NAZARETH LODGE CHILDREN'S HOME, BELFAST

1. In May 1992 I joined the Social Services Inspectorate as a Social Services Inspector. I undertook the first inspection of a children's home in November 1992 at Nazareth House in Londonderry, under Section 168 of the Children and Young Persons Act (NI) 1968.

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

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

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

(i) Issues emerging from the Inspection

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

- the plan to establish 4 units with a specialist remit without addressing the issue of short-term placements or the care needs of pre-adolescent children; (Para 2.5)

- the plan that each of the specialist units would retain an intake function and the potential for this to "place some children at considerable risk"; (Para 2.5)

- doubts regarding the advisability during 1992 of having admitted children aged 8, 7 and 6 years on a short term basis to Units 1 and 2 given "the behavioural difficulties of the resident adolescents and the pattern of long-term provision; (Para 2.5)

- the adequacy of the staffing complement, examples include:

- during March and April 1992 given the number of children then resident and their age profile a temporary increase in staffing may have been required (Para 2.7);
- the adequacy of the staffing level in one unit during December 1992 and its potential to adversely influence children's behaviour and/or staff's ability to cope (Para 11.6);
- on a number of occasions "one staff member was on duty each shift" with the Team Leader [Sister] supplementing this cover (Para 11.8);
- during the summer months when children were on holiday one unit had 4 staff to cover the roster. For staff and children this level of cover is less than satisfactory" (Para 11.9)

- the potential for the central lighting consul in Unit 2 to be used to frighten or bully some children; (Para 3.4)

- variability in recording of the individual log in respect of each child; (Para 4.3)

- the use made of residential staff which varied across Units. In some "units fieldwork staff may be contacted without permission" of Team Leaders. Some staff felt curtailed in the discharge of their keyworker responsibilities. (Paras 4.6 – 4.8) Some staff felt "their contributions and opinions were of secondary importance." (Para 11.11(ii))

- complaints identified which were not recorded in the Home's Complaints Register; (Para 8.3)

- the need to promote children's access to pay telephone and their privacy when using the phone; (Para 8.8)

- the need for admission criteria to specific Units "informed by the nature of the resident group plus the needs of the child requiring admission"; (Para 9.2)

- the unacceptability of the sleeping arrangements during Unit 2's holiday in Donegal which placed a primary school aged suspected victim of sexual abuse in the bedroom of a known perpetrator of abuse; (Para 9.3)

- the unacceptable nature of the sleep-in arrangements which "does not provide adequate supervision and protection for 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"; (Para 9.4 and 9.6)

- during the past year 2 incidents of sexually exploitative behaviour occurred during the night. Additionally, a fieldwork social worker "records that an adolescent perpetrator had been found wandering along the corridor at night by the Residential Social Worker who was undertaking sleep-in duties during the Team Leader's [Sister's] leave." "The level of cover at times leaves no margin for error or emergency; (Para 9.5)

- the potential for the Team Leaders' practitioner responsibilities to adversely affect their ability to fulfil their managerial duties and the absence of any slack in the staffing leave to deal with resignations or sick leave. (Pars 11.7 – 11.9) "Staffing levels adversely affect the professional development of Team Leaders. The reliance on Team Leaders to act as practitioners restricts their managerial and team building roles." (Conclusion, Page 24)

6. The issue relating to the central control of lighting in children's bedrooms in Unit 2, referred to above at Paragraph 5 (fifth bullet point), would appear to have been addressed by me with NHB 137 the social worker of Samuel Nicholl an 11 year old resident at Nazareth Lodge at the time of the 1993 Inspection. Paragraph 16 of NHB 137 Witness Statement (SNB-6095) refers to a discussion I had with him in 1993 regarding lighting in NL 164 bedroom. From the Statement it would appear that I had spoken with NL 164 in the course of the Inspection and that he had raised concerns with me about having no control over the lights in his bedroom. I have no recollection of discussions with NL 164 or NHB 137 It was, however, my practice in the course of an Inspection to talk with a number of children, field social workers and residential staff members. The purpose of such discussions was to acquire information on the quality of care provided within a children's home and to provided an opportunity for any concerns to be raised in the course of the inspection. I believe that it would have been in this context that I shared this information with NHB 137 , rather than, as suggested by his oral evidence to the HIAI on 25th March 2015, that I specifically asked to see him in relation to the matter of NL 164 complaint. As I had no management responsibility for NHB 137 if I had identified the need for immediate action I would have contacted senior managers within the relevant Unit of Management and/or the Southern Health and Social Services Board rather than make direct contact with a member of their staff. I also note that in his oral evidence, NHB 137 referred to a regulatory requirement for social workers to check children's bedrooms. There was no such requirement in Regulations, or Departmental guidance nor, to the best of my knowledge did HSS Boards' policy expect such checks to be made in relation to children in residential care.

