6. I did not believe, in the context of 1985 society, that there was sufficient evidence to present to the RUC, which would have resulted in a criminal investigation. My sense was that this matter needed further investigation by Social Services and personnel from the Home, although I note the disquiet in the Hughes Report when addressing this type of issue.

7. The May 1985 Guidance in relation to Complaints at sections 32 and 33 clarified that the decision maker, in relation to referral to the Police of matters of a criminal nature, was the Director of Social Services and or the Chairman of the Management Committee of the Voluntary Body. At this time, I had no previous experience of an issue such as this.

8. There were obvious issues for me about conducting such an investigation, there were no guidelines as to how such an investigation should be conducted; there was no training in place with regard to carrying out such investigations and to my knowledge no research had been undertaken as to what constituted best practice, given the fact that the introduction of similar complaints procedures across the UK, was so recent

9. Further to what I have stated in my initial statement at paragraph 7.15, instinctively I believed that I had neither the power nor the time to conduct such an investigation. In relation to the power. I had no authority to access records of the Home, nor to interview SR 62 or for that matter the previous Mother Superior. Nor did I have the power to interview children in the care of other Districts within the Eastern Board or other Boards. Intuitively I believed this was the responsibility of others, namely the Department and the Sisters of Nazareth. I would re-refer to Exhibit 8 of my initial statement which I understand is now identified at SNB 7032-7033 and to the last paragraph of this document.

10. I would also point out that the decision to ask me to undertake this investigation, was not consistent with Section 28 of the Complaints Procedure Guidance which stated that "Boards should be prepared to assist voluntary bodies in the investigation of the complaint". I appreciate that this Guidance could not be introduced in 1985 and was therefore operationally non-extant.

See Exhibit 8. NL 97 confirmed to me that SR 62 beat him and [redacted] HIA 210 egularly with a wooden spoon and a bamboo cane. He also confirmed that on one occasion SR 62 banged his head against a wash hand basin causing him to bleed. He indicated that SR 62 picked upon him and [redacted] HIA 210 to excess.

This information re NL 97 is referred to in the Director of Social Services letter of 30 April 1986 to the Chief Social Work Adviser. See Exhibit 9. Mr Moore states that this corroborates the allegations made by HIA 210 and [redacted] NL 145 with regard to the behaviour of SR 62. In this same letter he goes on "there can no longer be any question that the information, we now have available, from three former residents amounts to alleged general malpractice and in some instances physical assault by SR 62.

7.11 I am aware that SR 143 conducted her investigation of the allegations made by these three young people. I note that this occurred sometime in 1986. I cannot recall whether I saw this report in 1986 but I have not seen it as part of this process. However, I note that the Director of Social Services expressed his dissatisfaction with this investigation and as a consequence required that all three children should be approached, made aware of the outcome of this investigation and offered the assistance of social work staff, if they wished to make a complaint to the Police.

7.12 I note that in his letter of 19th February 1987 in relation to the allegations of ill treatment, Mr Bunting informs SR 143 that all three young people were contacted and informed of their right to make a complaint to the Police, if they so wished See Exhibit 10.
In the case of HIA 210 it appears that he did not wish to do this.

7.13 I have been asked to comment specifically on why I did not refer this matter to the police.
I would firstly cite the accounts provided to me by NL 191, of her interview with HIA 210 dated 21st February 1985 and with his brother NL 204 dated

5. A large element of my posting involved implementing the recommendations of the Sheridan Report. This work included the development of a complaints procedure for children in residential care.

6. The process of developing the complaints procedure covered a number of stages:

- a consultation paper was issued in October 1983;
- in the light of the responses received, draft guidance was drawn up and circulated in August 1984;
- again having regard to responses, the guidance was revised, finalised and issued in May 1985.

Copies of these documents are attached.

7. A significant difficulty encountered in the development of the procedure was the withdrawal of co-operation by staff organisations because of their concerns that staff would not be given adequate protection from unfounded allegations of mistreatment. Faced with this, DHSS had two options: to defer the issue of guidance until staff co-operation had been achieved; or to issue the guidance in the absence of co-operation. DHSS chose the former. While the position was not ideal, it was felt that proceeding to issue the guidance could be more helpful to those in the care system than countenancing a potentially open-ended delay.

8. The scheme outlined by DHSS required the Health and Social Services Boards and voluntary organisations to develop the detail of their own operational complaints arrangements. This was in recognition of the fact that, not only did voluntary organisations differ structurally one from the other, but so too did the Boards. The Boards would, rightly, have resisted any attempt by DHSS to impose a uniform detailed scheme on them.

9. One point which has been raised about the complaints guidance is the action which was expected when a complaint was made. Two areas of the guidance are relevant:

EXTRACT FROM HUGHES REPORT

Medical care

13.87 Our scrutiny of the files of residents, that is those files maintained in the homes, suggested that the requirements of the 1975 Direction and 1975 Regulations were not always met as regards the medical care of the children. We also noted some expressions of concern about this in both the Department's and the Boards' records. Mr Bunting of the Eastern Board told us that medical officers are appointed on a contract which usually entails an obligation to spend at least an hour each week in the home. This is over and above visits required to treat ailments among the residents. A doctor may, by virtue of his training and experience, be able to detect physical or emotional distress in a child which may not be recognised by others. We attach importance to the regularity of his visits. We recommend that the monitoring arrangements of Boards and voluntary organisations should cover the regularity of medical inspections as well as the maintenance of medical records.

Complaints procedures

13.88 The Sheridan Report recommended that the Department should consider "introducing adequate arrangements for looking at complaints made by children and their parents about treatment in children's homes".

13.89 On 21 October 1983 the Department issued a "Consultative Paper on a Complaints Procedure for Children in Residential Care and their Parents". Following consideration of comments received the Department issued on 31 August 1984 a "Draft Circular on the Provision of Information to and a Complaints Procedure for Children in Residential Care and their Parents". After a further round of consultation the Department on 30 April 1985 issued a circular entitled "Provision of Information to and a Complaints Procedure for Children in Residential Care and their Parents". This circular outlined a complaints system to be introduced by the four Boards and by voluntary residential child care organisations by 1 May 1985.

13.90 The main features of the Complaints Procedure are as follows:-

a. Boards and voluntary organisations are obliged to provide booklets to children in residential care and their parents, setting out information pertinent to the child's circumstances including the rules of the home;

b. the booklets must also include illustrative listings of grounds of complaint for both children and parents;

c. children and parents are to be encouraged to raise their complaints in the first instance with staff in the home but they may also complain to the child's field Social Worker or to the visiting social worker (generally in R&DC management) required to inspect the home each month;

d. it must be made clear to children and parents that the Complaints Procedure does not affect their rights to complain through other channels, such as members of the Board or Management Committee, Members of Parliament and of the Northern Ireland Assembly. The Department's circular does not refer specifically to the Police;

e. children are to be provided with prepaid Contact Cards, addressed to the Director of Social Services of the Board in whose care they have been placed. Complaints may be initiated through these cards and Directors are obliged to "put in train whatever investigatory action (they) deem appropriate", to keep themselves informed of the progress of the investigation, to receive a full report and to inform the complainant of the outcome;

f. all complaints which appear to allege criminal activity must be referred to the Director of Social Services who is "responsible for deciding whether, on the basis of the evidence available, the Police should be notified". Such complaints by residents of voluntary homes must be referred to the Chairman of the Management Committee who is obliged to inform the appropriate Director of Social Services. "The decision whether, or at what stage, to inform the Police may be taken either by the Director or the Chairman of the Management Committee";

g. the Department is to be informed of any complaints alleging criminal activity which are referred to the Police;

h. each children's home must keep a Complaints Book. This should record the nature of the complaint, the name of the complainant, action taken and the manner in which the complaint is resolved;

i. complaints are to be referred to the Assistant Director (Unit of Management) or Chairman of the Management Committee as appropriate for "secondary recording". The operation of the secondary recording procedure will be reviewed within a reasonable period to ascertain whether changes are necessary;

j. Boards and voluntary organisations are to give guidance as to which staff are to have access to Complaints Books but the field Social Worker for a child in a voluntary home should have right of access to the Complaints Book in the home;

k. Board staff at Unit of Management level and Management Committees are to regularly monitor complaints in statutory and voluntary homes respectively. In addition Directors of Social Services or their nominees at Area level are required to review complaints in statutory homes at three monthly intervals and to report to their Boards. A similar review of complaints in voluntary homes is to be conducted by the Department on the basis of quarterly returns from Management Committees.

13.91 The 30 April 1985 Complaints Procedure did not specify the investigation procedures to be applied to complaints but requested Boards and voluntary bodies to submit details of their procedures. The Department indicated that the procedures should reflect certain "points of principle":-

a. the complainant should know that his complaint is being recorded and be consulted about the accuracy of the record;

b. the complainant and the person against whom the complaint has been made should be kept informed at regular intervals of the progress of the investigation;

c. the complainant should be informed of the name and business address of the person who is taking the lead in the investigation;

d. there should be no time limit within which complaints are to be made if they are to be investigated;

e. staff against whom complaints are made should be informed at the earliest possible opportunity;

f. the rights of staff should be safeguarded during any investigative process.

13.92 Any guidance on the mode of initial investigations into complaints produced by the General Joint Council, on which Social Services management and staff interests are represented, would be incorporated into the investigation procedures of the Boards. Voluntary organisations would be advised to work within the spirit of any such revised procedures.

13.93 The Project for Children in Care and After Care told us that their discussions had revealed that "Some ..... felt that you could turn to a member of staff or your social worker and tell them your complaint, but ..... it was very much dependent on the attitude of staff and social workers. Some ..... felt that it was important to know and to have trust in the person we were complaining to as there is a real fear of reprisal. Others simply felt it was a case of 'them against us' and that an adult's word would be taken in preference to the young person". The PCCAC submission continued "..... opportunities for making complaints ..... through your social worker were not always possible as you only saw your social worker once a month..... Also privacy, when talking to your social worker was not always guaranteed" (see also paragraph 13.77). PCCAC recommended that "in order for young people to have confidence in the care system ..... a proper and fair complaints procedure be established as soon as possible with the needs of the young person central to its overall structure".

13.94 The written submission from the Association of Directors made a number of pertinent points. It stated that ".... children should have ready access to outside influences which should include the Homes Officer, their parents, social workers, independent visitors or, if necessary, the Police. Authorities should ensure that access to outsiders by children is not restricted. We do believe that children can be fairly easily diverted from making complaints about a grievance if the initial impulse to do so can be delayed". It went on to say that "structured, formalised complaints procedures directed to the needs of children in care have recently been introduced by a handful of Authorities..... We know of no research into how the newly modelled complaints systems are working". In commenting on the Department's proposed procedures, the Association maintained that "where an allegation of an illegal act is part of the substance of the complaint, notification to the Police should be automatic. It should be for the Police to decide, on advice, whether more detailed investigation is necessary, whether sufficient evidence exists to warrant prosecution, whether discretion should be exercised and whether or not to proceed with prosecution if particular circumstances warrant such a discretion. If such procedures are not followed, then dangerous precedents may be made regarding the rule of law".

13.95 BASW(NI) welcomed the introduction of the Department's procedures but suggested "... it should be a last resort. We should seek to open up communication with children in care on as broad a front as possible." The Association also observed that "staff in homes since this whole matter has become the subject of public controversy, are particularly vulnerable. They will be particularly careful about putting themselves in any situation which could in any way be compromising. They may be afraid to show appropriate affection to children seeking or needing it, and may refrain from any physical contact".

13.96 The NIPSA submission also drew attention to certain concerns of residential staff. It stated "Staff in homes now fear for their own positions if they physically comfort a distressed child or if they are alone with a child. The fear is partly of misunderstanding leading to allegations against them. It is also of children retaliating against their treatment by staff by deliberately fabricating allegations. Staff can hope that investigation will show such an allegation not be be substantiated but it is often a different matter to show that it was positively untrue ..... the reaction of management to the disclosures of abuse have heightened their fears that they will in essence have to prove themselves innocent in the event that an allegation is made against them, whatever the motives behind it ..... An essential part of (management's task) is reassuring the staff that, if they fall foul of the implicit risks, they will be fully supported. There is nothing in this approach inconsistent with the prevention of abuse".

13.97 In fact the Complaints Procedures were not fully implemented on 1 May 1985 as envisaged by the Department's circular. The Department informed us on 20 November 1985 that it had not been possible for Management & Staff Sides of the General Joint Council to reach agreement on the question of safeguards for residential child care staff. Pending resolution of this problem, NIPSA instructed its members not to co-operate in the implementation of the procedures and it was not possible for the Boards to distribute the explanatory booklets or introduce their procedures. Urgent negotiations were continuing at the General Purposes Committee of the General Joint Council. Voluntary organisations had been able to achieve a greater degree of implementation as far as their homes were concerned.

13.98 We ourselves are convinced that a formal complaints procedure designed specifically for residential child care is a necessity. We support a formal procedure because it encapsulates the principle that the child or young person has a right to complain about misconduct, mistreatment or poor standards of care. That right, of course, has always existed and was exercised on a number of occasions as evidenced in this report. While we believe that embarrassment and a misguided sense of guilt inhibited those residents who did not make any complaint about homosexual abuse, we are not satisfied that young people in residential care had a sufficiently strong sense of their status and rights. This manifested itself in a strain of resigned fatalism in the evidence of some of the former residents who assisted this Inquiry. A formalised right to complain goes some way to improving the self-image of those in residential care and to help them overcome inhibitions about lodging even well-founded complaints. In addition, a defined procedure is vital to protect Social Services staff who are faced with complaints from residents. The variety of approaches which we have described, some of which we have criticised, illustrates the need to provide staff with clear guidelines. Having established our support in principle, we also wish to record that we are substantially in agreement with the main features of the procedures as set out in the 30 April 1985 circular. We will, therefore, confine our comments to certain points on which we consider these procedures might be improved.

13.99 The provision of booklets explaining the procedures, in language which children and young people can understand, is to be welcomed. There is no point in having a procedure unless those who may have to use it have effective access to it. We examined the Northern Board's booklet and found that it strikes a good balance between comprehensiveness and simplicity of presentation. The booklet also describes certain rights and responsibilities which residents have and includes guidance on what staff may do to deal with misbehaviour. This introduces a useful and necessary counterbalance to the listing of grounds for complaint. It does not, however, refer to the right of children or parents to complain to persons outside the Social Services. It should be made clear that the Department's circular does not specifically require that this be written into the booklets, merely that it be explained to children and their parents. Even allowing for the opportunities provided within the Social

Services by the complaints procedure, we consider that this option ought to be expressly mentioned in these booklets. We further recommend that the examples of "other channels" through which to direct complaints quoted in the Department's April 1985 circular should be extended to include the police. This omission struck us as strange in view of the primary concerns of this Inquiry, since they also provided the stimulus for the formulation of the Complaints Procedures. The involvement of the police should, of course, be a last resort and would only be appropriate where a complaint alleges criminal behaviour. There may be an anxiety that specific mention of the police in the booklets could result in their involvement in cases where it is not necessary and also that recourse to other channels would detract from the effectiveness of the Social Services procedures. These are reasonable reservations but they are less important than acquainting children with their rights and allowing them to decide through which channel they wish to pursue their complaints.

13.100 The second point on which we take issue with the April 1985 circular relates to the involvement and responsibility of Directors of Social Service. We support their involvement through the Contact Card system, though we hope that residents will rarely find it necessary to use them. The provision that they should be actively involved in dealing with all complaints alleging criminal activity is also welcome, though we believe that this might be reviewed once the procedures have been tested and proved satisfactory. We do not believe, however, that Directors should have, in relation to complaints which appear to allege criminal activity, the unlimited discretion which might be implied in being "responsible for deciding whether on the basis of the evidence available, the Police should be notified, or whether further information will be required before a decision on this point can be made".

