been made so that their supervising social
workers may intervene children at the
appropriate time.

6. Mrs. N. S. Chamber has made Mrs. Bunting
aware of the major concerns about the home,
following the S. W. A. S. inspection of October 1985.
These do not include unacceptable methods
of discipline, nor did children make any
complaint regarding their care and treatment
in the Home.

[Signature]

Copy to Mrs. R. Bunting
Mrs. D. Brune.
An account of interview with NL 157

Present: NL 157
Patrick Conway, Social Worker (Falls Road Social Services)
Susan Toland, Senior Social Worker (Falls Road Social Services)

As far as is known (NL 157) was not aware of the allegation regarding soap having been put in his mouth. The interview opened with him being questioned about modes of punishment that were carried out in Nazareth Lodge. After some initial wariness (NL 157) thought he was being blamed for a particular incident) (NL 157) said that the usual sanctions were 1) "being told off" or "talked to" 2) given lines 3) being sent to bed early 4) being put in the "boot room" this is a cloakroom located opposite the television room. In principle (NL 157) did not appear to object to any of these punishments. He did not mention other punishments apart from deprivation of pocket money for items such as broken windows.

P. Conway asked NL 157 outright if anybody at any time had put soap in his mouth. NL 157 replied that this had occurred over an incident involving him cursing. According to NL 157, the incident involved a member of staff and (NL 18) who was fighting, NL 157 "let slip" a curse. Asked what this was exactly NL 157 replied "it was E.... and F... it slipped out". Then NL 157 apparently made to run out, he was held by (NL 163), at one time on the floor and she told NL 18 to get some soap and put it into NL 157's mouth which he did. NL 157 said he did not remember if the soap was broken up into small pieces. Asked if he was sick after this episode NL 157 replied that he didn't think he was.

It came across that NL 157 felt that the experience was disagreeable and he felt that it was wrong for it to have happened. It has happened to his once. He did mention that it happened to two other children, and but this involved a member of staff who apparently no longer works at the home.

The only people that heard about this were NL 157's natural mother and grandparents. Apparently his mother said that it was "wicked" and this is how NL 157 himself described it. He certainly does not see it fitting into the scheme of sanctions, as outlined previously, that operate within the unit.

NL 157 was asked if he wanted to make a complaint to ensure that there was no recurrence of this. NL 157 understands "complaint" as "shouting back at people" but after some explanation NL 157 said that he wouldn't like to be treated like that again. Nor would like other children to be treated in a similar fashion accordingly he would like to make a formal complaint.

Finally NL 157 was asked what he felt about NL 163. NL 157 said he got on well with her and liked her a lot.

Conclusion: From (NL 157) account it would seem that the basic incident did take place, in that after NL 157 was held by a member of staff, with her agreement a child, placed soap in NL 157's mouth. NL 157 feels that it was wrong for this to happen and insofar as he is able, would like to ensure that it does not happen again. It should also be noted that NL 157 is essentially quite fond of given that she has been working with him for approximately three years, and there would not appear to be any lasting ill-will directed towards her.

Patrick Conway
Mr. P. Conway, Social Worker

Susan Toland
Ms. S. Toland, Senior Social Worker.
Mr. McCaughey,

Something of a storm in a tea cup. What is our next step? I would need to acknowledge to the Director & indicate our intentions.

Mr. Walker to see as well.

Mr. Walker
Please discuss.

14/5

15/5/84.
Mr. Waiken.

To see obtain a

are file. gre. 28/5.

22 May 1984

Mr E S Gilliland
Director of Social Services
Eastern Health and Social Services Board
65 University Street
BELFAST
BT7 1HN

Dear Mr Gilliland

NAZARETH LODGE CHILDREN'S HOME

Thank you for sending me a copy of the report prepared by Mr Conway and Ms Toland on their interview with [NL 157] at Nazareth Lodge.

I note that [NL 157] has decided to make a formal complaint about his treatment in the home. Mr Walker has tried, without success, to contact Mr Bunting to arrange a meeting to discuss what further action the Board intends to take in the matter. I understand that Mr Bunting will not be available for some time. I would be grateful, therefore, if you would let me know what the Board intends to do about the complaint.

Yours sincerely

P J ARMSTRONG
Chief Social Work Adviser
Eastern Health and Social Services Board

Mr. P.J. Armstrong,
Chief Social Work Adviser,
Dundonald House,
Upper Newtownards Road,
Belfast,
BT4 3SF

CONFIDENTIAL

Dear Mr. Armstrong,

Thank you for your letter of 22nd May, 1984. It was understood that Mr. Chambers and Mr. Walker would discuss the complaints regarding child care practice in [SR 2]'s Unit with [SR 143], as it was implied that the unacceptable practices described could be taking place in regard to all the children. I have enclosed a copy of Mr. Bunting's note of the meeting with Mr. Chambers which was forwarded to Mr. Chambers.

From our point of view certain questions in regard to these practices remain unanswered by [SR 143].

1. Did [SR 2] advocate to staff the practice of putting soap into children's mouths as punishment for swearing? If not from whom did they learn this practice?

2. It is the intention to continue using a room in which there would appear to be cockroaches, as an isolation room for disruptive children? If so, is this acceptable to the Department?

3. Is it the intention to continue to accept food from Marks and Spencer's, even if it is provided free, when it would not be accepted by the general public? If so, is this acceptable to the Department?

I would be grateful for your view on these matters and information on what further action, if any, the Department intends to take before we pursue this complaint further.

Yours sincerely,

[Signature]

Director of Social Services
Note of a meeting with Mr. N. Chambers, Social Work Adviser and Mr. Walker, Social Worker, North & West Belfast District to discuss the processing of complaints regarding Nazareth Lodge Children’s Home.

Mr. Chambers confirmed that the Department of Health and Social Services had recently carried out an inspection of Nazareth Lodge but had not identified any of the practices outlined in the report from North and West Belfast District. It was agreed that the following action should be taken in regard to the complaints:

1. The Department of Health and Social Services will forward a copy of the report from North and West Belfast District regarding the complaints to Mr. Chambers and a colleague, probably Mr. Walker, will discuss the complaints with the Unit to ascertain her reaction and decide how the care arrangements in the Unit will be investigated by the Department of Health and Social Services.

2. Mr. Chambers will indicate to the Board that it is likely that Board Social Workers will have to discuss with individual children the care they are receiving and whether they have any complaints to make.

3. Mr. Chambers will notify the Southern Board as that Board has children in the Unit.

4. Mr. Bunting will clarify with Legal Department whether the forcing of soap into the child's mouth causing him to be sick amounts to a criminal offence of assault.

5. Mr. Bunting will liaise with South Belfast District to ascertain which Districts in the Eastern Board have children in Nazareth Lodge as these Districts will have to be notified of the proposed action in regard to the complaints. Board staff will have to be briefed prior to interviewing the children.

6. Mr. Bunting will be interviewed by the appropriate Social Worker as soon as possible after he has been notified of the complaints. It will be ascertained whether he confirms account of events and whether he wishes to make a formal complaint. His parents will have to be notified as soon as possible after he has been interviewed. Regardless of whether he wishes any action to be taken the complaint will have to be pursued.

R.J. Bunting,
Assistant Director of Social Services

12th April, 1984
K F McCoy

NAZARETH LODGE - BELFAST

COMPLAINT - NL 157

1. On 4 April I met Bob Bunting and my notes of the meeting (Tab A) were copied to R Bunting, Mrs D Brown and C Walker. Before sending these notes to the Board I spoke to Bob Bunting on 9 April to confirm that the complaint in respect of NL 157 would be investigated first. When the substance of the complaint was known a decision would be made whether or not to extend the investigation to other children and whether the Department should notify other Boards. On 19 April this was confirmed by letter to the Board by Mr Armstrong (Tab B).

2. Some time after 12 April (date of letter) Bob Bunting sent me a copy of his note of our meeting of 4 April (Tab C). This varies slightly from my note, and refers in paragraph 1 to SR 143 being interviewed by SWAG.

He also notes my telephone call to him of 9 April regarding procedure.

PROPOSAL

a. I think it would be helpful for SWAG to interview SR 143 in order to clarify and confirm various points, including those raised by the Board (letter of 13 June 1984). I suggest that we should not advise her that a formal complaint has been made or indicate how it is likely to be dealt with by the Board.

b. After (a) SWAG and the Board should meet to agree how the complaint will be handled and by whom.

N J CHAMBERS

26th June 1984

Bob is taking the view that the allegations do not justify excluding the other children in the home. He is uncertain about using out of date food, and less clear about what the use of the latrine was for punishment. D
Note of meeting with [SNB-19003] Nazareth Lodge Children's Home, Ravenhill Road, Belfast, on 22 June 1984

I thanked [NL 162] for her prompt help in investigating the complaints made by [NL 163] but explained that I thought there were three points that required clarification:

(i) I accepted that the incident involving soap put in his mouth by [NL 163] was an isolated one and that since she had been reprimanded we must assume that it would not be repeated. However I was concerned that [NL 162] had alleged that [NL 163] had told her that [SR 2] had said that it was the only way to cure swearing. [SR 143] told me that she had raised this point with [SR 2] who said that she was unable to recall having made such a comment. I expressed some concern that if this is the case the question of where [NL 163] learnt of this practice remains unanswered and I thought that we ought to ask her.

(ii) I asked [SR 143] about Marks & Spencer's donations of food. She told me it is their long established practice both in GB and NI to give the Sisters of Nazareth and some other charities any unsold food that is passed its "sell by" date. The arrangement in Belfast is that the handyman or one of the Sisters from Nazareth House goes to the shop at the end of trading each day and is given the remaining food. It is understood that it will be used within 24 hours. Most of it is eaten by the elderly people in Nazareth House but if there is too much some is occasionally passed on to the children at the Lodge to eat in addition to their normal meals if they so choose. [SR 143] said that she could only recall having received biscuits and yoghurt and she thought the last occasion was before Christmas. If some of the biscuits donated at that time were in one of the unit larders some months later it was an oversight. She rightly pointed out that the dates on Marks & Spencer's packaging referred to "Sell by ...." or "Best before ...." and not "To be used before ...." as was alleged in [NL 181]'s report.