7. Recommendation 1 of the 1993 Inspection Report addressed bedroom lighting in Unit 2. The Management Committee in its response to the recommendations

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.

13. At the conclusion of the telephone conversation I prepared a note of NL 269 concern for Mr N J Chambers, the Inspection Manager and my line manager. Mr Chamber's response of 2nd February 1993 stated:

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

14. My practice prior to this date (January 1993) and subsequently would have been to make no distinction between either a written or verbal complaint or an anonymous or known source of a concern regarding children's well being and protection. It is apparent from Paragraph 3 of my notes of my telephone conversation with NL 269 dated 26th January 1993 that I planned to follow up his comments with the Administering Authority.

15. I am, however, unable to recall what further discussions or action occurred following receipt of the note from Mr Chambers, dated 2nd February 1993, in respect of the handling of NL 269 concerns.

16. A letter on the Inspection file dated 29th March 1993 shows that I was seeking to acquire written confirmation from NL 269 in respect of the matters raised by him on 26th January 1993.

17. On 8th June 1993 Mr Chambers (Inspection Manager) and I met with the Management Committee. The concerns raised by NL 269 were at that time recent and had been raised in the context of the Inspection. I would have expected that an agenda for the meeting would have been discussed by Mr Chambers and me prior to meeting with the Management Committee, an expectation which is apparent from my memorandum to Mr Chambers dated 5th May 1993. I have no recollection whether NL 269 concerns were shared with the Management Committee during this meeting. I note that they were not reflected in my handwritten notes prepared after the meeting.

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

Marion Reynolds

Marion Reynolds
03.04.15

SOCIAL SERVICES INSPECTORATE

Summary Report

Inspection of Nazareth Lodge Children's Home

January 1993

Summary Report

Inspection of Nazareth Lodge Children's Home, by the Social Services Inspectorate, January 1993

Basis of inspection

The Social Services Inspectorate is empowered to carry out the inspection of children's homes under *Section 168 of the Children and Young Persons Act (NI) 1968.* Since 1985 voluntary children's homes have been inspected annually.

Nazareth House Children's Home

In January 1993 an Inspector spent approximately one week at Nazareth Lodge. During that time the Inspector interviewed staff, examined records and reviewed the procedures of the home. The children's views were sought in conversation and by questionnaire. The views of parents and past residents were also elicited by use of questionnaires.

Inspection findings

Policy

- Nazareth Lodge is registered to care for thirty children. It accepts children in the five to eighteen age range. The home has a statement of aims and objectives which is based on respect for the individual and developing behaviours and skills which will assist with a return to family living or independence within the community.
- In general children are admitted from the Eastern Health and Social Services Board's area. Reviews of children in care are held under the procedural requirements of the board and generally occur on a six monthly basis. The views of children and parents are sought in writing prior to reviews which they are invited to attend.

Premises

- Nazareth Lodge is sited off a main road and provides ready access to shops, schools and leisure facilities.
- The home consists of four units, which are comfortably furnished. They are well-maintained and there is no evidence of damage to the building or its fabric.
- Lighting along some bedroom corridors is quite poor, due to the design of the building. In one unit the bedroom light switches are located on a central consul and not within each room.
- Children have single bedrooms which they personalise by use of posters, family pictures and personal belongings.

Staffing

- At the time of the inspection twenty-one staff were in post. In the Inspector's opinion staffing levels were low and provided no slack to cope with either sick leave or staff turnover.
- Of the 15½ residential social workers in post, six are at various stages of professional training. Two residential social workers are already professionally qualified as are two-thirds of the team leaders.
- The home has actively promoted training for staff and is anxious to retain professionally qualified workers, this has, however, been difficult. Recently a Training and Development Officer has been appointed, on a part-time basis, to develop in-service training. Staff particularly welcome this development.
- From discussion with staff the Inspector noted their wish to be more involved in discussions and decisions regarding life within the home.

- The current work patterns of team leaders and the reliance on them to supplement the duty roster impaired, in the Inspector's view, their ability to discharge their managerial duties.