13.101 Our view of this can best be illustrated by considering circumstances most likely to occur. If a child alleges without corroboration that a member of staff has committed a sexual assault on him and the member of staff denies the allegation, it is unsubstantiated because corroboration is not available. It may still, however, be true. It seems to us that, in such circumstances, it should not be open to the Director to decide, on the basis of his assessment of the veracity of the two parties, not to inform

the police. The question of whether a criminal offence may have occurred is not primarily a social work or a management or a disciplinary issue, it is a matter for investigation by the police. We do not see the Director as having any discretion in this area, but under an absolute obligation to refer the allegation to the competent authority. To take another example, the child's allegation may be denied by the accused member of staff and the denial may be supported by a third party. The allegation is also unsubstantiated and the evidence against it is stronger than in the first example, but if there has been collusion between the accused and the third party it may still be true. In any event, the child has made an allegation in relation to a matter which falls within the competence not of the Social Services, but of the police. If the allegation is well founded but the police and/or the DPP decide that there is insufficient evidence on which to proceed, then that decision has been taken by the appropriate agency after due process. It follows that every criminal allegation which is made by a child and then sustained through the Complaints Procedure should be referred to the police. This reasoning appears to underlie the evidence of the Association of Directors (see paragraph 13.94).

13.102 It is, of course, possible to envisage an allegation which is clearly unsustainable. The circumstances may be such that it was literally impossible for the accused to have committed the offence or the denial by the accused may be corroborated by a large number of credible eye witnesses. We consider these to be an exception to our general rule. Accordingly we recommend that the Complaints Procedure should provide that Directors must refer all allegations of criminal activity to the police except those which are patently false. The evidence against such discredited allegations should be documented, by way of statements where appropriate, but in such cases purely for the protection of staff and the employing authority.

13.103 The Director does, of course, have a discretion in relation to what disciplinary action is taken in parallel with criminal investigations by the police. We have suggested that precautionary suspension was justified and necessary in certain cases (eg paragraph 4.225). The Director may also decide to initiate disciplinary action in relation to matters on

which the competent authorities have decided not to proceed (eg paragraph 7.76). All of these decisions, however, are separate and distinct from a decision as to whether a criminal offence has occurred.

Preliminary investigations and liaison with the police

13.104 This leaves the question of what, in practical terms, Social Services staff should do on receipt of an allegation of criminal activity implicating a member of staff. It is not our intention that staff should go to the police at the first hint of a complaint of a criminal nature. Some form of structured preliminary investigation is necessary. We endorse the "points of principle" set out in the April 1985 circular (see paragraph 13.91) and would summarise our recommended procedure for a preliminary investigation as follows:-

a. the member of staff receiving the complaint should contact the child's Primary or Key Worker, his Social Worker, and the home's line management;

b. the child should be interviewed by his Social Worker (Primary or Key Worker if the Social Worker is not available) in the presence of another officer and his complaint recorded;

c. the recorded complaint should be referred to the appropriate member of the home's management eg R&DC manager;

d. the R&DC manager, in the presence of another officer, should advise the accused member of staff of the allegation, give him an opportunity to involve his union, staff association or legal representative and record any explanation or evidence which he wishes to provide;

e. the R&DC manager should interview, in the presence of another officer, any parties who are suggested by the child or the accused as capable of providing corroboration or relevant evidence and make a written record of the interviews;

f. the R&DC manager should refer the product of this preliminary investigation through his Assistant Director (Unit of Management) to the Director for consideration in the context of the Complaints Procedure and the recommendations which we have made above;

g. if in any doubt as to whether a criminal offence is implied, the R&DC manager, Assistant Director or Director should seek advice from their legal staff or the RUC.

13.105 In October 1983 Sir George Terry recommended that "Consideration should be given to the appointment of an officer of Inspector rank on each Division as the main point of liaison between the Local Authorities and the Police". The RUC informed us that officers at Inspector level are to be appointed at sub-divisional level to liaise with the Boards and voluntary organisations on matters concerning children in care. We welcome this initiative and the fact that the RUC is to go further than Sir George Terry's proposal in establishing the network at sub-divisional level. Indeed its importance cannot be over-stressed. It provides the well-defined mode of approach to the police by child care services which we have repeatedly advocated. We are disappointed, however, that by December 1985 the recommendation had not been implemented although the RUC informed us that discussions are continuing with a view to introducing the arrangements for residential child care early in 1986 and also to widening the scope of the arrangements to cover other child care services.

Recording of complaints

13.106 The recording of complaints, of action taken on them and of their outcome raises complex issues. No difficulty arises in connection with complaints which result in convictions for criminal offences. These can be recorded by the employing authority and used as a basis for subsequent disciplinary action if considered appropriate. Similarly with cases where the police or DPP determine that no prosecution be brought but the employing authority initiates disciplinary proceedings which result in the accused member of staff being disciplined. In both cases, relevant papers should be held in a Unit of Management file and on the personnel file of the member of staff. The appropriate entries will also be made in the home's Complaints Book.

13.107 Complaints which do not result in conclusive criminal or disciplinary action against members of staff are much more difficult. Complaints which are withdrawn at the first stage or subsequently should be documented up to and including the point of withdrawal in the Unit of Management file, with no papers placed on the staff member's personnel file. Those which are deemed by the Director to be patently false should be similarly treated, with the Director's decision clearly marked on them. There may also be complaints which the police and/or DPP decide should not be made the subject of a prosecution, or which result in an acquittal, and which

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.

j. Boards and voluntary organisations are to give guidance as to which staff are to have access to Complaints Books but the field Social Worker for a child in a voluntary home should have right of access to the Complaints Book in the home;

k. Board staff at Unit of Management level and Management Committees are to regularly monitor complaints in statutory and voluntary homes respectively. In addition Directors of Social Services or their nominees at Area level are required to review complaints in statutory homes at three monthly intervals and to report to their Boards. A similar review of complaints in voluntary homes is to be conducted by the Department on the basis of quarterly returns from Management Committees.

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c. the complainant should be informed of the name and business address of the person who is taking the lead in the investigation;

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13.92 Any guidance on the mode of initial investigations into complaints produced by the General Joint Council, on which Social Services management and staff interests are represented, would be incorporated into the investigation procedures of the Boards. Voluntary organisations would be advised to work within the spirit of any such revised procedures.

5. A large element of my posting involved implementing the recommendations of the Sheridan Report. This work included the development of a complaints procedure for children in residential care.

6. The process of developing the complaints procedure covered a number of stages:

- a consultation paper was issued in October 1983;
- in the light of the responses received, draft guidance was drawn up and circulated in August 1984;
- again having regard to responses, the guidance was revised, finalised and issued in May 1985.

Copies of these documents are attached.

7. A significant difficulty encountered in the development of the procedure was the withdrawal of co-operation by staff organisations because of their concerns that staff would not be given adequate protection from unfounded allegations of mistreatment. Faced with this, DHSS had two options: to defer the issue of guidance until staff co-operation had been achieved; or to issue the guidance in the absence of co-operation. DHSS chose the former. While the position was not ideal, it was felt that proceeding to issue the guidance could be more helpful to those in the care system than countenancing a potentially open-ended delay.

8. The scheme outlined by DHSS required the Health and Social Services Boards and voluntary organisations to develop the detail of their own operational complaints arrangements. This was in recognition of the fact that, not only did voluntary organisations differ structurally one from the other, but so too did the Boards. The Boards would, rightly, have resisted any attempt by DHSS to impose a uniform detailed scheme on them.

9. One point which has been raised about the complaints guidance is the action which was expected when a complaint was made. Two areas of the guidance are relevant:

- the guidance expected allegations to be explored in order to make some assessment of their nature and substance (para 28.0 of the procedure - SNB-19080). This was intended to have regard to the position of staff who could be vulnerable to malicious or unfounded allegations (para 18.0 of the procedure - SNB-19079);

- however, the guidance also specified that complaints **alleging criminal activity** should be referred to the Director of Social Services in the case of a statutory home or, in the case of a voluntary home, to the Chairman of the home's management committee and, thence, to the Director of Social Services. The decision to inform the police would be made by the Director in respect of a statutory home; or by the Chairman of the management committee **or** the Director in respect of a voluntary home.

10. I was aware of allegations of mistreatment made in relation to a number of children in Nazareth Lodge and handled during the period 1984/5/6. When the initial allegations were made in 1984, the Department was already devising the complaints procedure for children in care, and had undertaken a process of consultation. An important principle was that a child in care was the responsibility of the Board which held the Care Order for that child. Therefore, it fell to the Board concerned to handle a complaint made by, or in respect of, that child, regardless of whether the child had been placed in a statutory or voluntary children's home. Where the child was in a voluntary home, the Board and the management of the voluntary home were expected to co-operate in the handling of any complaint.

11. DHSS had a role in monitoring complaints in relation to voluntary homes (and statutory homes) so that it would be aware of the extent and nature of complaints made and would be able to identify causes for concern, eg, in relation to the number of complaints in a particular home. Concerns arising from that monitoring process could trigger further Departmental action as necessary.

lie on a bed while she was beaten with part of 'a shower unit' by SR 62. Another girl received similar punishment. She has also spoken of a member of staff in the same unit who made the young people, boys and girls, roll up their trouser legs while she beat them with a stick across their legs.

She considers the physical punishment she received was minor compared with that experienced by two brothers and a '[redacted] boy'.

I am concerned that this young girl should have had such an adverse experience and that she has been deprived of the excellent standard of care currently practised in SR 2 's unit.

NHB 136

Social Worker

[redacted]/CE

19.11.85

EXHIBIT 1.



REPORT

Re: NL 145 D.O.B. [redacted]

I have been visiting NL 145, at least, monthly since 4th October 1983 and during this time I've discussed her years in Nazareth Lodge on several occasions and for 2 main reasons:-

(a) On my initial visit I was concerned about NL 145's unresponsive, negative attitude. In an effort to establish a more positive response I spoke to her of an eighteen year old whom I had met while I was a student at Queens. When I tentatively said that this girl had indicated that discipline had been strict NL 145 became animated named the girl (I've forgotten the name) and said they both had been in SR 62's unit and that she too had experienced similar forms of discipline as did some boys she named. In no sense was NL 145 distressed, rather she seemed to be happy to be able to communicate about something.

(b) However, I noted her comments and decided to return to the subject when I had developed a better relationship. On doing this and having made contact with NL 145's feelings she became very distressed and cried uncontrollably. This scene is repeated every time I focus on this area of concern. On two occasions I have discussed the topic with NL 145 while alone with NL 217 [redacted]. NL 217 have become concerned and surprised as they knew NL 145 during the relevant years and were not aware of anything. NL 145 insists she did try to tell them and her Social Worker but no one seemed to take her seriously. She believed no one would listen to her as SR 62 appeared so pleasant and interested in NL 145's welfare when Social Worker and NL 217 visited. There was a sense too that this punishment was acceptable to all adults concerned.

As NL 145 is now 18 years old, will not return to Nazareth Lodge and SR 62 [redacted] is elderly and no longer working with children. I focused on the essence rather than detail of the events NL 145 relayed *Apparently she resides in the main convent sometimes opening the main door.

NL 145 was happy in St Joseph's till she moved to Nazareth Lodge when she was 7 years old. She went to live with foster parents when she was 14 years (see C11's for details). Her father died in 1979 when she was nearly 12 years and it would appear that life in Nazareth Lodge was unpleasant from this time. She has spoken of being made to

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I have been visiting NL 145 at least, monthly since 4th October 1983 and during this time I've discussed her years in Nazareth Lodge on several occasions and for 2 main reasons:-

(a) On my initial visit I was concerned about NL 145's unresponsive, negative attitude. In an effort to establish a more positive response I spoke to her of an eighteen year old whom I had met while I was a student at Queens. When I tentatively said that this girl had indicated that discipline had been strict NL 145 became animated named the girl (I've forgotten the name) and said they both had been in SR 62's unit and that she too had experienced similar forms of discipline as did some boys she named. In no sense was NL 145 distressed, rather she seemed to be happy to be able to communicate about something.

(b) However, I noted her comments and decided to return to the subject when I had developed a better relationship. On doing this and having made contact with NL 145's feelings she became very distressed and cried uncontrollably. This scene is repeated every time I focus on this area of concern. On two occasions I have discussed the topic with NL 145 while alone with NL 217 [redacted]. NL 217 have become concerned and surprised as they knew NL 145 during the relevant years and were not aware of anything. NL 145 insists she did try to tell them and her Social Worker but no one seemed to take her seriously. She believed no one would listen to her as SR 62 appeared so pleasant and interested in NL 145's welfare when Social Worker and NL 217 visited. There was a sense too that this punishment was acceptable to all adults concerned.

As NL 145 is now 18 years old, will not return to Nazareth Lodge and [redacted] SR 62 is elderly and no longer working with children. I focused on the essence rather than detail of the events NL 145 relayed *Apparently she resides in the main convent sometimes opening the main door.

NL 145 was happy in St Joseph's till she moved to Nazareth Lodge when she was 7 years old. She went to live with foster parents when she was 14 years (see C11's for details). Her father died in 1979 when she was nearly 12 years and it would appear that life in Nazareth Lodge was unpleasant from this time. She has spoken of being made to

REPORT

Re: NL 145 D.O.B. [redacted]

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EASTERN HEALTH AND SOCIAL SERVICES BOARD

NORTH AND WEST BELFAST COMMUNITY UNIT OF MANAGEMENT

MEMORANDUM

From NL 223 - P.S.W. To Mr R Bunting - A.D.S.S. EH+SSB

Ref. [redacted]/mg Ref. AP3219

26 November 1985

Please find enclosed copy of a report forwarded to me on behalf of a girl who was a resident in Nazareth Lodge several years ago. As you will see, NL 145 is making a complaint about the harshness of the regime which prevailed at that time. She too is talking in terms of the physical punishment that she received but notes that for the boys, life could be much harsher.

You will remember that I carried out a limited investigation at the Department's request, the results of which I forwarded to yourself. At the time I remained unconvinced about the denials that I was receiving from ex staff in Nazareth. This complaint only heightens that lack of confidence.

NL 223

Principal Social Worker

Enc

Mr P J Armstrong

**NAZARETH LODGE CHILDREN'S HOME**

1. In March 1984 the Eastern Board referred a report to us setting out a number of complaints in relation to the running of this Home. These were:

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

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

   - the use of surplus food from Marks and Spencers.

   These complaints were investigated by Mr Walker and Mr Chambers 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.

2. On 15 May 1985 Mr Moore wrote to you with reports from North and West Belfast Unit of Management which contained allegations of physical abuse by a boy, HIA 210, who had lived in the Home from 28 September 1973 to 9 August 1981. These allegations were made when the child, who was placed with foster parents, was having nightmares and was interviewed about his experiences in the Home.

3. HIA 210 alleges that:

   - he regularly received beatings from SR 62 who used whatever implement would be at hand;

   - he was placed in a bath of cold water as punishment for informing his social worker about the beatings;

   - he was locked in a bathroom overnight without lights; and

   - he was placed in a locked cupboard.

4. The North and West Belfast Unit of Management staff investigated these allegations by interviewing the boy on 2 occasions, his brother on one occasion and a social worker who had responsibility for him during his time in the Home. The interviews with his brother and social worker did not corroborate his allegations and the Unit of Management report concluded "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".

   In his letter of 15 May Mr Moore stated "as these allegations described unacceptable child care practices rather than complaints relating to one child, I would be grateful for your

views on the appropriate action which should be taken in this matter".

5. In your reply of 29 May 1985 you stated "I think it would be better if HIA 210's complaint could be dealt with under the procedures laid down in the Department's Circular HSS(CC)2/85 dated 30 April 1985 with particular reference to paragraph 28".

6. The Board replied to your letter on 12 December 1985 submitting reports prepared by NL 223, North and West Belfast Unit of Management, on interviews with HIA 210 and interviews with NL 147 and NL 146, members of staff from Nazareth Lodge. NL 223 concluded that although the members of staff were only prepared to acknowledge that some physical punishment was used there was some substance in HIA 210's allegations.

7. In addition to submitting these reports Mr Moore also submitted a report of an interview with a NL 145 who had lived in the Home during the period 1974 to 1981 she is reported to have spoken "of being made to lie on a bed while she was beaten with part of a 'shower unit' by SR 62. Another girl received similar punishment. She has also spoken of a member of staff in the same unit who made the young people, boys and girls, roll up their trouser legs while she beat them with a stick across their legs". Mr Moore suggested that there were a number of outstanding issues which should be followed up and that it seemed that the Department is in the best position to follow up these issues with the appropriate officials of the Order of the Sisters of Nazareth.