(iii) I questioned whether they intended to go on using the boot room in Bethlehem unit for "time out". [SR 143] suggested that it would be best if I inspected the room for myself so that I could comment on its suitability. It proved to be a light and airy room on the opposite side of the corridor from the children's living room which makes supervision of any child placed there easy. It is rather bleak, having a tiled floor and walls and lacking furniture except for one chair. It was, however, clean and there were no signs of cockroaches. [SR 143] told me that they had had a problem with cockroaches on the whole ground floor but it had been remedied by Rentokil who called regularly to check if there had been a recurrence of the infestation. I also took the opportunity to look at the bedrooms. They are a considerable distance from the living room and would create a supervision problem, which I think would render them unsuitable for "time out". I told [SR 143] that in my opinion the boot room was not unsuitable but since there is a small, fully furnished sitting room which is used for homework next to it, it might be better to use that for "time out" when it is not otherwise occupied. [SR 143] accepted the suggestion.
Note of meeting with Miss Adair and Mr Small at Marks & Spencer on 22 June 1984

Having telephoned earlier in the day I called at Marks & Spencer after visiting Nazareth Lodge. Initially I saw Miss Barbara Adair, the manager of the food department but she suggested that it would be more appropriate to speak to the deputy manager, Mr Small.

Mr Small told me that they have an arrangement whereby the Sisters of Nazareth can collect any unsold food. It does not apply to any other organisations but their own staff are given the opportunity to buy it at half-price. They impose two conditions: i) that it should not be resold and ii) that it should be consumed within 24 hours. The second condition is for their own protection but they would not be unduly concerned if it were not rigorously adhered to. For example most of the fresh food, including meats could be frozen and used later without ill effect and the small number of products unsuitable for freezing, which include a quiche and a mackerel pate are clearly so marked on the packaging. They do not recommend freezing cheese but this is because it tends to crumble on thawing out. Other goods, including biscuits and crisps, could be used well after the "sell by" date without ill effects. They would become stale and unpalatable before they became harmful. Mr Small told me that Marks and Spencer crisps are marked for a shelf life of 10 days whereas some of their rivals are around two months. Mr Small reiterated that he felt that common sense was the best criterion for deciding whether food should be consumed or not.
SR 143
Nazareth Lodge
Ravenhill Road
BELFAST

23 June 1984

Dear SR 143

As promised I enclose a note of our meeting on Friday, 22 June. If there is anything that you would like me to add or amend perhaps you could let me know. I would be grateful if you could let me know the outcome of your interview with NL 163 as soon as possible so that I can reply to the Eastern Board.

Yours sincerely
Nazareth Lodge,
516 Ravenhill Road,
BELFAST,
BT6 0EW

27th June, 1984

Dear Mr. Walker,

You asked me to enquire further from NL 163 about the incident involving NL 157 and as a consequence I have elicited the following information:

(i) I spoke separately to SR 2 and NL 163 and asked each of them to comment on the statement made by NL 162 to the effect that she overheard Sister saying that the only way to cure swearing was to put Fairy soap in the child’s mouth. NL 163 states that she did not hear Sister make this comment and Sister has no recollection of making this statement.

(ii) However, NL 163 also stated that on one occasion she saw SR 2 rub shampoo across NL 157’s mouth after he had been swearing. The incident took place when NL 157 was having his hair washed.

(iii) I have, therefore, spoken to SR 2 about this incident and she confirmed that it took place. SR 2 stated that when NL 163 was washing NL 157’s hair he resorted to swearing and using foul language and she took the opportunity to rub the shampoo across his mouth. SR 2 states that she did not injure NL 157 nor was he sick and her actions were entirely spontaneous, without much thought. SR 2 very much regrets the incident and has confirmed that this type of thing is not a practice in her Unit.

In the light of my further investigations I have spoken to SR 2 and NL 163 and made it clear that it is completely unacceptable and, indeed, irresponsible to treat a child in the way described in this incident. I would confirm once again that no such practice will be permitted in any Unit in Nazareth Lodge and I have issued instructions to this effect.

Yours sincerely,

SR 143

Mr. C. Walker,
Social Services Department,
Department of Health and Social Services,
Dundonald House,
Upper Newtownards Road,
BELFAST,
BT4 3SF
Department of Health and Social Services
Dundonald House Upper Newtownards Road
Belfast BT4 3SF
Tel 7078
Telephone 7032 (Internal) 037110 ext

SR 143
Nazareth Lodge
Ravenhill Road
BELFAST

Dear SR 143,

As promised I enclose a note of our meeting on Friday, 28 June. If there is anything that you would like me to add or amend perhaps you could let me know. I would be grateful if you could let me know the outcome of your interview with NL 163 as soon as possible so that I can reply to the Eastern Board.

Yours sincerely,

[Signature]

PS. Thank you for your letter which I have just received.
Mrs. Susan Brown
Child Care Branch.

Margaret Lodge Children Home, Belfast.

I attach our file on the above case which includes records of the investigation of a complaint passed on by Mr. Gilliland on 15th March 1984. I also attach a copy of a letter for signature by Mr. Armstrong.
I would be grateful to receive any comments you may care to make.

Yours sincerely,

5.7.84

Mr. Keller

I apologize for not returning these papers to you sooner.

I am satisfied that the complaint relating to the Home have been properly investigated and that remedial action has been taken where deemed necessary.

My only suggestion were two lines of a letter to Mr. Gilliland is that the final paragraph might read along the lines of “in view of the fact that the staff of Margaret Lodge are clearly aware that the practice of putting soap in different wanted to discourage anything is unacceptable, and the light of the nature of the investigation. In the case of the complaint the Department does not intend to take any further action.” If you may wish to consider this.

Yours sincerely,

17.7.84

[Signature]
Mr R Bunting
Acting Director of Social Services
Eastern Health and Social Services Board
85 University Street
BELFAST
BT7 1YN

IN CONFIDENCE

Dear Mr Bunting

NAZARETH LODGE CHILDREN'S HOME, RAVENHILL ROAD, BELFAST

Thank you for your letter of 13 June 1984. Mr Walker and I spoke to Mr D E HH on Friday 22nd. He also spoke to members of the management staff of Marks and Spencer PLC later the same day. I attach copies of the notes of these meetings together with a copy of a letter from Mr Walker clarifying a point that could not satisfactorily be explained at the meeting with her.

In view of the fact that the staff of Nazareth Lodge are clearly aware that the practice of putting soap in children's mouths to discourage swearing is unacceptable, and in the light of the outcome of the other areas of complaint the Department does not intend to take any further action. I would be grateful if you could let me know what steps the Board intends to take in relation to this complaint.

Yours sincerely

P J ARMSTRONG

ENCS
Eastern Health and Social Services Board

Mr. P.J. Armstrong,
Dundonald House,
Upper Newtownards Road,
Belfast,
BT4 3SF

IN CONFIDENCE

Dear Mr. Armstrong,

NAZERETH LODGE CHILDREN'S HOME, RAVENHILL ROAD, BELFAST

Thank you for your letter of 17th July, 1984 and the copy of further information on the investigations into the complaints made by NL 162.

I will be making this information available to North and West Belfast staff and will be discussing with them what further action needs to be taken in regard to NL 157's complaint. I will let you know the outcome of this as soon as possible.

In the light of this further information, I would not intend to have all the children who are in the care of the Board and in the Bethlehem Unit interviewed by staff.

Yours sincerely,

R.B. Bruntwig

Acting D.S.S.
Eastern Health and Social Services Board

CONFIDENTIAL

Mr. P.J. Armstrong,
Chief Social Work Adviser,
Department of Health and Social Services,
Dundonald House,
Upper Newtownards Road,
BELFAST,
BT4 3SF.

Dear Mr. Armstrong,

Further to my letter of 2nd August, 1984 and Mr. McCoy's letter of 4th September, 1984 I am writing to let you know that it is proposed to take no further action in regard to the complaint concerning [NL 157].

District staff report that [NL 157] is doing well in Nazareth Lodge and has a good relationship with his primary worker, [NL 163] and with [SR 2].

[NL 157] and his parents are satisfied that the complaint has been properly dealt with and do not wish to pursue the matter further.

Yours sincerely,

[Signature]

Mr. R.J. Bunting,
Acting Director of Social Services
SR 143
Nazareth Lodge
516 Ravenhill Road
BELFAST
BT6 2RR

21 September 1984

Dear SR 143,

I enclose a copy of a letter that I have recently received from Mr Ruting, who is acting as Director of Social Services in the Eastern Board following Mr Gilliland’s retirement. I am sure you will be pleased to note that the Board does not intend to take any further action over NL 157’s complaint.

I would like to take this opportunity to thank you for your co-operation in the investigation of this matter.

Yours sincerely,

[Signature]

P J ARMSTRONG
Chief Social Work Adviser
1. NL 190 will say as follows: -

1. I was employed by the Southern Health & Social Services Board as a trainee social worker from 1976 until 1978 when I qualified. I then worked as a social worker with a generic caseload in Portadown Social Services office from 1978 to 1982, during which time I worked with the applicant in this case. Subsequent posts included social work in Nottingham Community Mental Handicap Team, generic social work in Lurgan and Brownlow Social Services Offices, social work in the Fostering Team (1989 – 1995) and in the Sensory Disability team (1995 until my retirement in 2014).

2. Regarding this case, I have read the available documents (attached) relating to HIA 210’s complaints about his treatment in Nazareth Lodge, and have noted that he says he told me on one occasion that SR 62 hit him with a stick. Unfortunately I have no recollection of him telling me this. That is not to say it did not happen, but that I do not remember it now.
3. I also see from NL 191 that (Senior Social Worker in N&W Belfast) report that in 1985 she contacted me about [REDACTED] allegation and that at that time I told her that he had never told me about being hit, and that I had not seen any signs of either [REDACTED] or his younger brother [REDACTED] being punished inappropriately when I was visiting them in Nazareth Lodge. I cannot now recall that conversation with NL 191.

4. I do remember that I visited HIA 210 and NL 204 at Nazareth Lodge on numerous occasions. They were already placed there when I took over the case in 1978. I was also the social worker for their older brother NL 263, who was placed in a Family Group Home in Armagh, and on a few occasions each year I brought all three boys together. They were part of a family of [REDACTED] children, of whom [REDACTED] were in long term care, in various places, under various social workers, with the result that some of the siblings did not even know each other. It was recognised that splitting up siblings was not good practice, but the reality was that sufficient places were not available in one establishment. We did bring the younger six children together occasionally but most were not very enthusiastic about the contact, as they did not really know each other and had not remembered living in the same family.

5. I recall that SR 62 was the person I usually liaised with when visiting at Nazareth Lodge. However, apart from her being middle-aged, I have very little recollection of what she was like.

6. My general impression is that [REDACTED] and NL 204 were not very happy in Nazareth. I cannot recall now exactly why I thought this, but it could have been because they both wanted to be fostered by a family. I recall that they would often ask if I had found a family yet.