Children

- Twenty-four children, eighteen boys and six girls, were living in the home at the time of the inspection. Three young people were resident in the Independence Training Unit while the reminder were cared for in one of the three units. 68% of the children had been resident for more than one year.
- Twenty of the children were from the EHSSB's area. There were two children resident from both the Southern and Western Health and Social Services Boards' areas.

Care, food, health, education and safety

- The care environment is structured, continuity of care is provided by the team leaders who live within the home.
- The home has adopted the EHSSB's booklet *"A Guide for Children in Residential Care and their Parents"* to provide care information and details on the complaints procedure to children and their parents. This booklet is to be amended to personalise it for use in Nazareth Lodge. The Inspector noted some under recording of complaints.
- Children expressed satisfaction with their clothing and pocket monies. The Inspector noted, however, that a practice has developed of children using clothing money to purchase other items.
- Children expressed general satisfaction with the daily routines of the home. Some, however, expressed a wish to have later bed-times or more choice regarding menus. The Inspector noted a reliance on the main meal of the day being provided by school and lack of variety of food at tea-time.
- Arrangements for medical and dental care of children were satisfactory.
- Education is valued and promoted. Children are encouraged to do homework and are assisted by staff when completing this task. Close liaison exists between the school and residential staff.
- The NI Fire Authority, in letters dated 13 and 18 March 1992, expresses satisfaction with the current fire safety arrangements.

Files and records

- A file for each child is held in the home and stored in locked filing cabinets. Files contain all board forms, legal documents, medical and school reports. A monthly summary report on each child is also provided by the child's keyworker.
- The Inspector noted on some files that minutes of review meetings were missing or dated some two months following the review.
- The content of daily records varies across the units. On occasions there were periods when daily records were not completed.

Monitoring

- The home was monitored in accordance with *The Children and Young Persons (Voluntary Homes) Regulations (NI) 1975*. Voluntary visitors visit the home on a monthly basis and generally sign all statutory records. A report is provided of each visit.
- In general children are seen at least monthly by a field social worker.

Recommendations

The following recommendations have been made to Nazareth Lodge for consideration :

- More lighting should be available in bedroom corridors. Consideration should also be given to relocating light switches in Unit 2 from a central consul to each bedroom.
- Recording should be given higher priority.
- The keyworker role should be reviewed to ensure consistency of work practice across units.
- The medical record card should record all relevant family and personal medical history and all contact with the doctor.
- Each unit should maintain a drug administration book. Medicines should be stored in locked medicine cabinets.
- Children's house meetings should be promoted.
- Care information and details of complaints procedure should be available too children and their parents on admission.
- Clothing monies should be used as designated.
- There should be more variety in the menu. Consideration should be given to the rescheduling of the main meal.
- Children should have ready and private access to a pay telephone. The number and location of pay telephones should be reviewed.
- Admission criteria should be established for each unit to ensure the appropriate placement of children.
- The current sleep-in arrangements should be reviewed.
- The team leader's work practices should be reviewed.
- Consideration should be given to establishing a pool of temporary workers.
- Staff should be regularly supported through supervision and team meetings.
- The time and day of fire drills should be varied. There should be adherence to fire door regulations.
- The religious and cultural practices of non-catholic chiildren should be reviewed.

Designed by : Forms Design Centre, Craigantlet Buildings, Stoney Road, Stormont, Belfast.

DHSS Department of Health and Social Services

13. RECOMMENDATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Consideration should be given to establishing a pool of relief workers to provide a back-up system of temporary workers. (Section 11.10.)

15. Staff should be regularly support through formal system of supervision and team meetings. (Section 11.11(ii) & (iii)).

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

17. The religious and cultural practices of non-Catholic children should be respected and promoted by the care practices within the home. (Section 12.2(g)).

APPENDIX 4

NAZARETH LODGE CHILDREN'S HOME

Untoward Events - March 1991 - March 1992

10 year old boy

Put fist through window during temper tantrum. Taken to hospital and had not sustained any injury to his hand.

16 year old boy

Physically threatened a member of staff.

Verbally and physically agressive to a male staff. Was restrained to prevent further injury.

16 year old boy

Absconded from the Home. His brother and girlfriend from another Children's Home also disappeared. The girlfriend returned and told that the boys were in Dublin with their mother.

10 year old boy

Hit another child and had to be restrained. Hit a member of staff with a stone. Abusive and again was restrained.