8. You replied to this letter from the Board on 21 January 1986 stating that you did not accept that this is a matter for the Department and suggesting that these issues should have been fully explored in the investigation of the complaints made by both children. You stated that the responsibility rests with the Board and the Administering Authority of the Home and that these matters should have been investigated in accordance with the procedures in Circular HSS(CC)2/85. Your letter and previous correspondence and reports from the Board were copied to SR 143, the Mother Regional.

9. Mr Moore replied to your letter stating that he felt "that we could reasonably conclude that we had moved from the particular to the general and that the investigation should be more wide-ranging. This being the case I do not think that the Board has the authority to undertake the sort of investigation which would now appear to be necessary and which would involve interviewing the former Mother in charge. At an earlier point in this letter he suggested that the complaints by the children alleged physical assault which amounts to a criminal offence and that there was the question of whether the police should be notified.

10. You replied on 7 February that there was no new information in the Board's letter which would lead you to alter your views as

outlined in your letter of 21 January 1986. This was "that in relation to HIA 210 you have mounted a limited investigation which was inconclusive and in relation to NL 145 no investigation has been undertaken. These complaints should be fully investigated by the Board and the administering authority of the Home in accordance with Circular HSS(CC)2/85. Paragraphs 28 and 29 would appear to be particularly relevant to both of these cases". You offered to discuss the situation with the Board.

11. On 30 April 1986 Mr Moore submitted a copy of a report of an interview by NL 223 with NL 97 of an account of his treatment in this Home. Mr Moore suggests that NL 97's account of his treatment at the Home corroborates to a considerable degree the allegations made by HIA 210 and NL 145 with regard to the behaviour of SR 62. He concludes "there cannot longer be any question that the information we now have available from 3 former residents amounts to alleged general malpractice and, in some instances, physical assaults by SR 62". He goes on to suggest that "any further investigation of these matters should be carried out by the Mother Regional with the Department either participating in or maintaining an oversight of the investigation in accordance with Section 130 of the Children and Young Persons Act (NI) 1968".

12. On 14 May 1986 you issued a reminder to SR 143 asking her to let you have some indication of the progress of her investigation of these matters and on 22 May she replied stating that SR 62 had rejected the allegations against her; that the policy of the Order, which does not permit any physical abuse of children, is rigorously adhered to in Nazareth Lodge; and that the latest information supplied by Mr Moore will be put to the staff named and statements made by Sisters and staff will be documented and supplied to you. A copy of SR 143's letter has been sent to Mr Moore.

13. Throughout the exchanges with the Board we have tried to impress upon them that these complaints by the 3 children which are clearly specific to them and SR 62 need to be treated individually and dealt with as complaints under the guidance set out in the Circular HSS(CC)2/85.

14. The essentials are that 3 children in the care of the Eastern Board were placed in Nazareth Lodge. They allege that, during their period of residence there, they were physically assaulted by SR 62. The Board has said these physical assaults may amount to a criminal assault, but they have failed to take the steps necessary in accordance with the Department's policy and their own procedures to have these matters investigated fully.

15. Instead they are calling for an investigation by the Department and the administering authority and refer to Section 130 of the Children and Young Persons Act as an appropriate cover for our participation in such an investigation.

The Way Ahead

16. It is unlikely that the Board will supply any additional information in relation to the 3 cases already referred. The only documentation outstanding is that referred to in paragraph 12 from SR 143. When that is received it should be copied to Mr Moore for his information.

17. You have offered to meet Mr Moore to discuss the way ahead and in his letter of 30 April he asks if "we need to discuss this matter further before I write to the Mother Regional". Once we receive the outstanding information from SR 143 and copy it to Mr Moore I think the best way forward would be to meet Mr Moore and discuss the situation with him.

18. In any discussion with the Board there are a number of important points to bear in mind.

a. Section 130 of the Children and Young Persons Act dealt with Inspection of Voluntary Homes. This Section was repealed by the Health and Personal Social Services Order in 1972 and the power of inspection of these Homes merged with a similar power in relation to statutory homes in a new Section 168.

The Department has general powers to hold an inquiry or cause an investigation to be made into any matter arising under the Children and Young Persons Act 1968 by virtue of Section 167 of that Act. In addition Inquiries may be held under the provisions of Article 54 and Schedule 8 of the Health and Personal Social Services Order 1972. It was this provision which governed the conduct of the Hughes Inquiry.

b. This Home was inspected by SWAG in October 1983 and more recently in January 1986. This latter inspection being the first under our new policy of annual inspections. On neither occasion was there any adverse comment about the harshness of the regime. Instead there was an acknowledgement in the latter report that the Home is receiving an "increasing number of difficult and disturbed children" and that "the Sisters reject corporal punishment" and the "usual range of sanctions are made use of". (See paragraph 8.3)

c. In earlier correspondence we had referred the Board to Sections 28 and 29 of the Circular HSS(CC) 2/85. As the Board are suggesting that the alleged assaults may constitute criminal activity Sections 33 and 34 would also be apposite.

d. The police have expressed some concern about the recommendation in the Hughes Report which states "allegations of criminal misconduct should be the subject of a preliminary investigation by Social Services staff before they are referred to the police". Perhaps, as the police suggest, this would be one for the Liaison Inspector to deal with in the first instance.

19. I have discussed the situation with Mrs Brown and we are agreed that there are insufficient grounds for the Department to become involved in an investigation of this Home, over and above our annual inspections and scrutiny of their monitoring arrangements.

K F McCOY

6 June 1986

cc Mrs D Brown
Mr N Chambers

14. Following the Report on Homes and Hostels for Children and Young People in Northern Ireland 1982 (The Sheridan Report) the Department issued a Complaints Procedure for Children in Residential Care [SNB 19076].

15. Paragraph 24.0 of the Complaints Procedure Circular refers to children being able to raise complaints with their social worker and Paragraph 28.0 refers to the role of the Director of Social Services with regard to children in a voluntary home.

16. When concerns about the behaviour of a member of staff were brought to the attention of SSI these would have been discussed with the Manager of the Home and an investigation of the concerns requested. This would have been sufficient in respect of complaints by individual children about a specific member of staff. In the event that the number of children making complaints was significant and involving the overall treatment and care that the group of children being accommodated an unannounced inspection could have been conducted. This was not thought to be necessary in respect of Nazareth Lodge.

17. The respective roles of Boards and the Department was considered at an earlier date (1984-1986) when the Eastern HSS Board referred a number of complaints to the Department and asked it to conduct an Investigation into the running of Nazareth Lodge. The Department took the view that the Board should have investigated these complaints in accordance with the Circular HSS (CC) 2/85 Provision of Information to and Complaints Procedure for Children in Residential Care and Their Parents.

18. It was not clear what the Eastern Board hoped to achieve by the Department mounting an investigation under the provisions of the Children and Young Persons Act 1968. While there had been a number of complaints made by children in the care of the Eastern Board these had been partially investigated by the Board without any clear outcome. The Social Work Advisory Group had inspected the home in October 1983 and in January 1986. On neither occasion was there any adverse comment about the harshness of the regime. My reference to the 1986 report comes from my memorandum to

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 corroboration, 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.

See Exhibit 8. NL 97 confirmed to me that SR 62 beat him and [redacted] HIA 210 regularly with a wooden spoon and a bamboo cane. He also confirmed that on one occasion SR 62 banged his head against a wash hand basin causing him to bleed. He indicated that SR 62 picked upon him and [redacted] HIA 210 to excess.

This information re NL 97 is referred to in the Director of Social Services letter of 30 April 1986 to the Chief Social Work Adviser. See Exhibit 9. Mr Moore states that this corroborates the allegations made by HIA 210 and NL 145 [redacted], with regard to the behaviour of SR 62. In this same letter he goes on "there can no longer be any question that the information, we now have available, from three former residents amounts to alleged general malpractice and in some instances physical assault by SR 62.

7.11 I am aware that SR 143 conducted her investigation of the allegations made by these three young people. I note that this occurred sometime in 1986. I cannot recall whether I saw this report in 1986 but I have not seen it as part of this process. However, I note that the Director of Social Services expressed his dissatisfaction with this investigation and as a consequence required that all three children should be approached, made aware of the outcome of this investigation and offered the assistance of social work staff, if they wished to make a complaint to the Police.

7.12 I note that in his letter of 19th February 1987 in relation to the allegations of ill treatment, Mr Bunting informs SR 143 that all three young people were contacted and informed of their right to make a complaint to the Police, if they so wished See Exhibit 10.
In the case of HIA 210 it appears that he did not wish to do this.

7.13 I have been asked to comment specifically on why I did not refer this matter to the police.
I would firstly cite the accounts provided to me by NL 191, of her interview with HIA 210 dated 21st February 1985 and with his brother NL 204 dated

EASTERN HEALTH AND SOCIAL SERVICES BOARD

NORTH AND WEST BELFAST DISTRICT

file

MEMORANDUM

From NL 223 - P.S.W.

Ref. [redacted]/mg

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

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

Ref. NL 281 - S.S.W. Cliftonpark

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, NL 281 - 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 one 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 [redacted] and [redacted] whom he thought had also been beaten by SR 62.

Like HIA 210, he was ambivalent towards SR 62, on the one hand expressir 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 recollect that HIA 210 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 229 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 NL 97 had returned from Nazareth with his thigh bruised as a result of having been beaten with a wooden spoon. NL 229 said that NL 97's version that SR 62 had beaten him 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...

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Copy to Mr. R. Black, A.D.S.S North and West Belfast
[redacted] " " "
Mr. R.S. Ferguson, A.D.S.S South Belfast C.U.M.

01 MAY 1986

File NL 145

RJB / KL

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

30th April, 1986

Dear Mr. Armstrong,

NAZARETH LODGE

You indicated in your letter of 7th February, 1986 that if I was dissatisfied with your proposals it would be best to discuss the matter with you rather than enter into further correspondence.

However, as you will be aware from my letter of 24th January, 1986 we were hoping to obtain from [redacted] an account of his treatment in Naxareth Lodge. This further information has now been obtained by Mr. [redacted] and I felt it best to let you have this prior to any discussion which may be necessary.

I feel that [redacted]'s account of his treatment at Nazareth Lodge corroborates to a considerable degree the allegations made by [redacted] and [redacted] with regard to the behaviour of [redacted]. There can not longer be any question that the information we now have available from three former residents amounts to alleged general malpractice and, in some instances, physical assaults by [redacted].

As [redacted] was a senior member of staff and accountable to the former Mother in Charge, I feel that any further investigation of these matters should be carried out by the Mother Regional with the Department either participating in or maintaining an oversight of the investigation in accordance with Section 130 of the Children & Young Persons Act (N.I.) 1968.

My staff will, of course, be prepared to assist in sypplying information and enabling former residents to make relevant information available to the Mother Regional or the Police.

The statement in paragraph 28 of the Department's Circular HSS(CC) 2/85 that 'Boards should be prepared to assist voluntary bodies in the investigation of the complaint' is open to interpretation. I see no problem in Board staff assisting in the manner I have already outlined. However, I do not consider that we have any authority to participate in the interviewing of senior members of staff of a Voluntary Home as we are neither the employers of these staff nor the registering authority. In addition, the information we have obtained amounts to allegations of general malpractice and physical assault.

OTHER YOUNG PEOPLE
NAMED IN PAPERWORK

ɔvember 1984

During this month HIA 210 was interviewed with regard to his experiences in Nazareth Lodge. This was necessary after HIA 210 began to have nightmares and at night wake up in a disorientated state, not knowing where he was. His nightmares woke the other members of the family who heard him shout in his sleep. He discussed some of these nightmares with NL 188 and began to describe the treatment he received whilst in Nazareth Lodge. It would appear from HIA 210's description that he regularly received beatings from the nun in charge of his group, SR 62. These he claimed would be with whatever implement would be at hand i.e. a stick and on one occasion a vacuum cleaner pipe. Apparently the vacuum cleaner pipe was used on one occasion when HIA 210 was in a hurry to finish his chores and go out and play. It would seem that he was not completing the task to SR 62's satisfaction and she hit him with the vacuum cleaner pipe. He claimed that on one occasion SR 62 split his brother's head open and it required stitches * At the time of one of these incidents the Social Worker involved was informed of a beating, according to HIA 210 The Social Worker spoke with SR 62. Both boys were then brought to the Office and told that they had deserved the beatings. After the social worker left both boys were put in a bath of cold water as a punishment for informing the Social Worker. On another occasion HIA 210 claimed that he was locked in a bathroom overnight without lights (both the lock and the light switch were on the outside of the bathroom). A darkened cupboard was also used for similar punishments. Another incident HIA 210 found very disturbing has been described by him in two ways. At one time a child was murdered and mutilated in Ormeau Park (the killer apparently was never captured). In his description to the foster parents he was told of the incident in a threatening manner. However in his description to me he claimed that SR 62 was warning them to be careful. HIA 210 said that other members of staff also beat the children, one in particular was forced to leave after a fight with another member of staff in which she threatened to throw hot chipfat round the other member of staff.

HIA 210'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 HIA 210's behaviour.

NL 180
Social Worker

7.1 During the time period 1985/6 there seemed to be a significant difference of opinion between the senior managers of the Eastern Health and Social Services Board and senior officers at the Department as to nature of the complaint(s) under consideration.

7.2 The Board appeared to hold the view that the complaints were of an historical nature and, taken together, raised an issue regarding the care practices operating within the home. As a consequence they believed this was a Departmental responsibility to resolve. This view could be considered to be in line with guidance issued in the 1983 Circular. The Departments view appeared to be that there were three individual complaints that should be followed up by the Board staff with the Management Committee as outlined in the guidance HSS 2/85.

7.3 That senior professionals and officers within two key statutory organisations could seemingly hold such strong, conflicting views as to accountability and responsibility around matters as important as the investigation of child care concerns would be a concern. I would be of the opinion that it stems from the lack of clarity in the key legislation and subsequent guidance around which organisation is ultimately accountable for the care and protection of children placed in voluntary homes.

## 8.0 The length of time from allegation to investigative outcome

8.1 The complaint from HIA 210 was presented to the North and West Belfast Unit of Management in early March 1985 whilst the investigation report was shared in a letter, dated 23rd July 1986, from Mr Armstrong, DHSS, to Mr Moore Eastern Health and Social Services Board.

8.2 Allegations were made to Judith Chaddock, Social Services Inspector, in early November 1995 by NL 168 and NL 170. The outcome of the investigation was shared with the two Trusts centrally concerned in May/June 1996.

8.3 Whilst in both time periods it is clear that the Sister at the centre of the allegations was no longer present in the home the length of time taken to produce an investigative outcome seems excessive.

8.4 It does stand in contrast to the speed of investigation in June 1994 when social worker NHB 137, investigated jointly with the police, an allegation of inappropriate sexual behaviour following the Child Protection Policy and Procedures.

## 9.0 The quality of the investigation and investigative reports

9.1 On3rd July 1986 SR 143 outlined in a letter to Mr Armstrong, DHSS,[SNB 6952] the details of the investigation into the complaints initially made by John Hegarty and its outcome. In what SR 143 describes as 'exhaustive enquiries' she interviewed a number of lay staff and Sisters in an informal way, who were not able to recall anything to substantiate the allegations. No young people were spoken to who were resident during the period of the complaints and no one who had spoken to the complainant was involved in this

investigative process.

9.2 The records of the investigation held in early 1996 regarding the complaints centring on NL 164 indicate the complaint investigation process had improved to be more in line with that outlined in the 1985 Circular There was a strategy discussion as to the nature of the investigation and the clear involvement of the HSS Trusts and Management Committee. An Investigative Subcommittee of the Management Committee included a representative from a HSS Trust in the three person investigative team. However the minutes of a special meeting of the Management Committee of Nazareth Lodge on 4th March 1996 item 1, revealed that the sub-committee had interviewed the complainants, SR 18 and Judith Chaddock but have not carried out further investigations. It seems from the minutes of the meeting (item 2) that it was SR 18 's co-operation that had enabled them to indicate that there was some validity to the allegations. This does leave open the question of what outcome the investigation would have revealed had SR 18 not admitted certain aspects of the allegations.