7. When I started working with them, HIA 210 and NL 204 were already being befriended by a family in Andersonstown, who would take them out some weekends. I think this arrangement was set up through their local parish priest, but I am not certain about that. This family used to take one or both boys out, but in the longer term they felt unable to manage more than one. I remember
completing a fostering home study with them, with the result that they were approved to foster. Whilst this was positive, I felt it was very difficult for [NL 204], who remained in Nazareth Lodge. I understand from [NL 191]'s report that later he did move to a foster family.

8. At that time, there was no specialist Fostering Unit in the Southern Board. If a child needed a foster family, and none was available, the social worker would place an advert in the newspaper, follow up any responses, complete a home study and obtain approval from senior staff. This was in addition to the pressures of a full caseload which included not only children in the care of the Board, but also child protection, learning disability, physical disability, mental health, older people, addiction, monitoring of childminders, etc. This made finding time to assess prospective foster carers particularly difficult.

9. Finally, I would like to add that as [HIA 210]'s social worker at that time, I very much regret if I failed in any way to ensure his safety and protection.

**Statement of Truth**

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

Signed NL 190

Dated 23 January 2015
THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of NL 180

I, NL 180, Head of Residential and Day Care in the Northern Health and Social Care Trust (NHSCT) would state as follows.

1. I qualified as a Social Worker in July 1981 having completed a Bachelor of Arts Honours Degree in Social Work and the Certificate of Qualification in Social Work. I was employed in the North and West Belfast Unit of Management in November 1981 as a Social Worker in a Child Care Team. I was based in Beech Hall, Andersonstown.

2. I can confirm that I have been provided with some file records to read in connection with HIA 210. He and his brother, NL 204, had been taken into care by the Craigavon Unit of Management in the Southern Board area and placed in Nazareth Lodge.

3. It is my understanding that the Southern Board remained responsible until both boys were settled into a fostering placement when the case was transferred to North and West Belfast. I do not know the date on which the transfer occurred.

4. [Redacted]’s initial placement broke down and he was placed in De la Salle in Kircubbin.
5. He remained there until December 1983 before being transferred to a smaller Home, Adelaide Park.

6. [HIA 210] was then fostered with a family in the area on the 20/1/1984. The foster family were very experienced. This initial placement broke down around the 13/4/1984 when [NL 191] was placed in Saint Patricks training School. This was for a short period after which he returned to the foster placement.

7. At this time [HIA 210] had been suffering nightmares which lead, on occasions, to him waking the family. He alleged to his foster parents that whilst in Nazareth Lodge he had been mistreated. This was around November 1984.

8. I interviewed [HIA 210] in the presence of his foster parents and he made a number of allegations which constituted abuse, being snatched, struck with implements such as a vacuum cleaner pipe. I had noted at the time that this may have provided some explanation as to the nightmares that he was experiencing.

9. Having listened to [HIA 210] I believed that there was some substance to the allegations he was making.

10. The allegations made by [HIA 210] were raised by me with my Senior Social Worker [NL 191].

11. [NL 191] and I subsequently met with [HIA 210] to discuss his allegations on the 21/2/1985.

12. The allegations were in turn raised with [NL 223], Principal Social Worker.

13. [NL 204]'s brother, was interviewed with regard to the allegations. He confirmed some of the caring practices though not to the same extent as [HIA 210].
14. NL 223 and NL 191 took responsibility for the continuation of the investigation.

15. I have no re-collection of being informed of the outcome of the investigation.

16. During my time in Child Care my contact with Nazareth Lodge would have been very limited.

17. Both HIA 210 and NL 204 I believe, had left Nazareth Lodge prior to my involvement.

18. Generally as Nazareth Lodge was outside of our Unit of Management area, we would tend to use homes in North and West Belfast area.

19. In general the aim would have been to maintain children at home or seek fostering placement. Residential Homes were used as a last resort or an interim measure to allow for the exploration of alternatives.

Statement of Truth

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

NL 180

Dated 23 January 2015
Relationships within the Family:

HIA 210

We have been surprised by the depth of feeling he has for the family and his very loving nature has warmed our home and won our hearts. The first month showed him to be inquisitive about our relationship as husband and wife and he would enquire about our feelings for one another and how we could reconcile so easily even after a disagreement. His mental picture of marriage seemed to be that pointed in T.V. shows like Dallas etc. where disagreement meant a family breakup. We did not shield him from the ups and downs of a normal marriage and we can see that he has grown to feel more secure with the display of feelings between us. In regard to the younger children, he did try to bully his who is six, but she dealt with herself and has become his greatest ally. The use of this term is deliberate as she shields and supports her daughter. He has corrected the little assertion in his bad behaviour in a way that makes it feels is acceptable. His who is two examines many times he will draw our attention to the new things that doing, remarking on the words is now using and enjoying the experience of teaching the baby. He will play with him and distract him to allow us to work about the house. When the children are disciplined we explain the reason for this and relate it to how our love for them and for him makes this imperative to prepare them for adult life.

HIA 210

There is nothing in the line of interests to draw the two closer except perhaps music but we have talked with about his responsibility towards as they are members of our family unit. There has been encouraging signs that this is helping and is showing an interest in the new things that he is doing. He sometimes is putting in an extra special effort to make sure that they are included in the games we play with the older ones, the concerts and story times. Recently has been having nightmares, he shouts and talks in his sleep, wakes with a sweating brow and appears to be unaware of his surroundings. It is impossible to understand what he is saying only one or twice could we hear his calling to be allowed out. He started through us talking about his own childhood experiences to tell some of the incidents that happened when he was in Nazeath Lodge. He received beatings as did the other children including his brother. He told their that were one of these and after she spoke they were brought to the office and told that they had deserved the beating. The social worker left both boys were put into a bath of cold water. He talks about being locked in a cleaning cupboard and on one occasion he was locked in the bathroom in the dark all night. When asked whether or not he was frightened by this his answer was ‘no, with delight’. We feel perhaps in the close environment of a Childrens Home he hid his reactions to any of these because of bravado. He could not express exactly why they were beaten, perhaps he was never told. He relates stories about Childrens Parties held by Organisations and toys and presents being given to them. One such gift was a hooter and gun which took off and he never saw them again.

We feel that perhaps these disturbing incidents are the cause of his nightmares. We along with the social worker are trying to build up a fuller picture of these events in an attempt to help him cope with his past.

Continued ............../3
THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of **NL 191**

1. **NL 191** will say as follows:

   1. I qualified as a Social Worker in 1976 after doing my professional Social Work qualification at University College Dublin and was awarded the Certificate Qualification in Social Work (CQSW). I hold a BSC honours obtained July 1974 and a Diploma in Applied Social Studies in 1976. I commenced work as a basically qualified social worker in 1974 and returned to work as a Social Worker in North and West Belfast Community Unit of Management after obtaining my professional qualification. I worked as social worker until my appointment as a Senior Social Worker in 1983 and was responsible for a team of Social Workers covering the west Belfast area. Subsequent to this post I continued to work in the Belfast Trust and moved to Older Peoples Services in 1987. I was appointed as an Assistant Principal Social Worker in 1991 and then as an Operations Manager in September 2004. I am currently an Assistant Services Manager, managing regulated services including domiciliary, residential and day care services.

   2. In relation to the applicant **HIA 210**, I was the Senior Social Worker who managed **NL 180**, social worker who was allocated **HIA 210**'s case. **HIA 210** had resided in the Southern area of management and was boarded out with a foster parent in West Belfast. His case was subsequently transferred to the North and West community unit of management and allocated to **NL 180** social worker. I have been shown the records available from that period, which highlights the issues raised by **HIA 210** in relation to Nazareth Lodge. **NL 180** brought to my attention as his line manager the issues raised by **HIA 210** concerning his time spent in Nazareth Lodge. At that time I also interviewed **HIA 210** and forwarded a record of my interview and issues
outlined to the principal social worker for further action to be taken. I can confirm that these reports, which I understand have also been submitted to the Inquiry, are a true reflection of my memory of this case.

3. As a social worker or as a team leader within the north and west unit of management I never had the responsibility for any other children who resided in Nazareth Lodge and had no contact with that residential facility.

4. I recall that this case was a very complex case in terms in trying to find suitable placements to meet HIA 210’s needs.

5. In relation to the concerns raised by HIA 210’s foster carers, NL 188, about HIA 210 having nightmares, then discussed this matter with HIA 210 and I have seen the report he prepared in respect of this. He followed this up by having a discussion with me and as a result, I decided that I would also interview HIA 210 which I did on 21st February 1985, see exhibit 1. Following this interview and my subsequent concerns with what HIA 210 had told me, I raised this issue with the senior manager NL 223 Principal Social Worker. I am aware from the notes in a historical file which I viewed on Monday 19 January 2015, that he reported this to the Eastern Health and Social Services Board who in turn reported this to DHSS, see exhibit 2

6. I clearly believe that there was credibility to HIA 210’s complaint about Nazareth Lodge and I believe that may have been a contributory factor to the nightmares he related at that time.

Statement of Truth

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

Signed: NL 191

Dated: 29 January 2015
Witness name: Health and Social Care Board

Date: 26 January 2015

The Inquiry into Historical Institutional Abuse 1922 to 1995

Exhibit 1
On 21. 2. 85 I interviewed [HIA 210] along with his foster parent, [NL 188] and [HIA 210] regarding the recent allegations that [NL 180] has been making about the way he was treated while in Nazareth Lodge. [HIA 210] has particularly bad memories of being locked in a cupboard for 4 – 5 hours as a means of punishment by both a member of staff called [NL 66] and [SR 62]. He said that he remembers that there was no light in this cupboard. He also said that he was hit with brush poles as a means of punishment. He described an incident concerning another child with whom he was in the Unit. According to [HIA 210] on one occasion [NL 97] was pushed against a sink and bashed his head. He had 2 black eyes as a result of this and was not brought to hospital for treatment. He said that was kept off school for about 2 to 3 weeks.

[HIA 210] said that he had told his Social Worker [NL 190] about being hit on one occasion by [SR 62] with a stick but the Social Worker he said believed [HIA 210] about this allegation. She said that he never told her about being hit and she never saw any signs of either [HIA 210] or [NL 204] being punished inappropriately while she was visiting them in Nazareth Lodge. On another occasion [HIA 210] remembers being hit and having a very sore arm and shoulder. [HIA 210] claims that [SR 62] would have used "anything she could get her hands on" to hit the children with. On one occasion he said that [NL 204] got hit with a hosepipe of a vacuum cleaner. [HIA 210] also said that he remembers being punched on the nose because he didn't want to go to his Irish Dancing classes. Another form of punishment which he described to me vividly was being locked in a bathroom all night long. He also remembers being put into cold baths.

