HIA REF: [ ]

NAME: [John Duffy]

DATE: [16/04/2015]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of John Duffy

I, John Duffy, will say as follows: -

I am currently a Commissioning Lead within the Health & Social Care Board, with responsibility for children's residential care. I am submitting this Statement on the basis of my knowledge from having worked in statutory children's services for 33 years, initially in Local Authority Children's Services in England and since 1995 in Northern Ireland. My posts within Northern Ireland have been within Commissioning Organisations.

My initial post on arriving in Northern Ireland was as a Children Order implementation officer with a responsibility for the development and implementation of policies and procedures relating to the new legislation.

A subsequent post was as a Principal Social Worker at the Sothern Health and Social Services Board. This post included a responsibility for child protection matters and included leading on the redrafting of the Board Child Protection Procedures following the introduction of the Children (NI) Order 1995.

1.1 In preparing this statement I have read:-

- My previous witness statement to the inquiry dated 12th November 2014
- Social Services file of NL164
- Social Services file of NL168
- Reports written by NL170 to SR121 and Judith Chaddock
- Documents regarding complaints relating to SR18
- Extracts of complaints re NL164, NL168 and NL260
- Inspection Reports – September 1994 and November 1995

Witness Statements of:-

Alan Chard
[redacted]
[redacted]
[redacted]
Marion Reynolds

- Departmental Circular HSS (CC) 2/85 - Provision of information to and a complaints procedure for children in residential care and their parents.

1.2 In responding to the Rule 9 Witness Request dated 24th March 2015 (the "Witness Request"), the factual information requested in points 1 to 4 of the Witness Request is contained in Appendix 1 which I incorporate as part of this statement Points 5, 6 and 7 of the Witness Request (analysis) are dealt within the body of this statement.

1.3 I have paid particular attention to the records of those events which took place between 1994 and 1996 relating to a young person [redacted], and a young person [redacted], including following statements made by [redacted] and staff member [redacted] to a Social Services Inspector in 1995, as requested by the Inquiry. In addition I have considered the records relating to three events concerning a young person [redacted] in 1993 and to assist in answering point 7 of the Witness Request I have also reviewed the records of the events which took place in 1985 and 1986 following allegations made by a young person [redacted].

1.4 My previous statement to the inquiry dated 12th November 2014 considered the statutory responsibilities in place for the provision of residential care for children living away from home in the period Rubane Children's Home was operating (approx. 1950 to 1985). As the primary legislation relating to children 'in care' did not subsequently change significantly until the introduction of the Children's (NI) Order 1995 in 1996 the legislative responsibilities of the Department of Health and Social Services (DHSS), Health & Social Services Boards/Trusts (HSSB/HSST) and the Voluntary Organisations (Administrative Authorities) would have been the same for the time periods under consideration in this current statement (1985/6 and 1993/4/5).

1.5 Paragraphs 23-26 of my previous statement outline a system with three main responsible bodies for the care of children, Welfare Authorities (later HSSBs), Training School Managers and Voluntary Organisations ('Administrative Authorities'). In considering the statutory arrangements set out in the 1950 and 1968 Acts, and the associated regulations, it seems that the three responsible bodies are largely independent from one another with their own statutory provisions (paragraph 25). The Ministry of Home Affairs, later DHSS, had the legislative responsibility for registration/certification, regulation and inspection for the three responsible bodies and for a general oversight of residential care (paragraphs 30 & 31).

1.6 Circular 10/1983 (the "1983 Circular")regarding[HIA 3990-HIA 3903] the Monitoring of Residential Childcare Services largely refers to homes operated by Health and Social Services Boards, known as 'statutory' children's homes. However paragraph 17 of the 1983 Circular does state that Boards must satisfy themselves about the standards of care being provided for each child placed (by them) in a voluntary home. It also goes on to confirm Boards are not involved in monitoring the overall standards, either professional or material, of voluntary homes.

1.7 Paragraph 18 outlines that DHSS, as the registering authority for voluntary children's homes, will undertake further discussions with Management Committees as necessary, with a view to arriving at an acceptable and consistent scrutiny of residential child care services provided by voluntary organisations.

1.8 A further circular HSS(CC)2/85, (the "1985 Circular"), see Exhibit 1 regarding the Provision of information to and a complaints procedure for children in residential care and their parents, describes a complaints system to be introduced by HSSBs, and by voluntary organisations which operate residential homes for children and young people in care.