9.3 The outcome of the investigation was shared with the relevant HSS Trusts as a copy of the relevant Nazareth Lodge Management Committee minutes, and later, in a brief letter from the Chair of the Management Committee to the individual Trusts, [SNB-19319]. No additional detail of the investigation or its findings appears to have been shared. The records do contain a report prepared by the Investigative Sub-committee outlining the allegations and the sub-committee's conclusions in respect of the individual allegations [SNB-19320]. This contains very limited information and no rationale as to how the conclusions were reached is included.

9.4 It is not clear what role the 'independent' member of the panel, Mr Chard, played in the investigation. Mr Chard's witness statement, dated 26th March 2015 seems to indicate that he was involved in the process alongside the other members of the Investigative Sub-committee in interviewing complainants and staff, and in reporting back to the Management Committee. Mr Chard statement indicates he was subsequently excluded from the Management Committee decision making process and was not informed of the outcome. There does not appear to be any guidance how this independent person role should operate in practice, nor did I note in the records any discussion between the Trusts or with the Management Committee as to the expectations on this person on this occasion.

## 10.0 The subsequent impact of the investigations

10.1 In both time periods the complaints investigation process reached a conclusion around the specific allegations raised. In the 1985/6 investigation no substance to the allegations was found whilst the 1994/6 investigation substantiated or partially substantiated some of the allegations. It is not clear from the records I considered whether there was a subsequent impact of these allegations and investigations on the care provided within the home.

10.2 Mr Armstrong, DHSS, letter dated 7th February 1986 indicates once the individual complaints were investigated and if they were substantiated the Department should be informed so that their 'relevance to the continued registration of the home' could be considered. The allegations were not

NAZARETH HOUSE,
CHURCH HILL,
SLIGO.

3rd July, 1986.

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

Dear Mr. Armstrong,

I wrote to you on 22nd May, 1986, in respect of the previous correspondence about alleged incidents having taken place in Nazareth Lodge some time ago. I have conducted exhaustive enquiries about this matter and I have interviewed the following people -

[redacted] - interviewed 25.6.86 - worked in Nazareth Lodge 1973-76, and in 1979.

[redacted] - interviewed 24.6.86 - worked in Nazareth Lodge 1979-82.

[redacted] - interviewed 24.5.86 - worked in Nazareth Lodge 1978-81.

[redacted] - interviewed 23.5.86 - worked in Nazareth Lodge in child care - still employed.

[redacted] - interviewed 23.6.86 - Principal, Bethelem Nursery School, and also worked in Nazareth Lodge.

[redacted] - interviewed 26.6.86 - worked in Nazareth Lodge for a period of years until August 1984.

[redacted] - interviewed 8.6.86 - now retired - worked in Nazareth Lodge in the late 70's and early 80's.

I saw each person individually and I conducted the interview informally so as to set the interviewees at ease. I also conducted the interviews in a format to take account of the complaints raised specifically in your letter of 27th May, 1986, numbered 1 to 8, and of the additional allegations appearing in the several reports made available to you by the Director of Social Services of the Eastern Health and Social Services Board.

i) In respect of the allegations that SR 62 had punched HIA 210 on the nose, none of the persons interviewed could substantiate this statement and equally none of the persons interviewed had ever seen any evidence or incident which suggested that this had taken place. The point was made to me that HIA 210 had been subject to frequent nose bleeds sometimes at night and sometimes during the day but as he grew older these nose bleeds stopped.

ii) None of the persons interviewed could throw any light on the allegation that NL 97 was struck by SR 62 and as a consequence banged his head off a wash hand basin. SR 62 expressly denies that this ever happened. NL 147 NL 147 however said that she had heard that there had been an accident in the bathroom on an occasion but she did not know what it was. Let me reiterate however that no-one recollected the outcome of any such accident.

NL 146 recalled that HIA 210 and NL 97 had a head-on collision which resulted in HIA 210 getting black eyes.

iii) None of those interviewed had any knowledge of beatings as described. All acknowledged that a child might get a smack on the back of the hand and NL 66 said that on one occasion she saw SR 62 give HIA 210 a slap on the hand with a wooden spoon. SR 62 herself acknowledged that she did use a wooden spoon on the hand on a few occasions. The particular incident recalled by NL 66 occurred in the kitchen where SR 62 was working and at the time HIA 210 was misbehaving. NL 147 also said that she saw SR 62 give HIA 210 a "box on the ear" once because he gave cheek and answered back.

iv) None of those interviewed had ever witnessed a child being locked or placed in a cupboard. It was confirmed by most of those interviewed that the form of discipline was that a child might be made to stand for a short period either in the corridor or in the study room or that certain privileges or treats would be withheld. NL 147 did however say that HIA 210 may have been made to stand inside a store room for 5-10 minutes with the door ajar and she said that the light switch is inside the door. She herself did not see this incident.

v) None of those interviewed could substantiate the allegation that HIA 210 was made to sleep in the bathroom as a punishment overnight. All said that they did not believe that such an incident could take place.

vi) None of those interviewed could substantiate the statement in respect of the cold baths used as a punishment and once again all stated that they did not believe that it would take place.

vii) None of those interviewed had ever witnessed or been aware of any child being deprived of food and expressed the view that this did not happen.

viii) No-one was aware of the alleged incident in respect of serving and eating of liver. SR 62 expressly denies that this event ever took place.

I also put as a general question to all those interviewed had they ever witnessed any beatings, brutality or abuse of the children in the Home. They all responded that they had not. Several mentioned that a child could be smacked usually on the hand for misbehaving but that such an event was very rare. Mention was also made of SR 62 having on one occasion hit HIA 210 with a wooden spoon when she was in the kitchen and SR 62 herself acknowledges that this took place and that on a few other occasions a similar thing happened. The reaction of those I interviewed was frankly one of disbelief that such allegations were being made but they understood the need for thorough investigation of such matters and co-operated with me during the course of the interviews.

In respect of the mention made by NL 145 the persons interviewed expressed surprise at the allegation. Most stated that NL 145 had been a quiet girl and did not require correction. No-one could substantiate the allegation that she had been required to lie on a bed and there was no recollection of the allegation made by NL 145 that a [redacted] boy was beaten.

Having completed what I regard as a very thorough investigation of the alleged incidents and recognising the difficulty of dealing with such matters after a lapse of time, I took the view that the allegations of brutality are not substantiated and did not take place. For example there was a suggestion that NL 97 had been beaten by SR 62 and had bruised his thigh. It has been established that SR 62 herself brought in the Social Worker at that time to enquire into the allegation and after enquiry it was admitted by NL 97 that he had not been beaten and that the bruising had occurred as a result of an injury.

The relationship with SR 62 seems to have been very close with a number of the children. She exhibited maternal instincts of care but did on a few occasions smack or beat the children on the hand with a wooden spoon. She should not have acted in this way but in my judgement these events were not regular and most certainly did not warrant any suggestion of brutality.

SR 62 herself is astounded at the allegations and deeply worried that such statements should be made. In a letter to me she reiterates her concern about the welfare and well-being of the children in her care and the comment of all those whom I interviewed substantiate this care and consideration.

Could I say once again that the policy of the Order does not permit any physical abuse of children and that this policy is rigorously adhered to in Nazareth Lodge.

It is my hope that in the light of the exhaustive enquiries made and in the light of the information I have given you it will be possible to satisfy you and the Director of Social Services in the Eastern Health and Social Services Board about the alleged incidents in the correspondence to which this letter refers.

Yours sincerely,

SR 143

NAZARETH HOUSE,
CHURCH HILL,
SLIGO.

10 MAR 86

3rd July, 1986.

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

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NL 146 - interviewed 24.5.86 - worked in Nazareth Lodge 1978-81.

NL 147 - interviewed 23.5.86 - worked in Nazareth Lodge in child care - still employed.

SR 2 - interviewed 23.6.86 - Principal, Bethelem Nursery School, and also worked in Nazareth Lodge.

SR 29 - interviewed 26.6.86 - worked in Nazareth Lodge for a period of years until August 1984.

SR 62 - interviewed 8.6.86 - now retired - worked in Nazareth Lodge in the late 70's and early 80's.

I saw each person individually and I conducted the interview informally so as to set the interviewees at ease. I also conducted the interviews in a format to take account of the complaints raised specifically in your letter of 27th May, 1986, numbered 1 to 8, and of the additional allegations appearing in the several reports made available to you by the Director of Social Services of the Eastern Health and Social Services Board.

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It is my hope that in the light of the exhaustive enquiries made and in the light of the information I have given you it will be possible to satisfy you and the Director of Social Services in the Eastern Health and Social Services Board about the alleged incidents in the correspondence to which this letter refers.

Yours sincerely,

SR 143

26/3

Mrs Brown
Dr McCoy
Miss Hayes

Nazareth House,
Malahide Road,
Dublin 3.
7th. March 1987.

13 MAR 87

Copied
13/3

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

Dear Mr. Armstrong,

Further to your letter of the 23rd. October 1986 I am forwarding a copy of a letter received from the Director of Social Services on the 12th. February 1987. I have not been informed of developments since that date but I will certainly let you know as soon as I hear of any progress in the matter.

Thanking you for your continued help.

Yours sincerely,

[redacted]

Regional Superior.

See Exhibit 8. NL 97 confirmed to me that SR 62 beat him and [redacted] HIA 210 regularly with a wooden spoon and a bamboo cane. He also confirmed that on one occasion SR 62 banged his head against a wash hand basin causing him to bleed. He indicated that SR 62 picked upon him and [redacted] HIA 210 to excess.

This information re NL 97 is referred to in the Director of Social Services letter of 30 April 1986 to the Chief Social Work Adviser. See Exhibit 9. Mr Moore states that this corroborates the allegations made by HIA 210 and NL 145 [redacted], with regard to the behaviour of SR 62. In this same letter he goes on "there can no longer be any question that the information, we now have available, from three former residents amounts to alleged general malpractice and in some instances physical assault by SR 62.

7.11 I am aware that SR 143 conducted her investigation of the allegations made by these three young people. I note that this occurred sometime in 1986. I cannot recall whether I saw this report in 1986 but I have not seen it as part of this process. However, I note that the Director of Social Services expressed his dissatisfaction with this investigation and as a consequence required that all three children should be approached, made aware of the outcome of this investigation and offered the assistance of social work staff, if they wished to make a complaint to the Police.

7.12 I note that in his letter of 19th February 1987 in relation to the allegations of ill treatment, Mr Bunting informs SR 143 that all three young people were contacted and informed of their right to make a complaint to the Police, if they so wished See Exhibit 10.
In the case of HIA 210 it appears that he did not wish to do this.

7.13 I have been asked to comment specifically on why I did not refer this matter to the police.
I would firstly cite the accounts provided to me by NL 191, of her interview with HIA 210 dated 21st February 1985 and with his brother NL 204 dated

KH. 11/2/87.

Mr. R. Black,
Mr. R. Ferguson
Mr. P. Armstrong

RJB/KH

The Reverend Mother,
Nazareth House,
CHURCHILL,
SLIGO.

10th February, 1987

Dear SR 143,

Nazareth Lodge Children's Home
Allegations of ill treatment by former residents

You will be aware from Mr. Armstrong's letter of 23rd October, 1986 of the further action we proposed to take following your investigation.

The three young people who made allegations have now been informed of your findings and of their right to make a complaint to the Police if they so wish.

HIA 210 NL 145 does not wish to do so but both NL 97 and intend to make a complaint directly to the Police and staff will assist them to do this.

I wished you to be aware that this will be happening in the near future.

Yours sincerely,

R G B Cutting

Fay Director of Social Services

OTHER YOUNG PEOPLE NAMED!

## Inspections

12. Unlike the continuous monitoring undertaken by Boards, inspection is essentially a periodic and selective activity. Boards are aware, however, of the inspection programme being carried out by the Social Work Advisory Group of the Department which will provide a comprehensive base of information about children's homes in Northern Ireland. This programme is approaching completion. SWAG will continue to carry out inspections, but these will be more selective and less frequent in future.

13. The existing inspection programme has already heightened awareness among Boards' and voluntary organisations' staff of the professional and environmental factors which the Department considers to be essential to good residential child care. Therefore, the Department is of the view that joint inspections by the Social Work Advisory Group and the Assistant Directors of Social Services (Child Care), as suggested in the Report on Homes and Hostels, would not be necessary or appropriate.

## Recording of Sensitive Information

14. The Report on Homes and Hostels referred to the need for sensitive information arising from SWAG's inspections of children's homes to be recorded in the Department and passed to the relevant Board or voluntary organisation for further investigation as necessary. The reports on inspections sent to Boards and voluntary organisations contain all the comments that advisers wish to make about the home or hostel and will continue to be as full as possible. The number of occasions on which information is regarded as sensitive and hence unsuitable for inclusion in a report which will receive wide circulation is likely to be very rare. Where this happens, however, the information will be passed to the Director of Social Services for action within the normal procedures of the Board, or to the Chairman of the Voluntary Management Committee for action within the management arrangements of the voluntary body concerned.

## Training in Monitoring

15. In order to ensure that Boards' monitoring arrangements operate effectively, training may be required for those Board officers and members involved in the process. This training could be provided through the Boards' own in-service training resources and through the Department's Short Course Programme. In order to determine how this need should be met, Boards are asked to indicate, in the statement of monitoring arrangements requested at paragraph 9, the training needs of those staff and members involved in the monitoring process, bearing in mind any differences in their roles in this respect; the extent to which training will be undertaken by their own in-service training personnel; and any training which might best be provided on a regional basis.

16. As an interim measure the Department will mount a small number of seminars/ courses on monitoring through its Short Course Programme. The personnel at whom these will be directed and the content of the courses will be the subject of discussion.

## Monitoring of Voluntary Children's Homes

17. The terms of this Circular apply to the Boards' monitoring of statutory children's homes. Boards also place children in voluntary homes and retain responsibility in law for the care of such children. Hence Boards must satisfy themselves about the standards of care being provided for each child placed in a voluntary home. Boards are not involved in monitoring the overall

**responsibilities and accountabilities in relation to investigating the more serious complaints within a children's home.**

Q. You also go on to look at the quality of the investigation and the reports that were produced. You make the point that -- you identify issues with the type of investigation. For example, you talk -- SR143 didn't speak to the children who had complained and those who hadn't spoken to them were not involved in either the interview of others or in any other way in the investigative process. You did make the point when we were talking earlier that children would still be reluctant to speak. The issue is how you speak to young people. So it wouldn't always be the case you would necessarily ask the child in an investigative process in any case even today.

**A. Well, no. I think if you have a specific incident involving an individual young child or young person, you would have a joint interview normally these days with the police and the social worker, or the social worker, if it was a single agency investigation, would definitely be speaking to the child or young person. The question is whether or not you would then go and talk to other children, young people within the home, which you would give considerably more thought to, you**

**know. So in some respects if you think there are issues in relation to the overall home, you may go back over and look at the records first, and then where there were specific things you could go and talk to the children and young people about, you would then make arrangements to do so, but you wouldn't go on a general fishing expedition without good cause.**

Q. You do make the point that you wonder how they were going to get to a proper conclusion, for example, in the NL164 case, had it not been for the acceptance of SR18 that she had engaged in some of the acts complained of.

**A. Well, I think it was in contrast to the previous investigations that had been carried out is where they weren't substantiated because the member of staff -- the member of staff spoken to denied it, and then in relation to SR18 ones, she clearly admitted various things and they were able to substantiate that. It looks from the records that if she hadn't admitted it, there didn't seem to be a particular way of reaching any -- reaching a conclusion.**

Q. By 1986 you say the complaint investigation process had improved and the difficulties that had been identified in the implementation of the '85 circular had by this stage largely been resolved, but you make the point there were still issues with regard to it.

Q. And you haven't subsequently formed a view about the Department's approach to not getting involved in going in to check was this home being run properly, given these issues that are coming to light?