[HIA 210] said that he remembers when he was about 6 or 7 years old going out to a family, [NL 190], with whom he was to be fostered. [NL 66] had bought him a bike for Christmas and when he brought it back to Nazareth Lodge it was taken off him and he never saw it again. [HIA 210] also said that the children in the Unit were threatened that if they misbehaved that the man who had abducted and murdered a young boy from the Ormeau Park would get them also.

On 3. 4. 85 I interviewed [HIA 210]'s brother [NL 204] with regard to the allegations which had made. [NL 204] had difficulty remembering who was in the Unit with him and along with his brother the other children he remembers were [NL 56] and [NL 66]. He has no memories of being moved to Nazareth Lodge. He remembered who he described as 'O.K.' He then said that she was "good and kind" to him. I asked him if he had ever remembered being hit by either [NL 56] or [SR 62]. He said that sometimes he would have got smacked around the head although this was never hard. [SR 62] he said would have hit the children with a wooden spoon or slipper. He denies ever having seen [HIA 210] being hit. When asked if he ever remembered seeing [NL 97] with black eyes he said he did – but this occurred when his brother and [NL 97] were playing 'hide and seek' and bumped into each other. When asked about the cupboard which [HIA 210] describes being locked into he said he remembers being told to go and stand in it. He also said that he found [HIA 210] in this cupboard on one occasion. This cupboard he said could be opened from both the inside and outside and was not locked when he found it. He does remember on one occasion being told to eat soup along with other children. However just as he was about to eat the soup it was taken off him. He also remembers not having a bike and there were bikes available for the children to play on.

NL 191

Senior Social Worker

GA: mc

11. 4. 85
Witness name: Health and Social Care Board

Date: 26 January 2015

The Inquiry into Historical Institutional Abuse 1922 to 1995

Exhibit 2
30 April 1985

Re HIA 210 - dob. 

Please find enclosed copies of 2 reports forwarded to me by NL 191, Senior Social Worker in the NL 188 office. They concern a boy, HIA 210, who is currently boarded out with NL 188 but who has been most of his life in Nazareth. The initial report dated 6.3.85 was not forwarded to you as it was felt that there were certain ambiguities in it and I asked NL 191 to follow up these issues. You will see from her report of 11.4.85 that she has been able to be somewhat more clear but there are still areas of discrepancy. The lad to whom she refers in this report, NL 188, is currently the subject of a transferred Fit Person Order from our Unit of Management to Antrim. I have not approached Antrim and felt that this might be something which you might wish to do formally.

The allegations that HIA 210 has made would certainly be of a serious nature. As a child he is not adverse to making allegations although we have no personal experience of him being dishonest in this nature although his interpretation of what has happened, as always the case, may be called into question.
21. 2. 85

On 21. 2. 85 I interviewed [ ] along with his foster parent, [ ] and [ ] S.W. regarding the recent allegations that [ ] has been making about the way he was treated while in Nazareth Lodge. [ ] has particularly bad memories of being locked in a cupboard for 4 - 5 hours as a means of punishment by both a member of staff called [NL 66 NL 66] and [SR 62 SR 62]. He said that he remembers that there was no light in this cupboard. He also said that he was hit with brush poles as a means of punishment. He described an incident concerning another child with whom he was with in the Unit. According to [ ] on one occasion [NL 97 NL 97] was pushed against a sink and banged his head. He had 2 black eyes as a result of this and was not brought to hospital for treatment. He said that was kept off school for about 2 to 3 weeks.

[ ] said that he had told his Social Worker [NL 190 NL 190] about being hit on one occasion by [SR 62 SR 62] with a stick but the Social Worker he said believed [NL 190 NL 190] about this allegation. She said that he never told her about being hit and she never saw any signs of either [NL 204 NL 204] or being punished inappropriately while she was visiting them in Nazareth Lodge. On another occasion [NL 204 NL 204] remembers being hit and having a very sore arm and shoulder. [NL 204 NL 204] claims that would have used 'anything she could get her hands on to hit the children with. On one occasion he said that he got hit with a hose pipe of a vacuum cleaner. [NL 204 NL 204] also said that he remembers being punched on the nose because he didn't want to go to his Irish Dancing classes. Another form of punishment which described to me vividly was being locked in a bathroom all night long. He also remembers being put into cold baths.

[ ] said that he remembers when he was about 6 or 7 years old going out to a family, with whom he was to be fostered. [ ] had bought him a bike for Christmas and when he brought it back to Nazareth Lodge it was taken off him and he never saw it again. [NL 66 NL 66] also said that the children in the Unit were threatened that if they misbehaved that the men who had abducted and murdered a young boy from the Ormeau Park would get them also.

On 3. 4. 85 I interviewed [NL 190] 's brother [NL 204] with regard to the allegations which had made. [NL 204] had difficulty remembering who was in the Unit with him and along with his brother the other children he remembers were [NL 56 NL 56] and [SR 62 SR 62]. He has no memories of being moved to Nazareth Lodge. He remembered who he described as 'O.K.' He then said that she was 'good and kind' to him. I asked him if he had ever remembered being hit by either or [NL 56 NL 56]. He said that sometimes he would have got smacked around the head although this was never hard. [SR 62 SR 62] he said would have hit the children with a wooden spoon or slipper. He denies ever having seen [NL 97 NL 97] being hit. When asked if he ever remembered seeing [NL 97 NL 97] with black eyes he said he did - but this occurred when his brother and [NL 204 NL 204] were playing 'hide and seek' and bumped into each other. When asked about the cupboard which [NL 204 NL 204] describes being locked into, [ ] said he remembers being told to go and stand in it. He also said that he found [ ] in this cupboard on one occasion. This cupboard he said could be opened from both the inside and outside and was not locked when he found it. He does remember on one occasion being told to eat soap along with other children. However just as he was about to eat the soap it was taken off him. [NL 204] also remembers having a bike and there were bikes available for the children to play on.

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Senior Social Worker

G.A. mc

11. 4. 85
21. 2. 85

On 21. 2. 85 I interviewed [NL 180] along with his foster parent, [NL 188] and [HIA 210] S.W. regarding the recent allegations that [SNB-6089] has been making about the way he was treated while in Nazareth Lodge. [HIA 210] has particularly bad memories of being locked in a cupboard for 4 - 5 hours as a means of punishment by both a member of staff called [NL 66] and [SR 62]. He said that he remembers that there was no light in this cupboard. He also said that he was hit with brush poles as a means of punishment. He described an incident concerning another child with whom he was with in the Unit. According to [HIA 210], on one occasion [NL 97] was pushed against a sink and bashed his head. He had 2 black eyes as a result of this and was not brought to hospital for treatment. He said that was kept off school for about 2 to 3 weeks.

[HIA 210] said that he had told his Social Worker [NL 190] about being hit on one occasion by [SR 62] with a stick but the Social Worker he said believed [HIA 210] about this allegation. She said that [HIA 210] never told her about being hit and she never saw any signs of either [NL 204] or [HIA 210] being punished inappropriately while she was visiting them in Nazareth Lodge. On another occasion [HIA 210] remembers being hit and having a very sore arm and shoulder. [HIA 210] claims that would have used 'anything she could get her hands on' to hit the children with. On one occasion he said that [NL 204] got hit with a hosepipe of a vacuum cleaner. [HIA 210] also said that he remembers being punched on the nose because he didn't want to go to his Irish Dancing classes. Another form of punishment which [HIA 210] described to me vividly was being locked in a bathroom all night long. He also remembers being put into cold baths.

[HIA 210] said that he remembers when he was about 6 or 7 years old going out to a family, [HIA 210] with whom he was to be fostered. [HIA 210] had bought him a bike for Christmas and when he brought it back to Nazareth Lodge it was taken off him and he never saw it again. [HIA 210] also said that the children in the Unit were threatened that if they misbehaved that the man who had abducted and murdered a young boy from the Ormeau Park would get them also.

On 3. 4. 85 I interviewed [HIA 210]'s brother [NL 204] with regard to the allegations which [HIA 210] had made. [NL 204] had difficulty remembering who was in the Unit with him and lives with his brother the other children he remembers were [NL 56] and [NL 66]. He has no memories of being moved to Nazareth Lodge. He remembered who he described as 'O.K.' He then said that she was 'good and kind' to him. I asked him if he had ever remembered being hit by either [NL 56] or [SR 62]. He said that sometimes he would have got smacked around the head although this was never hard. [SR 62] he said would have hit the children with a wooden spoon or slipper. He denies ever having seen [NL 97] being hit. When asked if he ever remembered seeing [NL 97] with black eyes he said he did - but this occurred when his brother and [NL 97] were playing 'hide and seek' and bumped into each other. When asked about the cupboard which he describes being locked into [NL 204] said he remembers being told to go and stand in it. He also said that he found [HIA 210] in this cupboard on one occasion. This cupboard he said could be opened from both the inside and outside and was not located when he found in it. He does remember on one occasion being told to eat soap along with other children. However just as he was about to eat the soap it was taken off him. [HIA 210] also remembers having a bike and there were bikes available for the children to play on.

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**NL 191**

Senior Social Worker

GA: mc
11. 4. 85
leave after a fight with another member of staff in which she threatened to throw hot chip fat round the other member of staff.

HIA210's view was that on the whole he did not deserve most of these beatings and that they were more severe than necessary. If these incidents are, in fact, true, it would give us a further insight into HIA210's behaviour."

Now in your statement you say that, having listened to HIA210, you believed there was some substance to the allegations that he was making, NL180.

A. Yes, I did.

Q. Can I ask why you felt that?

A. When HIA210 was telling me about the actual incidents as they -- that had happened, he seemed to relive part of them. He also was I think generally an honest child. He wasn't one that could create elaborate deceptions, and I do feel that in this instance he was telling the truth, and sitting face-to-face with him, that was my belief.

Q. You were saying -- we were talking about the type of child that he was earlier.

A. Uh-huh.

Q. You mentioned the fact he ended up in a special school.

A. Yes.
14. NL 223 and NL 191 took responsibility for the continuation of the investigation.

15. I have no re-collection of being informed of the outcome of the investigation.

16. During my time in Child Care my contact with Nazareth Lodge would have been very limited.

17. Both HIA 210 and NL 204, I believe, had left Nazareth Lodge prior to my involvement.

18. Generally as Nazareth Lodge was outside of our Unit of Management area, we would tend to use homes in North and West Belfast area.