1.9 Paragraphs 40, 41 & 42 of the 1985 Circular outline the general thrust in that Boards and Voluntary Organisations will have their own adequate arrangement to investigate complaints within the residential care system. Appendix 1(a) therein outlines the grounds for making a complaint.

1.10 The key aspects of the arrangement, as outlined in the 1985 Circular, in relation to children placed in voluntary homes seem to be:

- Voluntary organisations and the homes Management Committee are responsible for the investigation of complaints relating to children living in the home.
- HSSB social workers must visit the home regularly and have the right of access to the homes complaints book. Social Workers should be informed of any complaint made by a child within 24 hours of the complaint being made.
- Directors of Social Services at the Boards should respond to a 'contact card' by taking immediate action to ascertain the nature of the complaint. The Director should inform the Chairman of the Management Committee of the home and should agree the follow up action required.
- Boards should be prepared to assist voluntary bodies in the investigation of the complaint.
- Complaints which appear to allege criminal activity should be immediately referred to the Chairman of the Management Committee who should inform the appropriate Director of Social Services. A decision whether to involve the police may be taken by either the Chairman of the Management Committee or the Director of Social Services.

1.11 The role of the Department in relation to complaints involving voluntary homes

as outlined in the 1985 Circular is to:-

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

1.12 In paragraph 2.20 of his statement, dated 25th March 2015, DL518 indicates that there were issues in relation to the implementation of this circular which were not fully resolved until 1991/92. However, it seems appropriate to use the 1985 Circular as the descriptor of the arrangements that should have been in place during the time periods under consideration.

2.0 Events which took place in 1985/86

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

2.2 Also in March 1985, a Senior Social Worker reported that a former resident of the Home, HIA210, had made statements about the care he received whilst he was living in the Home. These included allegations that:

- he was regularly beaten by SR62
- he was placed in a cold bath as punishment for informing his social worker about the beatings
- he was locked in a bathroom overnight without lights; and he was locked in a cupboard

2.3 The North & West Belfast Unit of Management conducted a partial investigation into these allegations to establish the detail as outlined in the statements of Mr NL223 and Mr DL518, and the file records.

2.4 In the relevant file records there was also a series of correspondence between the Director of Social Services at the Eastern Health & Social Services Board and the Chief Social Work Advisor at DHSS regarding the conduct of an investigation into the allegations. An internal DHSS report by Mr K McCoy to Mr P Armstrong dated June 1986 **[SNB 6957-SNB 6961]** summarises the events from the Department's perspective, whilst in his statement of 25 March 2015 Mr DL518 outlines the view seemingly held by the Eastern Health and Social Services Board.

2.5 A letter dated 3rd July 1986 to Mr Armstrong from Mother Paul of the Order **[SNB 6952]** provides details of the investigation undertaken by the Home into the allegations.

3.0 Events which took place during 1993

3.1 In March 1993, young person NL260 reported to his social worker NL275 NL275 from North and West Belfast HSS Trust that another resident had approached him about NL260 sexually abusing girls. NL260 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, NL275 was informed by NL260 NL260 and another young person that Sister (assumed to be SR18) had locked them out of the until 2am.

3.3 On 2 May 1993, on attending the Home, following the reported concerns about NL260 's behaviour, NL275 found NL260 alone in the unit. The toilet door was open but other doors were locked. NL260 told her that SR18 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 SR18 was made by a young person, NL164 , to his social worker NHB137 of 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 NL164 regarding inappropriate sexual behaviour by another young person.

4.3 It seems from the records that in September 1994, NHB137 received two telephone calls from two different Nazareth Lodge staff members outlining two separate incidents involving NL164 . One, occurring in Donegal during a holiday, where NL164 had been assaulted by two other young people and that SR18 was aware of the assault. A second incident related to NL164 having been locked in the kitchen by SR18 .

4.4 NHB137 visited NL164 , on 14 September 1994, who did not wish to make a complaint. One of the staff members, who had made a telephone call, NL170 , declined to speak to NHB137 regarding the alleged incident. In the report of her earlier telephone call to NHB137 it is recorded that NL170 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, NL171 , to SR121 . This report outlines a conversation NL171 NL171 had with NL164 and NL168 in which they described the events which occurred in Donegal.