**A. I don't have a view on it, because I wasn't involved in it in any detail.**

**Having read the documentation recently, it simply occurred to me that, had the senior officials in the Unit of Management, the Board, the Department and preferably the police, had they got round the table at an early stage and looked at the issues, evaluated them and formed a strategy for taking it forward, that might have shortcircuited some of the rather lengthy correspondence that took place, but I really don't have any view or observation beyond that.**

Q. 1993, transporting you forward a period of nine years, Marion Reynolds is now an Inspector in the Social Services Inspectorate. You are an Assistant Chief Inspector.

**A. Uh-huh.**

Q. You were involved with her over the 1993 inspection.

**A. Uh-huh.**

Q. The particular issue that you are aware of -- I am going to just bring up, if we can, on the split screen 19070 and 19071. Just cutting to this --

did not consider that it had any authority to interview Senior Staff in the Home as it was neither the employer of the staff nor the Registering Authority, and it suggested that there were now general allegations of malpractice and assault. On 14 May 1986 the Chief Social Worker Advisor wrote to SR 143 the Mother Regional requesting "some indication of the progress of your investigation of these matters". He also wrote to the Eastern Board stating that he had copied Board correspondence to SR 143 . On 22 May 1986 SR 143 responded stating she had already spoken to Sisters and members of staff who were employed in Nazareth Lodge during the relevant period and that all had rejected the allegations, but that she had intended to speak to them once again and to put to them the account of NL 97 . On 6 June 1986 Dr Kevin McCoy, the Assistant Chief Social Work Advisor, provided an Opinion on the Board's request for investigation by the Department of the complaints recently received, and provided also his summary and commentary on those complaints. He indicated that he had taken advice from the Policy Branch which had agreed that there were insufficient grounds for the Department to become involved in this Home over and above their annual inspections and scrutiny of their monitoring arrangements. On 3 July 1986, NL 97 forwarded a completed report in which she indicated that none of the staff could substantiate any of the allegations and that it was the policy of the Order not to permit any physical abuse of children. This report was forwarded by the Department to the Eastern Board. By letter dated 18 August 1986, the Eastern Board indicated to the Chief Social Work Advisor that it remained unhappy, and that the report from SR 143 did not lead it to conclude that the allegations of brutality had not been substantiated. The Board was taking the view that the Police should be involved and that other children and parents should be given the opportunity to make complaints to the Police with the assistance of its staff. By letter dated 8 October 1986, the Board sought a response from the Chief Social Work Advisor to the proposals previously set out by the Board in its letter of 18 August 1986.

On 20 October 1986 there was a meeting between the Eastern Board and SWAG to discuss the way forward, but unfortunately there are no notes of this meeting. By letter dated 23 October 1986, the Chief Social Work Advisor

12. I was fully aware of the report prepared by Kevin McCoy for Pat Armstrong on 6 June 1986 (SNB-19050-19054) which described and explained the Department's position in relation to the complaints dealt with in 1984/85/86. It outlined the way in which the complaints had been handled. The Department had kept closely involved, but saw the Eastern Board as having responsibility to investigate the complaints from children for whom it held Care Orders. Paragraphs 13 and 14 of Kevin McCoy's report were particularly relevant in that respect.

13. The conclusion reached in that report was that, taking account of all the information compiled in relation to the incidents, there were insufficient grounds for the Department to instigate a further investigation of Nazareth Lodge. An important element in reaching that conclusion was the fact that an inspection of the Home had been carried out in January 1986 by the Department's Social Work Advisory Group - in the full knowledge of the complaints which were under investigation- and had not reported any concerns about the nature of the regime in the Home. On that basis, I, and my Departmental colleagues, supported the conclusion in Kevin McCoy's report.

Signed: 

Dated: 14.4.15

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 NL 269 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 NL 269 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;

H1A1(62)C-TAD1 T

**NOTES OF TELEPHONE CONVERSATION WITH NL 269 (SOCIAL WORKER, GRANSHA HOSPITAL)**

**Date: 26 January 1993**

NL 269 'phoned stating that he had heard that I was undertaking the Inspection at Nazareth Lodge and wanted to pass on a number of concerns he had regarding the Home. The following details his comments:

1. He was employed by Nazareth Lodge Children's Home and commenced work in September 1992. By November he felt he had no option but to resign.

2. He claims he raised concerns about policy and procedure with the Team Leader who made him out to be a trouble-maker. The following instances were cited:

   i. One of the children had demonstrated overtly sexualised behaviour. He reported this to the Team Leader who passed it off and did not report the matter to the field social worker. He queried this approach with the Team Leader who said that as he was newly qualified and a new member of staff she was unsure whether or not she could trust his judgement;

   ii. sleep-in arrangements. In the absence of Sister one residential worker is used to cover the sleep-in. He claims he expressed concerns about a male member of staff undertaking this duty on a single-handed basis feeling it exposed the individual to possible complaint. Sister rejected this view. He states he then checked with BASW who supported his view. He was, however, required to undertake these duties.

   iii. While on sleep-in one 17 year old [redacted] came in high on drugs. NL 269 claims that at the very least [redacted] is handling drugs and would admit to this fact. Surgical gloves have been found in his room with the fingers removed. It is felt these are used for carrying drugs. According to NL 269 the Team Leader is aware of this situation. As a sanction for returning home high on drugs NL 269 imposed a 2 day grounding on [redacted]. On the Team Leader's return she apparently censured him for:

      - imposing a sanction without permission;
      - liaising with the field social worker without permission;
      - taking action prior to her return to duty.

   NL 269 claims that the field social worker had told him that she did not feel she was "told the whole story" by residential staff. NL 269 stated it would have been general practice in his unit, not to contact field social workers without the Team Leader's consent;

iv. One of the ex-residents, NL 165, according to another member of staff, had previously sexually abused a child while in care. He now frequently visited the Home and had full run of the house;

v. NL 269 claims that staff in the Unit in which he worked are frightened to act or do anything as they are unqualified and have no way out. He states they are an excellent staff team who work under a regime of fear;

vi. NL 269 states a colleague from one of the other Units had told him that 2 boys who were sexually abused by their mother's cohabite were permitted by the Team Leader to have access to the perpetrator without a child in care review.

vi. NL 269 claims there is no role for qualified workers in the Home.

vii. He further states that he took his concerns to the Sister Superior who advised him that his Team Leader felt he was unsuited to residential work.

ix. he queried the rota as he had a disproportionate number of late shifts given that he was covering for 2 staff on CSS. His Team Leader apparently told him if he was a trouble-maker he could look for another job, which he did.

3. I have told NL 269 that I would prefer it if he placed his views on record by writing to me. Although I read back my notes to check that he was in agreement with the record of our telephone conversation. NL 269 queried what would happen to his comments. I advised him that the draft report was written and would be with the Home in the near future and some points raised had already been covered in that format. His comments would, however, be followed up in discussion. He asked to receive a copy of the report. I advised him to write in requesting a copy of the summary report as at this time the main report was the property of the Administering Authority.

MARION REYNOLDS

Mrs. Reynolds.

While NL 269 's expression of concern confirms your own findings. I don't think it can be used, unless he makes specific complaints in writing.

NL 269 is not entitled to access to the inspection report or to the summary. Should he request in writing, please decline, and advise him that his comments have been noted.

N. J. Chamberlain

2-2-93.

dated 23rd April 1993 confirmed that lighting switches in Unit 2 had been relocated.

8. The problem of retaining qualified residential staff was also flagged up within the Inspection Report at Paragraph 11.5. As work was ongoing across Northern Ireland to develop an enhanced role for residential social workers to retain such staff this matter was not a recommendation made during the Inspection.

**(ii) Inspection Questionnaires**

9. In addition to the fieldwork undertaken during which I met with staff and children. I also sought the views of current and residents discharged in the preceding year and their parents by way of questionnaire. Of the 14 current residents who completed a questionnaire there were no significant complaints made. One teenage girl articulated, however, that she felt she was not made welcome or respected by the Team Leader in her Unit. Three former residents completed and returned questionnaires and again nothing of note was reported. In total 8 parents (6 of current residents) returned questionnaires. One of the parents reported that in her opinion the home was not well run and that she was not made to feel welcome when she visited her children. This was, however, a minority point of view.

**(ii) Complaint made by former staff member on 26th January 1993**

10. From the Inspection file I had access to notes of a telephone conversation between me and NL 269 who had been a residential social worker at Nazareth Lodge between September and November 1992. From these notes the following concerns were highlighted by NL 269:

- an incident of one child demonstrating overtly sexualised behaviour and the failure to report this to social services;
- the adequacy of the sleep-in arrangements;
- the action of the Team Leader in respect of his concerns regarding one 17 year old boy's involvement with drugs and her response to his attempts to manage the incident;
- the practice in the Unit in which he was employed that residential social workers could only contact field social workers with the permission of the team leader;

- claims that an ex-resident who had previously abused a child while in care frequently visited the home and had the full run off the house;
- the staff in the Unit in which he worked were frightened to do anything as they are unqualified;
- claims that two boys who were sexually abused by their mother's cohabite were permitted by the Team Leader to have access to the perpetrator without a child in care review;
- that there is no role in the home for qualified staff;
- how his concerns were dealt with when raised with the Team Leader and the Sister Superior.

11. From the pre-inspection materials and the inspection fieldwork I had already identified a number of the concerns which NL 269 raised in his telephone call, specifically:

- a number of Untoward Incident Reports indicated that sexualised behaviour occurred within the children's home;
- the adequacy of the staffing arrangements, particularly the sleep-in arrangements;
- that practice varied across Units regarding whether or not residential staff could contact field social workers without permission from the Team Leader;
- the risk to children posed by perpetrators of sexual abuse as indicated by the sleeping arrangements while one Unit holidayed in Donegal;
- staff's perception that at times their opinions and contributions were of secondary importance;
- the difficulty in retaining qualified residential staff within the Units and the need for an enhanced role for such staff;
- the adequacy of the roster and the over-reliance on Team Leaders to support staffing deficits.

12. I asked NL 269 to confirm his concerns in writing. From the record of the telephone conversation it is apparent that I intended to raise the matters in discussion with the Administering Authority.

PERSONAL AND CONFIDENTIAL

NL 269
Social Worker
Gransha Hospital
LONDONDERRY

29 March 1993

NL 269

**NAZARETH LODGE CHILDREN'S HOME**

I refer to your telephone discussion with me on 26 January 1993 regarding the above-named children's home. As I have not yet received your written comments on the issues raised I am unable to seek the views of either the Order or the home's management committee on the matters you raised.

If you wish to process the matter further you could write to one of the following:

(i) Social Services Inspectorate: Room 3B Dundonald House, Belfast BT4

(ii) Mother Regional, Nazareth House, Malahide Road, Dublin

(iii) The Chairperson, Nazareth Lodge Management Committee, 516 Ravenhill Road, Belfast.

I hope the above information is of assistance to you.

Yours sincerely

**MARION REYNOLDS**
**Inspector**
**Social Services Inspectorate**

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 NL 269 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 NL 269 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;

other points would be raised by her in discussion of inspection findings with the Head of the home. She declined to let him have sight of the inspection report.

4.4 The concerns raised by NL 269 included:

4.4.1 When he reported to his Team Leader that a child had overtly demonstrated sexualized behaviour, she had not responded appropriately;

4.4.2 At times the "sleep-in" arrangements were not satisfactory as only one staff member was on duty, and that could be a male staff member, who could be the subject of a complaint;

4.4.3 NL 269 had been censored by a Sister on account of his having exceeded his professional remit;

4.4.4 Allegedly, a Field Social Worker had inferred to him that Nazareth Lodge staff had not told them "the whole story" regarding the behaviour of one resident who was known to be abusing drugs.

4.4.5 He said that residential staff were not permitted to contact Field Social Workers without the permission of their Team Leader, and that there was a lack of confidence between Field Social Workers and residential staff;

4.4.6 A former resident, who according to another member of staff had previously abused a child while in care, was a frequent visitor to the home, and had full run of the house.

4.4.7 Two boys, according to another member of staff, in another group, were permitted by the Team Leader to have access to their mother's cohabitee who had abused them, without the authority of a "child in care review".

4.4.8 He believed that there was not a role at Nazareth Lodge for qualified staff;

4.4.9 He believed that the staff rostering arrangements at Nazareth Lodge were unsatisfactory.

**Comment**

4.5 Examination of the report of the 1993 inspection indicates that Miss Reynolds had indeed covered in considerable detail most of the concerns raised by NL 269 (SNB 15298).

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**Comment**

4.5 Examination of the report of the 1993 inspection indicates that Miss Reynolds had indeed covered in considerable detail most of the concerns raised by NL 269 (SNB 15298).

**Sexualised behaviour at Nazareth Lodge**

4.6 At paragraph 8.3, the report states, "*No complaints have been recorded in the home's complaints register since the last inspection. From a review of individual logs, however, the Inspector identified 3 occasions where reference was made to a complaint. The records suggest that these matters were investigated either within the home or referred to social services for investigation.*"

4.7 NL 269 did not name the child who had demonstrated overtly sexualized behaviour. Paragraph 9.1 of the report of the inspection states that,
"*In total 80 untoward events were recorded since the last inspection. More than 25% of these involved physical interaction between children in the form of fighting, with another 7% involving behavior of a sexualised nature…….The risks* (arising from peer abuse) *carried are recognized by the Team Leaders who are conscious of the supervisory requirements in relation to the children in their care.*"

**Staffing**

4.8 Paragraphs 2.5 and 2.7 deal with the adequacy of staffing arrangements at the home and specifically refer to the high incidence of sexually abused children in Unit 2 and the implications for new admissions to that Unit.

**Sleeping in Arrangements**

4.9 Paragraphs 9.4 and 9.6 address the matter of Sleeping-in arrangements, "*This level of cover is unacceptable as it does not provide adequate supervision and protection for the children…….For a unit caring for a high number of children, who have been sexually abused, to have only one staff on duty during the night is of concern.*"

**Relationship with the EHSSB**

4.10 Paragraph 2.9 states, "*The Administering Authority has arranged satisfactory funding with the Board and reports excellent working relationship with the Board and its officers*".

**Freedom for a known offender to roam**

4.11 NL 269 alleges that he was told by another member of staff, who he did not identify, that child [redacted], who had previously sexually abused a child while in care" *now frequently had the run of the home*". The report of the inspection does not address this specific allegation. I am not aware if the Inspector subsequently discussed this matter with the Head of the home.

**Regime of Fear at Nazareth Lodge**

4.12 NL 269 alleged that there was a regime of fear at Nazareth Lodge. While the report of the inspection acknowledges that there were tensions arising from staff shortages at times and that arrangements varied between Units in the way staff were used, there was no indication of a regime of fear. NL 269 's statement is not specific.

**Contact by a known abuser with two children in the home**

4.13 NL 269 stated that he was told by an unnamed colleague in another Unit that 2 boys, who had been abused by the cohabitee of their mother, were permitted by the Team Leader to have access to the perpetrator, without a child in care review. The report of the inspection does not refer to this matter. I am not aware if this allegation was subsequently discussed with the Head of the home by the Inspector.

**Status of Qualified Staff**

4.14 NL 269 expressed dissatisfaction regarding his perception of the status of qualified social workers, the boundaries of their responsibility and their accountability to Team Leaders. Paragraphs 4.4 – 4.7 of the report of the inspection deal with the concept of Keyworker and acknowledges that there were variations in the way this was exercised at Nazareth Lodge. "*Some staff felt curtailed in their key worker role……..The home's policy is designed to promote and encourage the keyworker system".*

4.15 Paragraph 7.4 refers to the practice of house meetings. "*This system of regular house meetings and the sharing of information in an open manner is commended. Wider use of these processes should be given consideration".* Clearly there were differences between Units and development of the role of residential social workers was a work in progress.