19. In general the aim would have been to maintain children at home or seek fostering placement. Residential Homes were used as a last resort or an interim measure to allow for the exploration of alternatives.

Statement of Truth

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

NL 180

Dated 23 January 2015
On 21. 2. 85 I interviewed [NL 180] along with his foster parent, [NL 188] and [HIA 210] S.W. regarding the recent allegations that [NL 180] has been making about the way he was treated while in Nazareth Lodge. [HIA 210] has particularly bad memories of being locked in a cupboard for 4 - 5 hours as a means of punishment by both a member of staff called [NL 66] and [SR 62]. He said that he remembers that there was no light in this cupboard. He also said that he was hit with brush poles as a means of punishment. He described an incident concerning another child with whom he was with in the Unit. According to [HIA 210] on one occasion [NL 97] was pushed against a sink and banged his head. He had 2 black eyes as a result of this and was not brought to hospital for treatment. He said that he was kept off school for about 2 to 3 weeks.

[HIA 210] said that he had told his Social Worker [NL 190] about being hit on one occasion by [SR 62] with a stick but the Social Worker he said believed [HIA 210] in [SR 62]'s previous social worker [NL 190] about this allegation. She said that [HIA 210] never told about being hit and she never saw any signs of either [NL 204] or [NL 66] being punished inappropriately while she was visiting them in Nazareth Lodge. On another occasion [HIA 210] remembers being hit and having a very sore arm and shoulder. [HIA 210] claims that [SR 62] would have used 'anything she could get her hands on' to hit the children with. On one occasion he said that [NL 204] got hit with a hosepipe of a vacuum cleaner. [HIA 210] also said that he remembers being punched in the nose because he didn't want to go to his Irish Dancing classes. Another form of punishment which [HIA 210] described to me vividly was being locked in a bathroom all night long. He also remembers being put into cold baths.

[HIA 210] said that he remembers when he was about 6 or 7 years old going out to a family, [NL 190] with whom he was to be fostered. [NL 190] had bought him a bike for Christmas and when he brought it back to Nazareth Lodge it was taken off him and he never saw it again. [HIA 210] also said that the children in the Unit were threatened that if they misbehaved that the man who had abducted and murdered a young boy from the Ormeau Park would get them also.

On 3. 4. 85 I interviewed [HIA 210]'s brother [NL 204] with regard to the allegations which [NL 204] had made. [NL 204] had difficulty remembering who was in the Unit with him and along with his brother the other children he remembers were [NL 56] and [NL 66]. He has no memories of being moved to Nazareth Lodge. He remembered who he described as 'O.K.' He then said that she was 'good and kind' to him. I asked him if he had ever remembered being hit by either [NL 56] or [SR 62]. He said that sometimes he would have got smacked around the head although this was never hard. [SR 62] said he would have hit the children with a wooden spoon or slipper. He denies ever having seen [HIA 210] being hit. When asked if he ever remembered seeing [NL 97] with black eyes he said he did but this occurred when his brother and [NL 97] were playing 'hide and seek' and bumped into each other. When asked about the cupboard which [HIA 210] describes being locked into [NL 204] said he remembers being told to go and stand in it. He also said that he found [NL 97] in this cupboard on one occasion. This cupboard he said could be opened from both the inside and outside and was not locked when he found [NL 97] in it. He does remember on one occasion being told to eat soap along with other children. However just as he was about to eat the soap it was taken off him. He also remembers having a bike and there were bikes available for the children to play on.

NL 191

Senior Social Worker

GA:mo
11. 4. 85
outlined to the principal social worker for further action to be taken. I can confirm that these reports, which I understand have also been submitted to the Inquiry, are a true reflection of my memory of this case.

3. As a social worker or as a team leader within the north and west unit of management I never had the responsibility for any other children who resided in Nazareth Lodge and had no contact with that residential facility.

4. I recall that this case was a very complex case in terms in trying to find suitable placements to meet HIA 210's needs.

5. In relation to the concerns raised by HIA 210's foster carers, NL 188, about HIA 210 having nightmares, I have discussed this matter with HIA 210 and I have seen the report he prepared in respect of this. He followed this up by having a discussion with me and as a result, I decided that I would also interview HIA 210, which I did on 21st February 1985, see exhibit 1. Following this interview and my subsequent concerns with what had told me, I raised this issue with the senior manager NL 223, Principal Social Worker. I am aware from the notes in the historical file which I viewed on Monday 19 January 2015, that he reported this to the Eastern Health and Social Services Board who in turn reported this to DHSS, see exhibit 2.

6. I clearly believe that there was credibility to HIA 210's complaint about Nazareth Lodge and I believe that may have been a contributory factor to the nightmares he related at that time.

**Statement of Truth**

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

**Signatures**

NL 191

Dated 26th January 2015
30 April 1985

Re NL 223

Please find enclosed copies of 2 reports forwarded to me by NL 191, Senior Social Worker in the NL 188 office. They concern a boy, HIA 210, who is currently boarded out with NL 188, but who has been most of his life in Nazareth. The initial report dated 6.3.85 was not forwarded to you as it was felt that there were certain ambiguities in it and I asked NL 191 to follow up these issues. You will see from her report of 11.4.85 that she has been able to be somewhat more clear but there are still areas of discrepancy. The lad to whom she refers in this report, NL 97, is currently the subject of a transferred Fit Person Order from our Unit of Management to Antrim. I have not approached Antrim and felt that this might be something which you might wish to do formally.

The allegations that HIA 210 has made would certainly be of a serious nature. As a child he is not adverse to making allegations although we have no personal experience of him being dishonest in this nature although his interpretation of what has happened, as always the case, may be called into question.
5. He remained there until December 1983 before being transferred to a smaller Home, Adelaide Park.

6. [HIA 210] was then fostered with a family in the [REDACTED] area on the 20/1/1984. The foster family were very experienced. This initial placement broke down around the 13/4/1984 when [REDACTED] was placed in Saint Patricks training School. This was for a short period after which he returned to the foster placement.

7. At this time [REDACTED] had been suffering nightmares which lead, on occasions, to him waking the family. He alleged to his foster parents that whilst in Nazareth Lodge he had been mistreated. This was around November 1984.

8. I interviewed [REDACTED] in the presence of his foster parents and he made a number of allegations which constituted abuse, being snatched, struck with implements such as a vacuum cleaner pipe. I had noted at the time that this may have provided some explanation as to the nightmares that he was experiencing.

9. Having listened to [REDACTED], I believed that there was some substance to the allegations he was making.

10. The allegations made by [REDACTED] were raised by me with my Senior Social Worker [NL 191].

11. [NL 191] and I subsequently met with [REDACTED] to discuss his allegations on the 21/2/1985.

12. The allegations were in turn raised with [NL 223], Principal Social Worker.

13. [NL 204], [REDACTED]'s brother, was interviewed with regard to the allegations. He confirmed some of the caring practices though not to the same extent as [REDACTED].
14. **NL 223** and **NL 191** took responsibility for the continuation of the investigation.

15. I have no re-collection of being informed of the outcome of the investigation.

16. During my time in Child Care my contact with Nazareth Lodge would have been very limited.

17. Both **HIA 210** and **NL 204** I believe, had left Nazareth Lodge prior to my involvement.

18. Generally as Nazareth Lodge was outside of our Unit of Management area, we would tend to use homes in North and West Belfast area.

19. In general the aim would have been to maintain children at home or seek fostering placement. Residential Homes were used as a last resort or an interim measure to allow for the exploration of alternatives.

**Statement of Truth**

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

**NL 180**

Dated 23 January 2015
7.3 From the records, it would appear that I asked **NL 191** to seek, if possible, to clarify some ambiguities in the original statement. The record suggests that she wrote to me again on the 11th April 1985 to set out the position, see Exhibit 2.

7.4 Nazareth Lodge, was a Regional facility taking children from Districts across a number of Boards. The names of all the children, on the list provided by **NL 191** were not familiar to me; therefore, I believed that a number of these young people would be in the care of other Boards or Districts within the Eastern Board. Consequently, if this matter were to be progressed, along the lines suggested by **NL 191** in her letter of 6th March 1985 this would require a degree of central co-ordination at Board or possibly Departmental level.

7.5 I then wrote to Mr Bunting, Assistant Director of Social Services, Family and Child Care on 30th April 1985. See Exhibit 3. I did so to:-

- Draw this issue to his attention, as I was required so to do;
- Alert him to the fact that children from other Units of Management or Boards might need to be involved, and to
- Seek his advice.

I believe that my letter to Mr Bunting reflected the fact that initial enquiries had produced little corroboration of the allegations.

It appeared that inadvertently I caused some confusion by giving the wrong Christian name of a boy whom **HIA 210** had mentioned as also being the victim of possible physical abuse.

7.6 In April 1985 when these allegations were shared they were historical in nature. **HIA 210** was no longer a resident in the home. **SR 62** and **NL 66** against whom **HIA 210** made his allegations, had both left the home. I had learnt that **SR 62** was no longer working with children.

Therefore, whilst it was clear that these matters needed to be investigated, there appeared no longer to be any obvious or present risk to any child.
Eastern Health and Social Services Board
North and West Belfast Community
Unit of Management

CONFIDENTIAL

27 June 1985

SR 143

Nazareth Lodge Children's Home
516 Ravenhill Road
BELFAST BT6

Dear SR 143

Further to our discussion on the 25.6.85. You will recall that I mentioned that both
HIA 210 and NL 191, Senior Social Worker, Andersonstown office, had interviewed
HIA 210 on Friday 21.6.85. As you now, HIA 210 was in Nazareth from approximately

HIA 210 has made a list of complaints about the treatment he received in Nazareth and,
in particular, has cited 2 individuals, NL 66 and SR 62. The list of
complaints that HIA 210 has raised are as follows -

1. That on one occasion SR 62 punched him in the nose, drawing blood.

2. On another occasion another boy in the unit at that time by the name of NL 97
was struck by SR 62 and, as a consequence, banged his head off a wash-
hand basin causing him severe swelling to his face and 2 black eyes.

3. On numerous occasions he says that he was physically punished by both
HIA 210 and NL 66, the latter he recalls using a bamboo cane, and the former, a
stick or mop handle.

4. On numerous occasions he was locked in a store cupboard under the stairs. This
cupboard was normally used to store domestic equipment and he says he was made to
sit in it for lengthy periods of time.