16 year old boy

Physical threat to staff. Loss of temper and threatened to hit staff (male).

16 year old boy

Assaulted female member of staff. Asked to leave room due to use of foul language. Pushed female staff a number of times.

10 year old boy

Severe loss of temper on a number of occasions. Continually hit other children. Verbally and physically abusive towards staff members several times. Had to be restrained.

Sexual behaviour:- Asked another child for a kiss and later pulled down his trousers and showed himself to the younger boy.

Marked member of staff's car.

Ran away from the group and was returned in the evening by grandparent.

14 year old boy

Hit a member of staff.

Verbally and physically agressive and abusive to a male staff - had to be restrained to prevent further injury.

Continually hit and nipped a six year old boy.

Physically attacked two boys; threw and damaged furniture. Out of control for a period.

Engaged in fighting with another boy, and threatened to harm an eight year old boy. Pushed aggressively a member of staff and had to be restrained.

Hit a younger boy in the eye - bruising it.

13 year old boy

Absconded from the Home overnight.

13 year old boy

Hit and bruised another boy's eye.

13 year old girl

Six episodes of absconding. This young girl was vulnerable in that she consistently ran away to be with boys.

6 year old boy

Severe temper tantrums frequently - which were potentially dangerous.

Suspended from school for attempting to jump out of window on the second floor.

10 year old boy

Exposed himself to a 13 year old boy in the latter's bedroom.

13 year old boy

In a temper tantrum kicked the bathroom door and broke the lock.

13 year old girl

During a fight poked her finger into the eye of a 13 year old boy. No medical attention required.

15 year old boy

Continually returning late to the group and on one occasion returned with alcohol taken.

Lifted by police for shoplifting.

15 year old girls

Two girls stayed out overnight with two boyfriends in young man's flat.

15 year old girl

Ran away from group and was in car with two boys and another girl when it crashed. Police involved and boys charged with reckless driving.

On another occasion ran off with young man in car.

11 year old boy

Kicked male member of staff.

16 year old boy

Young person exposed himself, masturbating in front of female staff member.

13 year old girl

Continually running away from group. On one occasion took an 11 year old boy with her.

Verbally and physiclaly abusive and pushed two hands through pane of glass in temper.

Physically aggressive to female staff. Threw tape recorded at staff and marked female staff's hands by digging her nails into her until she bled.

Continually teasing the other children. Pulled a young boy by the hair and he then hit her.

On two occasions she was held in the police station after running away. Verbally abusive towards police and using foul language.

15 year old boy

Required four stitches to forehead as a result of a swimming pool accident.

Repeated incidents of thefts, culminating in another young person's cheque from work being stolen.

Kicked a senior member of staff quite deliberately and aggressively.

6 year old girl

Climbed into a wardrobe, which toppled causing minor bruising on her shoulder.

11 year old boy

Received a black eye after a 13 year old boy knocked him off his bicycle and hit him.

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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 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.

[redacted]

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

qualified, and who wished to make a formal complaint, should have done so in writing.

4.17 Departmental Circular HSS(CC) 2/85 (SNB 19076) deals with procedures for dealing with complaints in children's homes. The Circular is primarily to do with arrangements aimed at enabling children in residential home to articulate complaints and for such complaints to be investigated by the respective authorities. At Paragraph 28.0, it is explicit that complaints should be reported appropriately to ensure that they are acted upon. "*Boards should be prepared to assist voluntary bodies in the investigation of the complaint*".
While the Circular does not state that complaints should be made in writing, that is implicit. This is the requirement in all statutory authorities from the Police to the Commissioner of Complaints, to trade unions.

4.18 Nevertheless, it would not have been prudent for SSI not to have taken account of information and concerns that had been passed to us verbally.

Adequacy at that time and Scope of the Inspection -1993

4.19 I am satisfied that the report of the inspection was thorough in documenting evidence across a range of standards. In doing so, Miss Reynolds had addressed most of the concerns raised by [redacted] NL 269 which had a bearing on professional practice in Nazareth Lodge.

4.20 Whilst I am unable to recall whether I personally raised NL 269 concerns with the management committee, I have no reason to think that Miss Reynolds would not have pursued with equal rigor the findings of the inspection and any matters of concern articulated by NL 269 when she met the Head of Nazareth Lodge. This view is based on my knowledge of Miss Reynolds' work as an inspector over a number of years.

[redacted]

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