**Request by SSI for a written statement**

4.16 On the question of whether NL 269 should have been asked to make a written statement of complaint, I am in no doubt that he should. It is not possible to thoroughly investigate ill-defined complaints from whatever source. Some of the complaints had disciplinary implications and should have been addressed to the Administering Authority in the first instance. Others might have been dealt with under grievance procedure. NL 269 did not indicate whether he had pursued either course of action. I think it probable that I would have taken the view that a former member of staff of the home, who was professionally

conversation, Miss Reynolds stated "I have told NL 269 that I would prefer it if he placed his views on record by writing to me, although I read my notes to check that he was in agreement with the record of our telephone conversation". NL 269 was also advised that some points he had raised were already covered in the draft inspection report and that his comments would be followed up in discussion.

34. In response to the record of the conversation, Mr Chambers made a note to Miss Reynolds dated 2 February 1993 in which he stated "While NL 269's expression of concern confirms our own findings, I don't think it can be used unless he makes specific complaints in writing".

35. Miss Reynolds wrote to NL 269 on 29 March 1993 informing him that as she had not received his written comments on the issues raised by him she was unable to seek the views of either the Religious Order or the home's management committee on the matters raised. She also provided him with the names and addresses of relevant contacts to whom his comments should be sent.

36. The matters raised by NL 269 were of a serious nature and should have been followed up with the home. There was no protocol either within SSI or the wider Department that required such concerns to be conveyed in writing before being acted upon.

**Medical Input into SSI Inspections of Children's Homes**

37. I have no recollection of the arrangements for including a medical officer in the Inspection Teams for these homes. However, it would appear from Departmental papers that Dr Kilgore was involved in the 1988 inspection of Nazareth Lodge [SNB 13914].

**Inspections of Nazareth House**

38. In his memo of 29 October 1980 to Mr Armstrong [see RUB 41442] Mr O'Kane refers to two visits to Nazareth House on 21 November 1978 and 26 July 1979. Mr Norman Chambers recorded on Departmental File No. 2272/1992 –

## 8. COMPLAINTS PROCEDURE

8.1 A complaints procedure has been established in Nazareth Lodge since 1985 and has been updated in the light of the Boards new complaints procedure see Appendix G. One complaint was received since the last inspection. It was received on 30 September 1991 and was a complaint from a parent alleging that her child had been beaten by staff. The staff concerned had restrained the resident as advised by the Child Care Centre and Child Psychiatry. It was thoroughly investigated both by the Sister in Charge, the Team Leader and the Unit of Management staff. After discussion with the parent she withdrew the complaint and said she was satisfied with the explanation given. The complaint was fully written up and there was a letter on the file from the Unit of Management saying that they are satisfied with the explanation and felt that the complaint was groundless.

8.2 All residents are issued with a complaints booklet when they are admitted to Nazareth Lodge. The booklet is explained to residents in order that they are aware of their rights and the complaints procedures is closely adhered to.

described as appalling. The foregoing is an illustration of the challenges facing the Sisters in respect of some of the children who came into their care.

16. Prior to complaints procedures being formalised, SR30 dealt with the complaints from children about how they were being treated at school and, in particular, how a teacher said *"the home children can pick up rubbish in the playground"*[21]. The 1983 Swag report recorded that incidents of misbehaviour by children were dealt with in a variety of ways including the withdrawal of privileges and the inspector's considered that the forms of discipline about which they were informed were not excessive other than the practice of reducing pocket money for misdemeanours[22]

17. The 1989 monitoring statement recorded that there was no corporal punishment in the home and that control and discipline is necessary as exercised by the temporary removal of privileges[23].

18. The 1992 SSI inspection reported that a complaints procedure had been established in Nazareth Lodge since 1985 and had been updated in light of the Board's new complaints procedure. One complaint had been received since the last inspection and was a complaint from a parent alleging that her child had been beaten by staff. The staff concerned had restrained the resident as advised by the Child Care Centre and child psychiatry *"it was thoroughly investigated both by the Sister in charge, the team leader and the unit of medical staff. After discussion with the parents she withdrew the complaint and said she was*

[21] Day 93 125:2-18
[22] SNB50513
[23] SNB14376

## 3.0 Events which took place during 1993

3.1 In March 1993, young person NL 260 reported to his social worker NL 275 from North and West Belfast HSS Trust that another resident had approached him about NL 260 sexually abusing girls. NL 260 was noted as being upset as to how another resident had confidential information about him.

3.2 In April 1993, during a visit to the Home, NL 275 was informed by NL 260 and another young person that Sister (assumed to be SR 18 ) had locked them out of the until 2am.

3.3 On 2 May 1993, on attending the Home, following the reported concerns about NL 260 's behaviour, NL 275 found NL 260 alone in the unit. The toilet door was open but other doors were locked. NL 260 told her that SR 18 did not take him out due to his behaviour. It was noted that there were staff in adjoining units who could be contacted.

## 4.0 Events which took place during 1994-96

4.1 An initial complaint of being "poked" by SR 18 was made by a young person, NL 164 , to his social worker NHB 137 of Craigavon and Banbridge Community Health and Social Services Trust in May 1994

4.2 In June 1994, a Joint Protocol Investigation took place following a complaint by NL 164 regarding inappropriate sexual behaviour by another young person.

4.3 It seems from the records that in September 1994, NHB 137 received two telephone calls from two different Nazareth Lodge staff members outlining two separate incidents involving NL 164 . One, occurring in Donegal during a holiday, where NL 164 had been assaulted by two other young people and that SR 18 was aware of the assault. A second incident related to NL 164 having been locked in the kitchen by SR 18 .

4.4 NHB 137 visited NL 164 , on 14 September 1994, who did not wish to make a complaint. One of the staff members, who had made a telephone call, NL 170 , declined to speak to NHB 137 regarding the alleged incident. In the report of her earlier telephone call to NHB 137 it is recorded that NL 170 had said that she was told by senior staff at the Home not to share this report with social services.

4.5 There is a report, dated as received by Craigavon and Banbridge Community HSS Trust on 22 September 1994, from a Nazareth Lodge staff member, NL 171 , to SR 52 . This report outlines a conversation NL 171 had with NL 164 and NL 168 in which they described the events which occurred in Donegal.

4.6 Various records outline NHB 137 's follow up actions and correspondence with his managers.

4.7 In August 1995 a young person, NL 168 , made a complaint about a staff member NL 227 following an incident in the Nazareth Lodge Office. The

Regional Superior
The Poor Sisters of Nazareth
Nazareth House
Malahide Road
Dublin 3

JAC/SSI

December 1995

Dear Mother Regional

Re: Nazareth Lodge Ravenhill Road Belfast

I am writing to you about certain allegations regarding [redacted] SR 18 which were brought to my attention during the recent inspection of Nazareth Lodge. These are referred to in the attached report which was prepared by a staff member who has now left. You will see that matters referred to include the following:-

1. forcing a young person to eat food retrieved from the waste bin in front of other children

2. striking a young person in the course of a violent argument, then dropping him off in the countryside in Co Donegal at night leaving him to make his own way back to the holiday home

3. undermining of staff who had voiced concerns about the effects of such behaviour on the young people

4. refusing to speak to a young person for almost two months before the inspection

5. treating him unfairly in relation to her treatment of other children within the group

6. was reluctant to give him his clothing allowance

I ask that you investigate these matters further and that a report is sent to me in due course. I am copying this letter to the Management Committee for information, SR 148, Operational Manager and have notified the Trusts responsible.

Yours sincerely

J.A.Chaddock
Inspector - Social Services Inspectorate

(1)

I report for SR 52

I was doing an overnight shift with NL 171 on Monday 5 September when NL 171 asked me had I known that NL 164 said he was attacked on holiday in Donegal by two ex-residents NL 165 and NL 166. I said that at the time of the holiday I had heard this. I did not go into any detail with NL 171.

The following day, Tuesday September 6th, another resident NL 167, told me of an incident when SR 18 allegedly locked NL 164 in the electric cupboard in the kitchen. He described the incident as though he had been present and said that when NL 164 was let out of the cupboard after 5 minute he looked as though he was about to cry. I did not question NL 167 at this stage as another resident was present.

Following this, however, I chose to speak to NL 169 as I was concerned about what I had heard. I spoke informally to NL 169 as I simply wanted advice on what to do. I mentioned 3 incidents and following this NL 169 advised me to speak to SR 52.

The three incidents I spoke of where as follows.

- On 26/07/94. after the residents had returned from Donegal NL 168 told me of a conversation she had with SR 18. I recorded the conversation at the time. NL 168 said that during the second week of the holiday SR 18 had asked her if she drank alcohol. NL 168 said she did not. SR 18 then said that NL 168 was not a good liar and then apparently asked if NL 168 knew her limit. NL 168 replied that she did. NL 168 then told me that SR 18 gave her permission to go to an over 18s disco, said that she

could drink alcohol but could not come home drink. NL 168 then added that SR 18 had given her money to go to the disco.

I later showed NL 168 what I had recorded and she asked me to rip it out of the book or change what I had written to make it sound 'better'. I asked her if what I had written was incorrect and she said no but that she was frightened SR 18 would be angry that she had told me. I explained to NL 168 that I would not remove or alter what I had written and that I was now concerned NL 168 would abuse the freedom she had been given. It was after this incident that NL 168 absconded overnight from the unit to return to Donegal to stay with friends. I did not necessarily connect the incidents although I remained concerned about them. I had no opportunity to talk with SR 18 due to the fact that both SR 18 and I took holidays in July and August.

The second incident I mentioned to NL 169 and SR 52 concerned NL 164 being locked in a cupboard. I said, however, that I had not spoken to NL 164 but had only heard this from another resident. Following my discussion with SR 52 I asked NL 164 if this was true. He said he had not been locked in a cupboard but that he had been locked in the kitchen. He said that the incident occurred approximately two weeks ago. He explained that he and SR 18 had been arguing and that everyone was preparing to watch a video. It was around 9pm. NL 164 said that SR 18 had locked one kitchen door after NL 164 had snubbed it. He said SR 18 had then gone around to the other door and locked it. NL 164 said he remained

3

locked in the kitchen while the residents watched a video. I asked how was he certain both doors were locked and he said they had been. Apparently after the video SR 18 then went upstairs with the other children. According to NL 164 this was around 11pm. NL 164 then climbed out a kitchen window as he said he needed to go to the bathroom. However, the front door was locked so he then rang the bell both for our unit and for the Independent Unit. NL 164 said that SR 18 appeared with some other residents and stopped the Independent staff member opening the door. NL 164 thinks it was [redacted]. He claims SR 18 then told him to go back through the kitchen window. NL 164 said that he heard the kitchen door being unlocked with the key and that he then unsnibbed the door and left the kitchen. He went on to bed. NL 164 admitted that he had been arguing with SR 18 and that he had snibbed the kitchen door. He said, however, that it had later been locked as he had tried to open the door to go out to the bathroom.

I asked NL 167 where he had heard that NL 164 had been locked in a cupboard. He said he thought a staff member had told him and I explained that, according to NL 164, this had never happened.

The final incident I mentioned concerned an event in Donegal during July. I had known that NL 164 had trailed another resident around the room one evening following their visit to a junior disco. NL 168 had described this to me as she was the person involved. I recorded this in NL 168 's day book. However, later that evening NL 166 then told NL 168 and myself that she had hit NL 164 because of his

behaviour. She said she had hit NL 164 on the face. NL 166 later explained that she and NL 165 had both hit NL 164 because of the way he had treated NL 168 NL 166 said the lights in the room were turned off before they hit NL 164 I then asked NL 164 the following day if anything had happened to him. He said that after everyone had gone to bed he was downstairs with SR 18, NL 166 and NL 165 He said that SR 18 had given permission to NL 166 and NL 165 to hit NL 164 but not to hurt him too much. NL 164 added that SR 18 then turned the lights out and that he could see her outline at the door and hear her laughing as NL 165 and NL 166 hit him. He thinks he was hit with a shoe. He said he was pushed to the floor before being hit, that he was not hit hard but that he was frightened. I asked NL 164 what he wanted to do and he said that noone would believe him against SR 18 and that there was no point complaining as he would only end up having to drop the complaint. NL 164 also said that he had dropped a previous complaint because people did not believe him. The rest of the week in Dorgal NL 164 asked me to take him home and he said repeatedly he was afraid of NL 165 and NL 166 I remained very concerned about this incident and felt that if NL 164 did not wish to make a complaint then there was little I could do. However, when NL 171 explained he had told her about it I decided to speak to NL 169

NL 170

This is a report for Judith Chadwick following ~~the~~ conversation of Monday 6th November 1995. I explained to Judy my concerns on leaving Nazareth Lodge and my reasons for doing so.

On a professional level I am quite disheartened as I believe the staff group are not given either a professional rate of pay, or professional terms and conditions. Although our starting rate of pay is equal to that of statutory field workers, we do not receive yearly increments for years of service. Similarly I believe staff morale would improve if, for example, we were offered pension schemes and better terms for sickness pay.

Another example highlighting my frustration regarding employee terms and conditions would be in reference to holiday times when staff take the visit to Donegal. This year we worked for seven days, living in the same building with the children and we did not, contrary to Union recommendations, receive overnight pay. I worked from 9.30am to 1am or later on alternate days and from 9.30am to 7.30pm the remaining days. I was allocated eight hours in lieu only, despite the overtime and was told that this was a holiday for me as much as for the children. I have already raised these issues with a member of Nazareth Lodge's Management committee, [redacted]

NL 35

More pressing concerns regard my perception

2

of how some of the children in the unit would be treated. I have forwarded Judy a copy of the report I was asked to write by SR 52 following my discussion with her last year. This related to two incidents with NL 164 and are concerning NL 168

A further incident which occurred this July in Donegal relates to NL 164 NL 172 and myself were working in Donegal for this particular week of the children's holiday. We had left the house around 7.30pm as we were out for the evening and we returned at 1.15am. Sr was in bed at the time and several of the children were watching a video. SR 18 came out to speak with NL 172 and myself and she informed us that she had left NL 164 in Culdaff following an argument with him. Sr. explained that she and NL 164 had started to argue in the minibus while they were at the beach. I do not know what the argument was about. She explained that both NL 164 and herself had struck blows at each other and that this had taken place in front of the children SR 18 then told NL 164 to get out of the bus and explained that he could make his own way home. NL 164 had been left in Culdaff, which was approximately 25 miles away by minibus, between 9pm and 1.30am. NL 164 returned as we were talking. He told NL 172 and I that he had walked around for several hours and had then gone into the house of a friend of SR 18

just before 1am and that the friend, [redacted] had given NL 164 home. Both NL 172 and I could see a reddening below NL 164 eye. He was visibly shaken and soon after he returned he went to bed.

NL 164's account of the incident, from memory, was that he and SR 18 had argued in the minibus. He said that SR 18 had then instructed one of the children, NL 173, to hold NL 164 by the shoulders and that she had then hit NL 164. She pulled him out of the minibus and left him to find his own way home. This is similar to an incident which occurred the previous year when SR 18 had apparently put NL 164 out of the minibus leaving him to walk home. This incident occurred during daylight hours and NL 164 was eventually picked up by a friend of SR 18 who had gone to find him. He had walked seven miles when he was collected.

I have witnessed many occasions between SR 18 and NL 164 where I feel NL 164 is unfairly treated. I am aware that prior to Judy's inspection SR 18 had refused to speak with NL 164 for approximately seven weeks. Staff members were asked to convey messages to NL 164 from SR 18 which then placed us in positions whereby we were the recipient of NL 164 anger towards SR 18. This was a constant problem in that we were continually attempting to restrain NL 164's anger and manage him within the unit. NL 164 is frequently ostracised within the unit, usually at SR 18

4.

instigation. Sanctions used against him are obviously invalid and, I consider, extremely damaging to his own feelings of self worth. NL 164 has frequently expressed his belief that if he chose to complain, no-one would listen to him and that SR 18 would give a different version of events. I have also witnessed NL 164 being forced by SR 18 to eat food from the bin. She refused to let him out of the kitchen until he had eaten the remainder of a hamburger that NL 164 had thrown in the bin earlier that day. This occurred in front of the other children, again singling NL 164 out in front of the group.

Both NL 168 and NL 164 [redacted] would seem to experience a greater degree of difficulty in receiving their monthly clothing allowance. Whereas other children will be given their money when requested, NL 164 and NL 168 are asked to wait. I have known NL 164 to wait for days, without reason. He will then lose his temper and shout at SR 18 and will be told by SR 18 that he won't receive his money, given his attitude.