5. On 2 or 3 occasions he says he was made to sleep in the bathroom as a punishment
over-night.

6. He says that on one occasion he complained to his social worker, NL 190, who
was then employed by the Southern Health and Social Services Board, that she
took this issue up with HIA 210 and on leaving, SR 62 put both him
and his younger brother, NL 204, into a cold bath as a punishment for having spoken
to his social worker.

7. He says on numerous occasions he was deprived of food for periods up to one day, and

8. On one occasion he was served liver as his meal, disliking liver one of the other
children placed this in a waste-bin. When SR 62 came into the room he
discovered the liver, took it out of the waste-bin and made him eat it.

As you will be aware we suggested to you that HIA 210 was quite prepared to confront anyone
on these allegations and was strenuous in his insistence that he was telling the truth.
He quoted a number of other children who were in the unit at that time whom he alleged

/.....
would collaborate his story. He recalled other members of staff, namely NL 146 and NL 147, whom he spoke highly of and, indeed, he recognised in himself a certain attachment to SR 62. We therefore believed that whilst there is a possibility that there might be some exaggeration, nevertheless SR 62’s allegation must be taken seriously.

As you will know, Mr Bunting, with whom I have consulted, has suggested that in the company of yourself I should speak to NL 146 and NL 147 about their time in the unit. I have told Mr Bunting that SR 62 is currently in Middlesborough and is not working with children and that the whereabouts of NL 66 are unknown, although we will try to ascertain this. At this stage it is not my intention to interview any of the other children cited by HIA 210, although I presume this remains a possibility.

Yours sincerely

NL 223

PRINCIPAL SOCIAL WORKER

cc NL 191

Mr R Bunting ADSS
7.7 Subsequently, and following correspondence between the Director of Social Services and the Chief Social Work Adviser, I was required by the Director of Social Services as set out in his letter to \[**SR 143**\] dated 13th June 1985 to investigate this matter. See Exhibit 4.

7.8 On the 21st June 1985 the record suggests that I and \[**NL 191**\] met with HIA 210 I wrote to \[**SR 143**\] on the 27th June 1985 setting out the allegations which HIA 210 had made. I concluded that NL 191 and I "believed that whilst there is a possibility that there might be some exaggeration, nevertheless HIA 210's allegation must be taken seriously" See Exhibit 5.

7.9 On the advice of Mr Bunting, I arranged to interview two members of staff, mentioned with some fondness by HIA 210. One of these was still a member of staff in the home but the other had left some time ago. The result of these interviews is set out in my letter of 8th July 1985 to Mr Bunting, a copy of which was also given to \[**SR 143**\] See Exhibit 6. Despite neither member of staff corroborating his account I remained of the opinion that his account of events "should not be lightly dismissed", and set out the reasons why I had come to this conclusion.

Despite the fact that there was no corroborations, it was my opinion having conducted these interviews, that there was a need for a fuller investigation. I note from my letters that I was impressed by the manner in which HIA 210 told his story.

7.10 A related issue arose in relation to a child, \[**NL 145**\] who revealed to her Social Worker NHB 136, that she had been abused in Nazareth. This was brought to my attention and therefore, I brought this to the attention of Mr Bunting in a memo with an attached report on 26 November 1985. See Exhibit 7

HIA 210 also referred to another child \[**NL 97**\] and further to my discussions with Mr Bunting, I undertook to interview \[**NL 97**\] I did so and this is detailed in a subsequent memo that I sent to Mr Bunting on 18 February 1986.
7.17 In relation to the debate between the Board and the Department as to how any investigation should be conducted, I did not believe that I had the authority to conduct a full and thorough investigation, I had no power to interview staff, access Nazareth House records or for that matter interview children from other Boards or Districts. These were my views then and they are my views now.

7.18 However, I believe it important to try and put this incident into its historical context. I want to state that the Complaints Procedure for children in Residential Care issued on 30th April 1985, did not come into operation as expected. There followed protracted discussions, primarily with Management and Staff Side of the General Joint Council to seek safeguards for Residential Care staff. Pending resolution of this problem NIPSA instructed its members not to co-operate with the implementation of these procedures. This was referred to in the Hughes Report see Exhibit 11 paragraph 13.97.

7.19 This, I believe, reflects the significant change in practice which was associated with the introduction of a Complaints Procedure, which indirectly changed the relationship of the Social Worker, the child and the institution. The fact that this debate was taking place at the same time as the Hughes Inquiry was gathering evidence is also not co-incidental.

7.20 However, irrespective of this, matters such as this always both need time to "bed in" and more importantly practice time for these systems to be tested, reviewed and revised. The issues here were complex, today they would be handled much more straightforwardly because practice is stronger and better informed by experience.
8 July 1985

Re: Nazareth Lodge and the Complaint of HIA 210

As you requested I interviewed NL 147 and NL 146, the two staff members mentioned by HIA 210 whose whereabouts are known and who are currently available. SR 143 kindly organised these interviews as NL 147 continues to work within Nazareth and NL 146 (although no longer employed) lives close by.

Both state that they have no previous knowledge of the complaints that are being made. They deny any knowledge of practices of children -

1) being locked in the domestic cupboard,
2) being allowed to sleep on the bathroom floor,
3) having their mouths washed out with soap and
4) having meals withheld from them.

They acknowledge that there was some element of physical punishment of the children but both put this very much at the minor end of the continuum using words such as 'snapped' or 'tipped'. They are unaware of the incidents that are cited with regard to himself and NL 97. They further said that they have no knowledge of implements, sticks or canes, being used to beat the children.

NL 147 worked in the Unit from 1979-81. She was the member of staff who replaced NL 68 and NL 146 worked in the Unit from November 1978 through to her marriage in July 1981. They both said that the atmosphere in the Unit was good at that time, the children were a happy, contented bunch. They knew of no reason why HIA 210 should be making these allegations as they say he was very much the favourite of SR 62 and she quite frequently made excuses for him.

In conclusion, there was nothing stated at that meeting to confirm any of the allegation which HIA 210 has made. However, as I have relayed to SR 143, I feel that even allowing for the fact that HIA 210 is undoubtedly a child who has suffered quite a disturbed early experience and is of limited intelligence, I believe that there is some substance to the allegations that he has made. These, I have no doubt, may well be exaggerated or, indeed, distorted by his perception of relationships but the way in which he told his story, the fact that he was very specific about incidents and was anxious to be believed and to tell his story to anyone including staff in Nazareth, plus the fact that he was discriminating in terms of the members of staff whom he mentioned, leads me to believe that his story should not be lightly dismissed.
SNB-7032

EASTERN HEALTH AND SOCIAL SERVICES BOARD
NORTH AND WEST BELFAST DISTRICT

MEMORANDUM

From: P.S.W.

To: R Bunting - A.D.S.S.

cc: R G Black - A.D.S.S.

Ref: NL 223

18 February 1986

re: NL 97 Nazareth House Complaint

When last we spoke on this matter I undertook to interview NL 97 at the earliest opportunity. This I did in the presence of his mother who wished to be present on 7.2.86. Prior to seeing NL 97 - Senior Social Worker, Cliftonpark Office - who was known to the family, had made contact and explained the background.

NL 97 is physically a very small boy for his age and was also quite immature. He was quite embarrassed initially, giggling frequently, but as the discussion wore on he played a more responsible part. I think it would be difficult to give great credence to his views other than on this matter, namely, the fact that he was frequently physically abused by SR 62.

He confirms that SR 62 beat him and HIA 210, in particular, regularly with a wooden spoon or a bamboo cane. He confirms that on one occasion SR 62 banged his head against a wash-hand basin causing him to bleed. There was no swelling to his face and no black eyes as reported by HIA 210. He does however recall an incident involving HIA 210 when the two boys were playing, ran into each other and he ended up with two black eyes and a swollen face. He is quite specific in his complaint that SR 62 picked upon him and HIA 210 to excess although he again was in a position to name other children, particularly SR 57 and SR 62 whom he thought had also been beaten by SR 62.

HIA 210, on the one hand expresses very strong feelings that she had beaten him unnecessarily and yet, on the other hand, expressing considerable affection for her. He denies that any other member of staff beat him and he also denies that he was ever locked in a cupboard or had his food withheld as a punishment. He does however recall that SR 62 was sometimes locked in a cupboard although he thought this was upstairs rather than downstairs as HIA 210's story would indicate. He reports that he was regularly put into a cold bath although it would appear that this was more to do with the temperature of the water being insufficient rather than any desire to punish him, unlike HIA 210 who says that he was given cold baths as a punishment.

During this part of the interview NL 97 sat quietly. When encouraged to speak she substantiated what NL 97 had said in that she reported a particular incident towards the end of 1979/beginning 1980 when he had returned from Nazareth with his thigh bruised as a result of having been beaten with a wooden spoon. NL 229 said that she had a version that SR 62 had beaten him which was confirmed by her elder daughter who was also in the unit. She challenged SR 62 who denied the incident. NL 229 said that she was not prepared to accept the denial. She also recalls telling one of the other nuns (I think she said SR 29) who was in charge of one of the other units and finally she said she told NL 110 who was then the social worker. NL 110 left our employ approximately two years ago and is working in a third world country. I have had the files checked for that period and there is no mention of this incident.

Contd...
re: NL 97/ Nazareth House Complaint Contd

In conclusion, NL 97 again confirmed that during this period there had been a heavy handedness and put the responsibility for this on to SR 62. NL 223 is convinced that there was at least one incident where this resulted in NL 97 being bruised and said that she did not know of the other incident where his head had been struck against the wash-hand basin. NL 97, to a limited extent, has confirmed the practice of locking at least HIA 210 in a store cupboard but he has not confirmed any of the other allegations that made.

I honestly believe that I can take this matter no further as I do not feel that I have the authority to deal with any of the issues that this incident now raises and I would ask to be freed from any further involvement in this issue until matters of accountability have been clarified.

NL 223
Principal Social Worker
section 168 is ‘examination’, which we considered covered both. Besides, they had accepted it as their responsibility with regard to the complaint by

2.10 While a discussion was offered rather than further correspondence, arrangements were already underway for the PSW to interview the third complainant and this took place on the 7th February 1986, the same date as the CSWA’s second letter, see Exhibit 3 in relation to sequence of correspondence in relation to this. He must have been aware that this was going to happen before he sent his letter. Consequently we decided to complete this interview rather than discuss the matter as we expected to obtain further corroboration of HIA 210’s allegations.

2.11 The Department appeared to be concerned about their responsibilities, while we were trying to ensure that we had the best arrangements in place to provide an opportunity for the children to be heard, as to the care and treatment they had received during this period; and, if they had been abused, to hold the relevant staff to account for this, including investigation by the Police, if necessary.

With regard to the legal principles underpinning complaints I have already referred in the statement in relation to parens patriae and the Paramountcy Principle; the latter ensuring that the welfare of the child supersedes all other considerations. We were of the view that the best way of implementing these principles was through a co-operative approach to investigation, when dealing with general malpractice; with the Department as the Registering Authority and Inspectorate taking the lead role, as the outcome could have implications for the continued registration of the Home. Instead, we were being told to implement procedures which were not fit for purpose as far as general malpractice in residential care was concerned.

2.12 was interviewed on the 7th February 1986, and the report from the PSW to me is dated the 18th February 1986, see Exhibit 4. It is the copy for District records and the original is not available, consequently I am unable to confirm whether I received this report at the time. If I did, I would
have discussed it with the DSS, but this would have been done within a matter of days normally and could not account for the delay in sending it to the CSWA (30th April 1986).

2.13 To date, no other records have been located in relation to this period. However there are records relating to the 1984 – 1986 Hughes Inquiry and I can still clearly recall the few months following the publication in January 1986 of the Hughes Inquiry Report. This was a very busy period for both the Director and myself and indeed the Department, as we had to respond to the Report and prepare papers for the Board in relation to the recommendations which had been accepted, as well as dealing with the press and media.

This had to be given top priority. It was also a traumatic period for me personally, as I considered that I had been treated unjustly in this Report and the Board had agreed that I could put a written response on the Board’s records, as this was also the view of my colleagues and Board members who knew me well.

2.14 Although it was historic abuse, and the children in Nazareth Lodge were no longer at risk, we were anxious to bring this matter to a conclusion and the Report should have been forwarded to the CSWA within a week of me receiving it.

I cannot recall having seen it at this time. There are only two possible explanations; either I did not receive it at this time, or it was mislaid and it’s discovery, in either, eventuality, was prompted by the PSW contacting me to find out what was happening, as any correspondence with the CSWA was copied to him. The latter is more likely to have happened in my view.

2.15 This had happened on a number of occasions in the past, when different correspondence had become attached. I always had a full in-tray and a full pending tray because of my workload. I had to prioritise my work on a daily basis and was usually only able to respond quickly to high priority cases. Other cases were treated as pending and it would sometimes be a few
In the event of the Administering Authority's non-co-operation, the Department could have deregistered the home, in which case the Administering Authority should have closed the home.

Failure to close the home following deregistration might have led to the Department taking legal action against the Administering Authority.

5.7 Regulations at that time did not specify procedures to be followed or criteria to be met when considering the question of the continuing registration of a voluntary home. It is not clear, for example, whether failure by an Administering Authority to close a home following its deregistration by the Department would have been a criminal offence. Nevertheless, the above actions could have been followed had circumstances arisen, which required the Department to act against an Administering Authority.

5.8 Where investigation by an Administering Authority led to disciplinary action against a member of its staff, the Administering Authority was required under Departmental Policy, which established the Pre-employment Consultancy Service in 1983, to notify the Department of details of any person who had either been dismissed or who had resigned in circumstances that suggested that children might be placed at risk if that person were again appointed to a position involving responsibility for children's welfare.

Options in respect of a child in the residential home

5.9 Where an Inspector had reason to believe that a child was at risk because of the behaviour of a member of the home's staff, SSI would have been expected to notify both the HSS Trust responsible for the child, and also the Administering Authority. In accordance with its child protection responsibilities under Section 94 of the Children and Young Persons (NI) Act 1968, the responsible HSS Trust would have been required to investigate and, where necessary, take action to protect the child. If criminal behavior was suspected, the police would also have been notified by the responsible HSS Trust.

5.10 The Departmental guidance document, Co-operating to Protect Children (DHSS, 1989 - Appendix 3) and subsequent child protection policy and procedures implemented by HSS Boards in 1991 under Area Child Protection arrangements, provided for child abuse allegations to be investigated under joint protocol arrangements between the Police and Social Services. (HIA 7746)

6.0 Overview of inspections of Nazareth Lodge in 1993, 1994 and 1995

6.1 In my capacity as Assistant Chief Inspector I would have read and signed off each of these inspection reports. Reading them again some 20 years later I remain satisfied that these reports reflected progress in the conduct of inspections at that time. They adhered to the use of agreed professional standards, the requirement for reports to be
Dear Sir

CO-OPERATING TO PROTECT CHILDREN

A Guide for Health and Social Services Boards on The Management of Child Abuse

Introduction

1. This circular introduces revised guidance on procedures for the prevention, detection and management of child abuse, including child sexual abuse. This guidance is set out in the attached document Co-operating to Protect Children: A Guide for Health and Social Services Boards on the Management of Child Abuse. The circular summarises the main points in the Guide; draws attention to some specific recommendations in Lord Justice Butler-Sloss's Report of the Inquiry into Child Abuse in Cleveland 1987 (the Cleveland Report); refers to resources and other issues, and outlines action which Boards should take to implement the guidance.

Background

2. The Guide is the outcome of a detailed and comprehensive review of existing Departmental guidance on child abuse. The review was undertaken by the Child Abuse Review Group, a multi-disciplinary group set up within the Department to examine the existing guidance in the light of developments here and in Great Britain, and to produce new or revised guidance as necessary. As part of their review, the Group consulted extensively with a wide range of interests, and carried out a number of exercises to assess how child abuse cases were being handled under current procedures by the various professional groups within Boards.

3. The Guide corresponds in many respects with the guidance contained in Child Abuse: Working Together issued jointly by the Department of Health and Social Security (now the Department of Health) and the Welsh Office, and incorporates many of the recommendations in the Cleveland Report, copies of which were sent on publication to General Managers for distribution to the relevant chief professional officers. The Guide also reflects comments and views received during the consultation period which followed its issue in draft form.
Purpose and Scope of Guide

4. The Guide replaces much of the existing Departmental guidance on child abuse, in particular the guidance contained in:
   - Circular HSS(Gen 1) 1/75, Non-Accidental Injury to Children, issued on 15 April 1975;
   - Circular CCB 1/78, Child Abuse, issued on 24 February 1978; and
   These circulars are now cancelled.

5. Circular HSS (CCB) 7/78, Release of Prisoners Convicted of Offences against Children in the Home, issued on 20 November 1978, remains in force. That circular sets out the arrangements under which probation officers in prison and other custodial establishments notify Directors of Social Services of the release of prisoners convicted of certain offences against children in the home. The Northern Ireland Office intend to review these arrangements in the light of changes which the Home Office are expected to introduce to the corresponding arrangements in operation in England and Wales. The Department will issue revised guidance on this subject as necessary.

6. The Guide is aimed particularly at staff who are professionally concerned with the protection of children. However, it is now recognised that effective child protection requires the co-operation of agencies other than the Police, the National Society for the Prevention of Cruelty to Children (NSPCC), the education services and the Probation Service. The Guide should also be of use to these agencies and to those of their staff whose duties bring them into contact with children. Copies of the Guide have, therefore, been distributed to these and other agencies concerned with the protection of children.

7. The Guide is concerned primarily with the procedural aspects of managing child abuse and is intended to provide a general framework within which to develop and strengthen the detailed local procedures set out in the handbooks which they have each produced. It does not attempt to provide guidance on professional practice, nor is it intended to replace professional judgement or initiative. The Guide must be read, therefore, in conjunction with any relevant guidance on professional practice which may be issued from time to time. To date the following guidance has been issued:

   - Diagnosis of Child Sexual Abuse: Guidance for Doctors; a report prepared by the Standing Medical Advisory Committee for the Secretaries of State for Social Services and for Wales; issued by the Chief Medical Officer to each doctor in Northern Ireland on 8 July 1988;

   - Child Protection: Guidance for Senior Nurses, Health Visitors and Midwives; a report prepared by the Standing Nursing and Midwifery Advisory Committee for the Secretaries of State for Social Services and for Wales; issued by the Chief Nursing Officer to Chief Administrative Nursing Officers on 15 July 1988;

   - Protecting Children: A Guide for Social Workers Undertaking a Comprehensive Assessment; prepared by the Department of Health (London); issued by the Chief Inspector, Social Services Inspectorate to Directors of Social Services on 24 November 1988;
- Working with Child Sexual Abuse: Guidelines for Training Social Services Staff: produced by a training group on child sexual abuse established by the Department of Health (London); issued by the Chief Inspector, Social Services Inspectorate to Directors of Social Services in June 1989.

Summary of Guide Contents

3. In summary, the Guide:

- advises on the establishment of appropriate management procedures and organisational structures to enable *boards* to respond effectively but sensitively to the problem of child abuse;

- clarifies the roles and responsibilities of the various agencies and professionals involved in the child abuse field, which should help to promote a proper understanding of each other's functions in respect of children;

- outlines the steps to be followed in the management of child abuse cases, and stresses the need for an interdisciplinary and interagency approach in this process;

- introduces a greater degree of consistency than there has been to date in the definition of child abuse;

- clarifies that the full application of interagency procedures may not be necessary or appropriate for the investigation of cases of extra-familial abuse;

- gives guidance on the handling of child sexual abuse cases which should be brought within the broader child abuse procedures; particular problems are highlighted which need to be considered in the investigation stages and which call for close co-operation between the *people* and the Police in the fields of interviewing and medical examination;

- refers to the need to direct attention to perpetrators of child sexual abuse, with the aim of tackling child sexual abuse effectively in the longer term and reducing its incidence;

- requires *teams* to replace child abuse registers with child protection registers which in future will have a more proactive and positive role as a management tool, and gives advice on the purpose, status and maintenance of such registers, and on the criteria for registration;

- clarifies the role and purpose of interdisciplinary case conferences;

- stresses the need for the provision of expert advice to and supervision of staff working in the child abuse field, and for training in child abuse including child sexual abuse;

- gives guidance on the involvement of children and parents in the investigation processes, including attendance and representation at case conferences;

- requires *teams* to reconstitute existing Area Review Committees under the new name of Area Child Protection Committees, and advises on their accountability, composition and responsibilities;

- seeks to promote a clear understanding of the main points of child care law as it applies to the care and protection of children and its implications
for the discharge of professionals' and agencies' respective responsibilities.