I expressed to Judy my belief that Hayeswell Lodge was a "time bomb waiting to go off." I am deeply concerned at how NL 164 and NL 168 would be continually manipulated by SR 18 and are then sanctioned or ostracised for losing their temper. This occurs with all of the children but most especially with NL 164 and NL 168. I have maintained firm links with both of the above and

have believed at times that this annoys SR 18. For example, at times when I have been talking with NL 168 SR 18 has given me another job to do, often cleaning. I overheard SR 18 discussing with SR 148 her distaste at NL 164 telling her he liked me working here, and following my discussion with SR 52 last year I am aware that SR 18 told NL 168 and NL 164 I had compliance about her and that I could not be trusted. I believed very strongly that this was an attempt to cause the young people to remain cool or distant with me.

Further issues which concern me relate to similar situations of ~~the~~ some of the young people being treated unfairly. I witnessed SR 18 telling NL 173 to go away because she hated him and he was stupid; of NL 168 [redacted] continually being told she shouldn't be here as there were children who needed the bed more, and to remember that she was only in an emergency bed and could be returned home or placed in Huddletown at a moments notice. I have continually had to deal with children who are angry and upset at how they have been treated by SR 18 and who feel powerless to do anything. I have raised these concerns with SR 18 only to make my own position more difficult as I would then be told off for something in front of staff and children alike. I have been informed by children of comments made about me by SR 18 and have witnessed this occurring against

6.1

other members of staff.
Whilst I consider the working environment within this unit to be made more difficult by the above situations, I also consider the unit to be seriously understaffed. We are frequently left on our own to manage all the children and I was given no option recently and told that I had to supervise unit one and two for my shift. All of the staff group have raised their concerns about staffing levels to no avail. We frequently manage the unit on minimum and less than adequate, or safe, staffing levels. I have received very little support or professional social work input into my role here.

- Jody - I could go on for hours + hours and have seen many things. Please let me know if there is any more I can do'

NL 170 [redacted]

go outside the system that operated within Nazareth Lodge. I kept copies of my report.

20. NHB137 was NL164 social worker. He stood out from the other social workers as he made regular visits to the home – his monthly visit together and any other time NL164 made a request to see him.

21. I remember NHB 137 coming to speak to NL164 and I in Nazareth Lodge on 14th September 1994. I specifically remember Sister SR18 buying NL164 a pink hairdryer either the day before or on the day of the visit. I saw the hairdryer myself. She knew that NHB 137 would be coming as he would have booked in for a visit and NL164 probably told her NHB 137 was coming. She often bought NL164 gifts when NL164 threatened to tell NHB 137 about her behaviour. When NL164 received gifts from her his attitude towards the staff changed and he turned on us. He became provocative and verbally abusive.

22. On 14th September I remember NHB 137 stood at the door of the unit and I remember asking him what was going to be done about the complaints I had made involving NL164 He said that there was nothing he could do and that he didn't want to hear anymore. He had a helpless tone in his voice when he said it. His attitude was that this was the Sisters of Nazareth and that nothing could be done to change things. I cannot remember if I gave him a copy of my report which I had prepared for SR52 I would have thought that I did and I cannot understand why I wouldn't have as I was the person that contacted him to raise my concerns. NL164 attitude was also very much 'no one is going to listen to me'. I liked NHB 137 as he was very good with NL164 but my abiding memory of him is him telling me he was powerless to do anything about my complaints and that he didn't want to know anymore.

23. NL164 and SR18 had a volatile relationship. NL164 could explode. When someone is being emotionally abused where can you go. I never witnessed SR18 being physically abusive with anyone. I did hear her and NL164 screaming at each other.

actions taken by Nazareth staff to "safeguard" NL 164 including immediately moving him to another adjacent unit to ensure no contact with the alleged perpetrator.

22. **21 June 1994** – A Referral was made to Child and Adolescent Mental Health Services (CAMHS) for NL 164 by me. The focus of this referral was to assess and support NL 164 and to acknowledge he did not always engage with social services and hopefully this would provide him an alternative opportunity to raise any matters of concern which he may have had. No concerns were raised by NL 164 to CAMHS and NL 164 subsequently withdrew from this service.

23. **8 September 1994** – I received a telephone call from a member of staff of Nazareth Lodge, named NL 171 . The nature of this telephone call was to outline an incident which NL 164 stated occurred on holiday in Donegal when he had been assaulted by other young people and that SR 18 was aware of this assault. NL 164 indicated to me that he wished to make a complaint to the staff member and that he wished for this staff member to agree to contact me on his behalf. I subsequently met NL 164 in relation to this. I refer to documents exhibited herewith at **exhibit 5**

24. **13 September 1994** - Telephone call from NL 170 , NL 164 s keyworker, Nazareth Lodge, advising she had compiled reports relating to incidents where NL 164 had been locked in the kitchen by SR 18 . She advised she was told not to share this report with social services by senior staff in Nazareth. She indicated she would share this report with me. See contact sheet, **exhibit 6** I agreed to come to the unit the next day and to meet with both her and NL 164 . I advised senior staff in my organisation of the nature of this call and the action that I was taking

25. **14 September 1994** – Spoke with NL 164 in relation to allegations made both in relation to incidents concerning alleged assault in Donegal and incident re the kitchen. NL 164 indicated that there was nothing to this and did not wish to make any complaint, see contact sheet, **exhibit 7.**

26. **14 September 1994** – I spoke with NL 170 who did not wish to speak to me in relation to any complaints, see contact sheet, **exhibit 8**.

27. NL 170 was also asked about the reports which she indicated had been complied in relation to the incident. However, no such reports were forthcoming. I assured her that any complaint she made would be investigated as detailed in the contact sheet referred to at **exhibit 8**, however at this time, no complaints were made. The outcome of these series of contacts with both NL 164 and NL 170 was outlined in correspondence to my then manager, Mr Vincent O'Rourke, Assistant Principal Social Worker, see **exhibit 9**.

28. **6 October 1994**. I made a request to the Residential Staff in Nazareth Lodge SR 18 to see NL 164s file as I wished to satisfy myself if there was any other evidence of any incidents or reports within the unit which had not been shared, see **exhibit 10** At this time I also spoke to SR 18 and indicated I was also requesting copies of all untoward incidents from Christmas 1993 held within the unit. I indicated that would wish to speak to her and SR 52 in relation to any complaints regarding NL 164. As no complaints were actually made or any evidence of any other reports held within the unit files, no further action could be taken

29. In respect of the discussion with NL 164 on 14 September 1994, I had a recollection of asking about the role of NL 165 within Nazareth Lodge. NL 165 as a young person had been placed in Nazareth Lodge by Port down Social Services and I was the social worker for his half siblings resident in Craigavon. I was aware that at this time NL 165 was no longer in care. The extent of the time he was present t in my view would have been in excess of what I would have expected of an ex resident and it was this that raised my concern. NL 165s role in the unit also seemed to me to be akin to that of a senior staff role. When asked, NL 164 would not comment any further other than to say that he was SR 18 's "pet". I recall having a conversation with NL 165s social worker from Portadown about the level of presence he had in the unit. Her response was that NL 165 had left care and the authority of the care order in respect of him had lapsed.

12. There was an older resident called NL242 who lived in the independent unit in the Lodge. I think he may have been 17 or 18 years old. I witnessed SR18 bringing breakfast to him in his bedroom. We all thought they were having some form of relationship. I didn't report my concerns about SR18 's behaviour because I think I was in a state of disbelief at what was going on. I was usually on my own whenever I directly witnessed anything and I felt that no one would believe me. I felt so powerless within the system.

13. In the unit SR18 listened in on our telephone calls from the extension upstairs. We used to hear the extension being lifted. Sometimes she even spoke during the conversation. We even made comments during the call just to let her know we knew what she was doing. She prevented us from talking freely to the children's social workers. I would usually wait until SR18 was in the convent so I could make telephone calls privately.

14. When I arrived in Nazareth Lodge in January 1994 it was mindboggling. I had never worked with nuns before. I had worked in other environments before including Africa. However, I had never worked in such an environment where there was silence, power and authority, all of which surrounded the nuns.

**NL164 (NL 164)**

15. NL164 was a resident in SR18 unit. I was NL164 keyworker at a time. This meant that I was involved with him on a daily basis and did work one on one. I loved him. He was a very witty, intelligent and a real character. I think he 'camped it up' to annoy her. He twirled and danced a lot. I believe he was struggling with his sexuality and he didn't know how to deal with it. I had a good relationship with him. SR18 hated him. I think NL164 also hated SR18 Staff who were in the home longer than me such as NL221 and NL261 indicated that Sister SR18 had a reputation for 'grooming' boys. She would have chosen a boy

investigative process.

9.2 The records of the investigation held in early 1996 regarding the complaints centring on NL 164 indicate the complaint investigation process had improved to be more in line with that outlined in the 1985 Circular There was a strategy discussion as to the nature of the investigation and the clear involvement of the HSS Trusts and Management Committee. An Investigative Subcommittee of the Management Committee included a representative from a HSS Trust in the three person investigative team. However the minutes of a special meeting of the Management Committee of Nazareth Lodge on 4th March 1996 item 1, revealed that the sub-committee had interviewed the complainants, SR 18 and Judith Chaddock but have not carried out further investigations. It seems from the minutes of the meeting (item 2) that it was SR 18 's co-operation that had enabled them to indicate that there was some validity to the allegations. This does leave open the question of what outcome the investigation would have revealed had SR 18 not admitted certain aspects of the allegations.

9.3 The outcome of the investigation was shared with the relevant HSS Trusts as a copy of the relevant Nazareth Lodge Management Committee minutes, and later, in a brief letter from the Chair of the Management Committee to the individual Trusts, [SNB-19319]. No additional detail of the investigation or its findings appears to have been shared. The records do contain a report prepared by the Investigative Sub-committee outlining the allegations and the sub-committee's conclusions in respect of the individual allegations [SNB-19320]. This contains very limited information and no rationale as to how the conclusions were reached is included.

9.4 It is not clear what role the 'independent' member of the panel, Mr Chard, played in the investigation. Mr Chard's witness statement, dated 26th March 2015 seems to indicate that he was involved in the process alongside the other members of the Investigative Sub-committee in interviewing complainants and staff, and in reporting back to the Management Committee. Mr Chard statement indicates he was subsequently excluded from the Management Committee decision making process and was not informed of the outcome. There does not appear to be any guidance how this independent person role should operate in practice, nor did I note in the records any discussion between the Trusts or with the Management Committee as to the expectations on this person on this occasion.

## 10.0 The subsequent impact of the investigations

10.1 In both time periods the complaints investigation process reached a conclusion around the specific allegations raised. In the 1985/6 investigation no substance to the allegations was found whilst the 1994/6 investigation substantiated or partially substantiated some of the allegations. It is not clear from the records I considered whether there was a subsequent impact of these allegations and investigations on the care provided within the home.

10.2 Mr Armstrong, DHSS, letter dated 7th February 1986 indicates once the individual complaints were investigated and if they were substantiated the Department should be informed so that their 'relevance to the continued registration of the home' could be considered. The allegations were not

getting a lift from a stranger many miles from their accommodation. I recall also being concerned at SR 18 reading aloud to a group of residents, details of a press report about the remand of NL 168 s brother on criminal charges.

9. The sub-committee were invited to present the report of our investigations to the Management Committee of Nazareth Lodge at their meeting on 4/3/1996 (SNB 49402). My recollection of that meeting was that the Management Committee members, especially the Chair and the Honorary Secretary questioned us in considerable detail about our conclusions and that they appeared to be reluctant to accept a number of these on the grounds that they appeared to require a higher standard of proof than was possible due to the nature of the allegations. I recall feeling that the questions of members of the Management Committee appeared to be defensive of Nazareth Lodge and of SR 18.

10. When the sub-committee had presented our report to the Management Committee and when we had been questioned about our conclusions, I was asked to leave the meeting as I was not a member of the Management Committee. The other two members of the sub-committee, being members of the Management Committee, remained. I was therefore unaware of the decisions made and action taken by the Management Committee on foot of our report. I was not permitted to retain a copy of our report.

11. I have only recently had sight of the minutes of the meeting of the Management Committee at which we presented our report. I have only recently become aware that SR 18 accepted that she "made some error of judgement" and decided to withdraw from child care following our report.

12. In summary I was the Independent member of a sub-committee set up to investigate allegations in respect of SR 18 We found many of these allegations substantiated and we presented a report to the Management

getting a lift from a stranger many miles from their accommodation. I recall also being concerned at SR 18 reading aloud to a group of residents, details of a press report about the remand of NL 168 s brother on criminal charges.

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12. In summary I was the Independent member of a sub-committee set up to investigate allegations in respect of SR 18 We found many of these allegations substantiated and we presented a report to the Management

We the panel, appointed by the Management Committee of Nazareth Lodge home, interviewed a number of people about allegations made in respect of SR 18 in connection with her role as Head of Unit in Nazareth Lodge. We have concluded that many of the allegations have a degree of validity. The allegations and our conclusions are outlined below.

1 *Forcing a young person to eat food retrieved from the waste bin in front of other children.*

**We accept that there is some validity in this allegation.**

2 *Striking a young person in the course of a violent argument, then dropping him off in the countryside in Co Donegal at night leaving him to make his own way back to the holiday home.*

**We accept that there is some validity in this allegation.**

3 *Undermining of staff who had voiced concerns about the effects of such behaviour on the young people.*

**We accept that the complainant felt undermined on occasions.**

4 *Refusing to speak to a young person for almost two months before the inspection.*

**We accept that there is some validity in this allegation.**

5 *Treating him unfairly in relation to her treatment of other children within the group.*

**We accept that he was treated differently to other children but not necessarily unfairly.**

6 *Was reluctant to give him his clothing allowance.*

**This allegation is not substantiated.**

7 *The capacity of the minibus was regularly exceeded on occasions.*

**We accept that there is some validity in this allegation.**

8 *The minibus was driven (in Donegal) by non insured drivers, including Mr* NL 165 *(ex resident, 20 years).*

**We accept that there is some validity in this allegation.**

9 SR 18 *incited* NL 165 *(and another female adult* [redacted] *to physically assault* NL 164 *(resident, 14 years). This incident allegedly took place in Donegal in the summer of 1994.*

**We accept that there is some validity in this allegation.**

10 NL 164 *was held by another child while* SR 18 *"pulled the hair out of him".*

**This allegation was not substantiated.**

11 *Formal complaints were discouraged by bribery or threats.*

**This allegation was not substantiated.**

12 NL 165 *was harboured by* SR 18 *within the unit.*

**We accept that this allegation was substantiated.**

13 SR 18 *was emotionally abusive toward the residents "putting people down", undermining self esteem of residents, not making people feel "wanted". One incident was cited in which she shouted at a child "I hate you".*

**This allegation was not substantiated.**

14 *Preferential treatment of "favourites". Discriminatory practice against other children was in evidence.*

**This allegation was not substantiated.**

15 *Breach of confidentiality and indiscretion regarding residents' circumstances took place.* SR 18 *read aloud from a newspaper article concerning the remand of* NL 168 *s brother on serious criminal charges. Other children and residential worker (* NL 262 *were present.*

**We accept that this allegation was substantiated.**

16 SR 18 *took younger children into her bed. This happened on a very regular basis in the past (with* NL 276 *) and more occasionally at the present time (with* NL 277 *, 4 years).*

**We accept that this allegation was substantiated.**

17 *Communal presents for residents (eg, from social workers who were leaving the unit) are being withheld from the children.*

**We accept that there is some validity in this allegation.**

that even after, such as it was, that process had taken place and a head of a unit in the home had resigned over it, there doesn't appear from the material to have been any consideration in the Department about, "Okay. Serious issue here. It's resulted in the head of one of these three units resigning. What do we need to do, because at our back is that statutory duty to make sure the place is being run in the best interest of the kids. The balloon has gone up as far as, yes, one member of staff, but the head of a unit who has got staff under them and potentially ten to twelve children that she is looking after".

Can you remember at all was any consideration given to, "What have we got to do now? How should we react to this?"