Recommendations in the Cleveland Report

Parents

9. The Cleveland Report highlighted the need to inform and where appropriate to consult parents at each stage of the investigation, to involve them as far as possible in the decision making process, and to ensure that they are fully informed of the decisions made and their implications, and their rights of appeal and complaint. Where practicable, arrangements for the attendance of parents at case conferences for all or part of the meeting should be made unless in the view of the Chairman their presence would preclude a full and proper consideration of the child's interest. Where allegations or suspicions of abuse prove unfounded this should be made explicitly clear to parents.

10. Parents should be encouraged to seek help, as the prompt and early provision of advice and services can do much to keep families together and to prevent child abuse. When suspicions have been raised it is important to have regard for the anxieties parents may feel.

11. Insofar as it is consistent with the need to protect the child, every effort should be made to support and work with the parents and to obtain their co-operation in and support for child protection plans. This always requires that they are kept properly informed of what is intended and why, and their views sought and taken into account.

Children

12. Although the procedures recommended in the Guide are needed if children at risk of being abused are to be given effective protection, it is important that all those involved in the investigation and subsequent management of child abuse cases are conscious of how the process may affect the children concerned. Points of good practice to remember are set out in Part 3 of the Cleveland Report as follows:

"a. Professionals recognise the need for adults to explain to children what is going on. Children are entitled to a proper explanation appropriate to their age, to be told why they are being taken away from home and given some idea of what is going to happen to them.

b. Professionals should not make promises which cannot be kept to a child, and in the light of possible court proceedings should not promise a child that what is said in confidence can be kept in confidence.

c. Professionals should always listen carefully to what the child has to say and take seriously what is said.

d. Throughout the proceedings the views and the wishes of the child, particularly as to what should happen to him/her, should be taken into consideration by the professionals involved with their problems.

e. The views and the wishes of the child should be placed before whichever court deals with the case. We do not, however, suggest that those wishes should predominate.

f. Children should not be subjected to repeated medical examinations solely for evidential purposes. Where appropriate, according to age and
understanding, the consent of the child should be obtained before any medical examination or photography.

g. Children should not be subjected to repeated interviews nor to the probing and confrontational type of 'disclosure' interview for the same purpose, for it in itself can be damaging and harmful to them. The consent of the child should where possible be obtained before the interviews are recorded on video.

h. The child should be medically examined and interviewed in a suitable and sensitive environment, where there are suitably trained staff available.

i. When a child is moved from home or between hospital and foster home it is important that those responsible for the day to day care of the child not only understand the child's legal status but also have sufficient information to look after the child properly.

j. Those involved in investigation of child sexual abuse should make a conscious effort to ensure that they act throughout in the best interests of the child.

Place of Safety Orders

13. The Cleveland Report recommended that place of safety orders should only be sought for the minimum time necessary to ensure protection of the child, and that records related to the use of statutory powers on an emergency basis should be kept and monitored regularly by social services departments. The Department endorses these recommendations which should be reflected in Boards' local child abuse procedures. These should contain a section setting out in what circumstances place of safety orders should be sought and how the case should be handled if they are granted, including the provision of information to parents. The existing statutory provisions relating to place of safety orders are contained in the Children and Young Persons Act (Northern Ireland) 1968. These have been reviewed, and, as indicated in the Consultation Paper issued jointly by the Department and the Office of Law Reform in September 1989, it is intended to bring forward new provisions for the emergency protection of children, corresponding broadly with those in the Children Act 1989. Such provisions will be contained in the draft Order in Council to replace the 1968 Act, which is expected to be published for consultation in 1990.

Child Sexual Abuse Perpetrators

14. The Guide acknowledges in paragraphs 5.18-5.22 that if child sexual abuse is to be tackled in the longer term and its incidence reduced, attention must be directed to perpetrators, but that work in this field is at an early and developmental stage. It acknowledges also that the treatment of perpetrators requires an interdisciplinary, interagency approach. The Department will be discussing with the other interests involved how best this work might be developed on a co-ordinated basis so that the most effective use is made of existing resources, knowledge and skills.

Statistics

15. [Blank] provide the Department with statistical information on the number of children on child abuse registers on 31 December each year, and on the number of confirmed and suspected new cases of child abuse and child sexual abuse which arise in the course of the year. The Department will review its statistical requirements in the light of the revised guidance and will issue advice to [Blank] early next year. In reviewing its requirements, the
Department will also take account of progress made in England and Wales in developing a set of national statistics.

Resources

16. The Department recognises that the implementation of the new guidance will have resource implications. Additional funds have already been made available under the Department’s 3 year central training initiative on child abuse, which started in September 1988, to enable boards to improve and extend training for staff involved in child abuse work. In addition, following the 1989 Public Expenditure Survey, an extra £350,000 has been included in boards’ revenue allocations for 1990/91 for the implementation of the guidance. The expenditure of these funds will be reviewed through the annual Accountability Review process.

Action for Boards

17. Specific action which boards should take on foot of this circular to implement the new guidance is outlined below. For ease of reference, the relevant paragraphs in the Guide are shown in brackets.

a. boards should ensure that their arrangements for safeguarding information received about abused children on a confidential basis, and for ensuring the prompt transfer of relevant records when a child and/or family moves to or from another area, are adequate (paragraph 4.9);

b. boards should also ensure that they have effective arrangements for enabling members of the public to report suspected cases of child abuse, and that these arrangements are widely publicised within their respective areas (paragraph 4.13);

c. In addition, boards should have clear and specific procedures for investigating cases of child abuse involving their staff (paragraph 4.15);

d. boards should take the lead in liaising with other agencies concerned with the protection of children with a view to developing agreed local procedures for co-operating in the investigation and subsequent management of child abuse cases. The two agencies principally concerned are the Police and the NSPCC. The procedures should, in particular, provide for:

i. early informal inter-professional discussions (described in the Guide as strategy discussions) to decide the strategy for investigation in an individual case (paragraph 4.16);

ii. arrangements for joint interviews to avoid unnecessary repeated interviewing by social workers, doctors and Police of children who have been or are suspected of having been sexually abused (paragraphs 4.17);

iii. arrangements to avoid subjecting children to repeated medical examinations solely for evidential purposes by, for example, providing for joint examinations by a forensic medical officer and a paediatrician, or by a paediatrician with forensic training (paragraphs 4.19 and 5.5); 

iv. medical examinations in cases of child sexual abuse to be carried out by nominated officers, who could be forensic medical officers, paediatricians or other doctors with the required expertise, in
designated settings for example, hospitals, doctors' surgeries or Police special examination suites for victims of child abuse and sexual crimes (paragraph 5.5);

v. interdisciplinary assessment of sexual abuse cases of particular difficulty (paragraphs 5.11 and 5.12).

Liaison on these procedures could be conducted through the mechanism of the Area Child Protection Committees, or, where the Police are involved, it may be more appropriate to use the machinery of the Liaison Arrangements agreed by the Department, Police and Boards in April 1986;

e. Boards should ensure that place of safety orders are sought for the minimum time necessary to ensure the protection of the child and that their child abuse procedures contain adequate instructions on the taking of such orders (paragraph 4.18 and Appendix 6);

f. Boards should ensure that they have clear procedures to enable parents to challenge decisions or to pursue complaints about the way in which their cases have been treated, and that both staff and parents are aware of these procedures (paragraph 4.40);

g. Boards should ensure that in all the relevant disciplines their arrangements for providing professional supervision and support for fieldwork staff dealing with child abuse, particularly those dealing with child sexual abuse are adequate (paragraphs 4.42 and 5.13);

h. Boards should identify a suitable person within each relevant discipline to provide expert advice on child abuse procedures and practice, if necessary arranging for the persons concerned to receive appropriate training, and also to be responsible for giving advice to staff outside their own disciplines (paragraph 4.43). In addition, Boards should try to ensure as far as practicable that cases of child sexual abuse are handled only by staff who have been prepared and trained for the task, and that access to advice is available from experienced personnel when required (paragraph 5.10);

i. a single, suitably experienced and senior person should be nominated to be responsible for co-ordinating child abuse matters within the Board as a whole, and to act as a central point of contact and liaison with other agencies. It is considered that this function would be most appropriately carried out by the person identified within the social work profession as responsible for the provision of expert advice on child abuse procedures and practice (paragraph 4.44);

j. Boards should continue to develop appropriate training strategies on child abuse and child sexual abuse, including interdisciplinary and interagency training, for relevant staff, drawing on whatever expertise is available locally and elsewhere (paragraphs 5.15 and 9.2);

k. Boards should continue to explore ways of preventing child sexual abuse (paragraphs 5.16 and 5.17);

l. existing child abuse registers whether at Area or local level should be replaced with child protection registers in each Unit. An experienced social worker with knowledge of child abuse work ("the register manager") should be given responsibility for managing each register. Information on arrangements for access to the registers should be incorporated in procedural handbooks and disseminated to those concerned (paragraphs 6.1, 6.6 and 6.7);
m. when a child's name is entered on or removed from the child protection register, the Board should ensure, where relevant, that the school is informed of this and of other details such as the care status or placement of the child or changes thereto (paragraphs 3.3, 6.5 and 6.11);

n. Area Review Committees should be reconstituted under the new name of Area Child Protection Committees (paragraph 8.2). Each Committee should make an annual report as soon as possible after the end of each financial year to the Board and to the head of each participating agency, and copied to the Department (paragraph 8.10). The first report should cover the period from the present up to the end of March 1991 and should be submitted to the Department by 29 June 1991;

o. Boards should review and if necessary revise the guidance contained in their local procedural handbooks in the light of the advice contained in the Guide. They should consider the adoption of a loose-leaf format which would facilitate regular review and revision in future (paragraph 2, Appendix 6).

Review of Action by Boards

18. The Department intends to review, on a multidisciplinary basis, the progress which Boards have made in implementing the guidance. In preparation for this, Boards should report to the Department by 29 June 1991 on the action taken to implement the guidance, and should submit at the same time the first annual reports from the reconstituted Area Child Protection Committees referred to in paragraph 17 above and in paragraph 8.10 of the Guide. The Departmental review will take place in the Autumn of 1991 and will include an inspection by the Social Services Inspectorate of the handling of child abuse cases being dealt with by social workers.

Guidance to Education Services

19. Corresponding guidance on the action which should be taken in relation to cases, or suspected cases, of child abuse encountered within the education services is being issued simultaneously by the Department of Education. The Department will send copies to Boards.

Enquiries

20. Any enquiries about this circular and the attached Guide should be made to Mr S T P Wilson, Child Care Branch, at the above address, telephone number: Belfast 650111, Ext 355.

Yours faithfully

J R KEARNEY
Assistant Secretary
Child Care & Social Policy Division