**A. No. I have no recollection of ever seeing a report back from the Nazareth home in relation to Miss Chaddock's letter of 1995. So, as I say, whether we did or not I don't know. I can't recollect. At that stage it is important to bear in mind there was -- as Norman Chambers has said, he left the post he was in. A new Assistant Chief Inspector was appointed, and now whether that person saw any report or not I do not know, but I haven't seen any report in any files from the Department at that stage.**

Regional Superior
The Poor Sisters of Nazareth
Nazareth House
Malahide Road
Dublin 3

JAC/SSI

December 1995

Dear Mother Regional

Re: Nazareth Lodge Ravenhill Road Belfast

I am writing to you about certain allegations regarding [redacted] SR 18 which were brought to my attention during the recent inspection of Nazareth Lodge. These are referred to in the attached report which was prepared by a staff member who has now left. You will see that matters referred to include the following:-

1. forcing a young person to eat food retrieved from the waste bin in front of other children

2. striking a young person in the course of a violent argument, then dropping him off in the countryside in Co Donegal at night leaving him to make his own way back to the holiday home

3. undermining of staff who had voiced concerns about the effects of such behaviour on the young people

4. refusing to speak to a young person for almost two months before the inspection

5. treating him unfairly in relation to her treatment of other children within the group

6. was reluctant to give him his clothing allowance

I ask that you investigate these matters further and that a report is sent to me in due course. I am copying this letter to the Management Committee for information, SR 148, Operational Manager and have notified the Trusts responsible.

Yours sincerely

J.A.Chaddock
Inspector - Social Services Inspectorate

(1)

I report for SR 52

I was doing an overnight shift with NL 171 on Monday 5 September when NL 171 asked me had I known that NL 164 said he was attacked on holiday in Donegal by two ex-residents NL 165 and NL 166. I said that at the time of the holiday I had heard this. I did not go into any detail with NL 171.

The following day, Tuesday September 6th, another resident NL 167, told me of an incident when SR 18 allegedly locked NL 164 in the electric cupboard in the kitchen. He described the incident as though he had been present and said that when NL 164 was let out of the cupboard after 5 minute he looked as though he was about to cry. I did not question NL 167 at this stage as another resident was present.

Following this, however, I chose to speak to NL 169 as I was concerned about what I had heard. I spoke informally to NL 169 as I simply wanted advice on what to do. I mentioned 3 incidents and following this NL 169 advised me to speak to SR 52.

The three incidents I spoke of where as follows.

- On 26/07/94. after the residents had returned from Donegal NL 168 told me of a conversation she had with SR 18. I recorded the conversation at the time. NL 168 said that during the second week of the holiday SR 18 had asked her if she drank alcohol. NL 168 said she did not. SR 18 then said that NL 168 was not a good liar and then apparently asked if NL 168 knew her limit. NL 168 replied that she did. NL 168 then told me that SR 18 gave her permission to go to an over 18s disco, said that she

could drink alcohol but could not come home drink. NL 168 then added that SR 18 had given her money to go to the disco.

I later showed NL 168 what I had recorded and she asked me to rip it out of the book or change what I had written to make it sound 'better'. I asked her if what I had written was incorrect and she said no but that she was frightened SR 18 would be angry that she had told me. I explained to NL 168 that I would not remove or alter what I had written and that I was now concerned NL 168 would abuse the freedom she had been given. It was after this incident that NL 168 absconded overnight from the unit to return to Donegal to stay with friends. I did not necessarily connect the incidents although I remained concerned about them. I had no opportunity to talk with SR 18 due to the fact that both SR 18 and I took holidays in July and August.

The second incident I mentioned to NL 169 and SR 52 concerned NL 164 being locked in a cupboard. I said, however, that I had not spoken to NL 164 but had only heard this from another resident. Following my discussion with SR 52 I asked NL 164 if this was true. He said he had not been locked in a cupboard but that he had been locked in the kitchen. He said that the incident occurred approximately two weeks ago. He explained that he and SR 18 had been arguing and that everyone was preparing to watch a video. It was around 9pm. NL 164 said that SR 18 had locked one kitchen door after NL 164 had snubbed it. He said SR 18 had then gone around to the other door and locked it. NL 164 said he remained

3

locked in the kitchen while the residents watched a video. I asked how was he certain both doors were locked and he said they had been. Apparently after the video SR 18 then went upstairs with the other children. According to NL 164 this was around 11pm. NL 164 then climbed out a kitchen window as he said he needed to go to the bathroom. However, the front door was locked so he then rang the bell both for our unit and for the Independent Unit. NL 164 said that SR 18 appeared with some other residents and stopped the Independent staff member opening the door. NL 164 thinks it was [redacted]. He claims SR 18 then told him to go back through the kitchen window. NL 164 said that he heard the kitchen door being unlocked with the key and that he then unsnibbed the door and left the kitchen. He went on to bed. NL 164 admitted that he had been arguing with SR 18 and that he had snibbed the kitchen door. He said, however, that it had later been locked as he had tried to open the door to go out to the bathroom.

I asked NL 167 where he had heard that NL 164 had been locked in a cupboard. He said he thought a staff member had told him and I explained that, according to NL 164, this had never happened.

The final incident I mentioned concerned an event in Donegal during July. I had known that NL 164 had trailed another resident around the room one evening following their visit to a junior disco. NL 168 had described this to me as she was the person involved. I recorded this in NL 168 's day book. However, later that evening NL 166 then told NL 168 and myself that she had hit NL 164 because of his

4.

behaviour. She said she had hit NL 164 on the face. NL 166 later explained that she and NL 165 had both hit NL 164 because of the way he had treated NL 168 NL 166 said the lights in the room were turned off before they hit NL 164 I then asked NL 164 the following day if anything had happened to him. He said that after everyone had gone to bed he was downstairs with SR 18, NL 166 and NL 165 He said that SR 18 had given permission to NL 166 and NL 165 to hit NL 164 but not to hurt him too much. NL 164 added that SR 18 then turned the lights out and that he could see her outline at the door and hear her laughing as NL 165 and NL 166 hit him. He thinks he was hit with a shoe. He said he was pushed to the floor before being hit, that he was not hit hard but that he was frightened. I asked NL 164 what he wanted to do and he said that noone would believe him against SR 18 and that there was no point complaining as he would only end up having to drop the complaint. NL 164 also said that he had dropped a previous complaint because people did not believe him. The rest of the week in Dorgal NL 164 asked me to take him home and he said repeatedly he was afraid of NL 165 and NL 166 I remained very concerned about this incident and felt that if NL 164 did not wish to make a complaint then there was little I could do. However, when NL 171 explained he had told her about it I decided to speak to NL 169

NL 170

This is a report for Judith Chadwick following ~~the~~ conversation of Monday 6th November 1995. I explained to Judy my concerns on leaving Nazareth Lodge and my reasons for doing so.

On a professional level I am quite disheartened as I believe the staff group are not given either a professional rate of pay, or professional terms and conditions. Although our starting rate of pay is equal to that of statutory field workers, we do not receive yearly increments for years of service. Similarly I believe staff morale would improve if, for example, we were offered pension schemes and better terms for sickness pay.

Another example highlighting my frustration regarding employee terms and conditions would be in reference to holiday times when staff take the visit to Donegal. This year we worked for seven days, living in the same building with the children and we did not, contrary to Union recommendations, receive overnight pay. I worked from 9.30am to 1am or later on alternate days and from 9.30am to 7.30pm the remaining days. I was allocated eight hours in lieu only, despite the overtime and was told that this was a holiday for me as much as for the children. I have already raised these issues with a member of Nazareth Lodge's Management committee, [redacted]

NL 35

More pressing concerns regard my perception

2

of how some of the children in the unit would be treated. I have forwarded Judy a copy of the report I was asked to write by SR 52 following my discussion with her last year. This related to two incidents with NL 164 and NL 168 and are concerning

A further incident which occurred this July in Donegal relates to NL 164 NL 172 and myself were working in Donegal for this particular week of the children's holiday. We had left the house around 7.30pm as we were out for the evening and we returned at 1.15am. SR was in bed at the time and several of the children were watching a video. SR 18 came out to speak with NL 172 and myself and she informed us that she had left NL 164 in Culdaff following an argument with him. SR explained that she and NL 164 had started to argue in the minibus while they were at the beach. I do not know what the argument was about. She explained that both NL 164 and herself had struck blows at each other and that this had taken place in front of the children SR 18 then told NL 164 to get out of the bus and explained that he could make his own way home. NL 164 had been left in Culdaff, which was approximately 25 minutes away by minibus, between 9pm and 1.30am. NL 164 returned as we were talking. He told NL 172 and I that he had walked around for several hours and had then gone into the house of a friend of SR 18

just before 1am and that the friend, [redacted] had given NL 164 home. Both NL 172 and I could see a reddening below NL 164 eye. He was visibly shaken and soon after he returned he went to bed.

NL 164's account of the incident, from memory, was that he and SR 18 had argued in the minibus. He said that SR 18 had then instructed one of the children, NL 173, to hold NL 164 by the shoulders and that she had then hit NL 164. She pulled him out of the minibus and left him to find his own way home. This is similar to an incident which occurred the previous year when SR 18 had apparently put NL 164 out of the minibus leaving him to walk home. This incident occurred during daylight hours and NL 164 was eventually picked up by a friend of SR 18 who had gone to find him. He had walked seven miles when he was collected.

I have witnessed many occasions between SR 18 and NL 164 where I feel NL 164 is unfairly treated. I am aware that prior to Judy's inspection SR 18 had refused to speak with NL 164 for approximately seven weeks. Staff members were asked to convey messages to NL 164 from SR 18 which then placed us in positions whereby we were the recipient of NL 164 anger towards SR 18. This was a constant problem in that we were continually attempting to restrain NL 164's anger and manage him within the unit. NL 164 is frequently ostracised within the unit, usually at SR 18

4.

instigation. Sanctions used against him are obviously invalid and, I consider, extremely damaging to his own feelings of self worth. NL 164 has frequently expressed his belief that if he chose to complain, no-one would listen to him and that SR 18 would give a different version of events. I have also witnessed NL 164 being forced by SR 18 to eat food from the bin. She refused to let him out of the kitchen until he had eaten the remainder of a hamburger that NL 164 had thrown in the bin earlier that day. This occurred in front of the other children, again singling NL 164 out in front of the group.

Both NL 168 and NL 164 [redacted] would seem to experience a greater degree of difficulty in receiving their monthly clothing allowance. Whereas other children will be given their money when requested, NL 164 and NL 168 are asked to wait. I have known NL 164 to wait for days, without reason. He will then lose his temper and shout at SR 18 and will be told by SR 18 that he won't receive his money, given his attitude.

I expressed to Judy my belief that Hayeswell Lodge was a "time bomb waiting to go off." I am deeply concerned at how NL 164 and NL 168 would be continually manipulated by SR 18 and are then sanctioned or ostracised for losing their temper. This occurs with all of the children but most especially with NL 164 and NL 168. I have maintained firm links with both of the above and

have believed at times that this annoys SR 18. For example, at times when I have been talking with NL 168 SR 18 has given me another job to do, often cleaning. I overheard SR 18 discussing with SR 148 her distaste at NL 164 telling her he liked me working here, and following my discussion with SR 52 last year I am aware that SR 18 told NL 168 and NL 164 I had compliance about her and that I could not be trusted. I believed very strongly that this was an attempt to cause the young people to remain cool or distant with me.

Further issues which concern me relate to similar situations of ~~the~~ some of the young people being treated unfairly. I witnessed SR 18 telling NL 173 to go away because she hated him and he was stupid; of NL 168 [redacted] continually being told she shouldn't be here as there were children who needed the bed more, and to remember that she was only in an emergency bed and could be returned home or placed in Huddletown at a moments notice. I have continually had to deal with children who are angry and upset at how they have been treated by SR 18 and who feel powerless to do anything. I have raised these concerns with SR 18 only to make my own position more difficult as I would then be told off for something in front of staff and children alike. I have been informed by children of comments made about me by SR 18 and have witnessed this occurring against

6.1

other members of staff.
Whilst I consider the working environment within this unit to be made more difficult by the above situations, I also consider the unit to be seriously understaffed. We are frequently left on our own to manage all the children and I was given no option recently and told that I had to supervise unit one and two for my shift. All of the staff group have raised their concerns about staffing levels to no avail. We frequently manage the unit on minimum and less than adequate, or safe, staffing levels. I have received very little support or professional social work input into my role here.

- Jody - I could go on for hours + hours and have seen many things. Please let me know if there is any more I can do'

NL 170 [redacted]

HIA REF: [ ]

NAME: [John Duffy]

DATE: [15/04/2015]

# THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

## Witness Statement of John Duffy
## APPENDIX ONE

1. As already noted, I have paid particular attention to information available from 1994 to 1996 relating to young person, NL 164, NL 168 and NL 260. To consider who knew what was known about these allegations, when, by whom and what was done I set out below an outline in respect of each young person.

2. Firstly, in respect of SR 18, I note that after joining the Order in 1964 she had placements in both Derry and Belfast. I understand that she was in Nazareth Lodge, Derry, from 17 July 1972 to 7 October 1973 when she first came to Belfast. She then returned to Derry on 5 August 1977 where she remained until 13 November 1985. She commenced in Nazareth Lodge, Belfast on 26 August 1986 and remained until a voluntary leave of absence in late 1995 as referred to in more detail below.

3. I am aware that references were also made to SR 18 within Module 1 and my attention has been drawn to two particular Applicants mentioning her:
   - HIA 105 stated that she told SR 18 (as an adult) that she was sexually abused by a nun in Nazareth Lodge, Derry;
   - HIA 169 said that SR 18 witnessed another senior nun assaulting her so as to cause a head injury.

   It does not appear that any direct allegation has come to the attention of the Inquiry against SR 18 relating to her time in Derry. This has been considered to place a context first on what might have been known regionally, but it appears that no concern would have been apparent.

4. NL 260

5. NL 260 was in the care of North and West Belfast Health & Social Services Trust ("N&WBHSST"), which fell within the Eastern Board. Three records in particular have been identified on his file, which are relevant.

6. On 6 March 1993 NL 275, NL 260's Social Worker, recorded that she discussed a significant incident between NL 260 and another resident with him. NL 260 reported that another resident NL 165, had approached him about sexually abusing girls. NL 260 was noted as very upset about how another resident had confidential information about him, but did not want to make a complaint. SNB 110341

7. On 25 April 1993 NL 275 visited him. During their discussion NL 260 indicated that he was treated differently and also reported SR 18 locked him and another resident, called NL 266, out until 2.00am. The record does not say which Sister was involved, but as NL 260 was resident in SR 18' unit it is likely this was a reference to her. NL 275 records in the same entry that she discussed the "issues" with staff, but did not record whether that included this allegation. SNB 110337

8. On 2 May 1993 NL 275 again visited NL 260 in the Home. This followed staff from Nazareth Lodge reporting concerns to her about his behaviour. On attending NL 275 recorded that she found NL 260 alone in the unit, and that the toilet door was left open but other doors were locked. NL 260 told her that SR 18 did not take him out due to his behaviour. NL 275 noted that there were staff in adjoining units who could be contacted. SNB 110335

9. There is no record on the file available regarding NL 260 that confirms any of the above information was formally passed in writing to any other person by NL 275.

NL 164:

10. NL 164 was in the care of Craigavon & Banbridge Community Health & Social Services Trust ("C&BCHSST"), which fell within the Southern Board.

11. The first allegation brought by this young person was on 12 May 1994, when he told his Social Worker that he had received bruises having been poked by SR 18. This information was relayed directly by NL 164 to NHB 137 during a discussion at Nazareth Lodge. SNB 49419

12. Records indicate that on the same date, 12 May 1994, NHB 137 advised his Senior Social Worker, that NL 164 wished to make a complaint against SR 18. It is documented that they agreed that a report would be requested from SR 18 and that the complaint would be investigated in line with agreed procedures. SNB 49589

13. On 13 May 1994 up-dated her Assistant Principal Social Worker, Mr Vincent O'Rourke. The record suggests that she advised him of the complaint and the intention to investigate it. SNB 49589