4.6 Various records outline NHB137 's follow up actions and correspondence with his managers.

4.7 In August 1995 a young person, NL168 , made a complaint about a staff member NL227 following an incident in the Nazareth Lodge Office. The

police were involved, initially in response to an allegation of assault by NL168 NL168 on NL227. There are reports of the Home follow up complaints investigation.

4.8 In November 1995 NL168 and staff member NL170 complained to SSI inspector Judith Chaddock, about the behaviour of SR18 towards young people in the Home, including NL164.

4.9 Records detail the follow up actions of the Craigavon & Banbridge Community HSST, the North and West Belfast HSST, DHSS and the Nazareth Lodge Management Committee.

5.0 Analysis

5.1 To make a judgement on the individual actions of social workers and others based solely on 20 or 30 year old written records is difficult. However, it is, I believe, possible to extract some general points in respect of the social work response. In both of the time periods the records indicate that social workers took the complaints seriously and made efforts to establish the detail and accuracy of the information. Social work managers were informed and information was shared between Boards (Trusts) and with the Department. There was engagement with the voluntary organisation and/or Management Committee to have an investigation pursued and the detail around the outcome of the investigation was sought by Board (Trust) managers from the voluntary organisation or Management Committee.

5.2 Whilst there could be a question raised by some of reports as to the threshold of what constituted a 'complaint' and the extent to which young people needed to 'formally make a complaint', I did not find any indication that social workers or managers were ignoring issues raised. The events regarding NL260 in 1993 and those in respect of NL164 would fall into this grey area of threshold and effective response.

5.3 There are areas where some detail is lacking, such as the period around October 1994 in respect of young person NL164. Information is present that suggests social worker NHB137 was seeking Nazareth Lodge records to try and verify the allegations made to him by telephone but the outcome of the these actions does not seem to have been recorded. Nor is there information as to the Trust's eventual response to the receipt in September 1994 of the statement made by NL171.

5.4 In considering the events a number of issues are I think worthy of comment in relation to the Witness Request in that they seem to be issues which to a greater or lesser degree were present across both the time periods.

6.0 There is a separation of a 'Complaint' investigation within a residential care setting from a 'Child Protection' or non-accidental injury investigation in the community

6.1 Exhibit 11 attached to the DL518 witness statement, dated 25th March 2015 **[SNB 6972-SNB 7000]** contains a copy of the Eastern Health and Social Services Board procedures for dealing with cases of child abuse and neglect

that I understand were in operation in 1984/5. There is also a copy, Appendix 6 of the witness statement of John Compton December 2013, of the 1991 Child Protection Policies and Procedures in operation during the period under consideration from 1994/1996, see **Exhibit 2.**

6.2 Both these policies and procedures have clear arrangements in place for the investigation of abuse. There are clear guidelines for staff around actions to be taken and for the involvement of the police. Lines of accountability around decision making are fairly clear. For example section 8. 1.1 of the 1991 Policies and Procedures identifies those agencies with the statutory duties and/or powers to investigate and intervene in cases of abuse. These are the 'investigating agencies' i.e. Boards, the police and the NSPCC.

6.3 However, section 8.1.5 of these Policies and Procedures excludes allegations made against a member of staff of an organisation providing social care services including residential care when the complaints procedures of the organisation are to be used.

6.4 As outlined earlier, the 1985 Circular places the responsibility for the investigation of 'complaints' in voluntary children's homes such as Nazareth Lodge with the provider organisation or the homes Management Committee. That this complaints arrangement covers allegations that could be considered the abuse of children by staff is clear from the 1985 Circular Appendix 1 and from the Nazareth Lodge Complaints Procedure (Craigavon and Banbridge Community HSST records fax dated 15/12/95 **[SNB49818 – SNB49820].**

6.5 In comparison to the child protection policies and procedures the detail around timescales and the nature of any investigation is lacking, as is the involvement of the police in this process. This may be, in part due to the wide range of possible complaints the procedure is expected to cover. The 1985 Circular Appendix 1 sets out the situations where a child should 'talk to someone' or which would be 'grounds for complaint'. These range from 'feeling ignored' and 'not getting the clothes you need' to being 'slapped or shaken or beaten'.

6.6 In correspondence dated 16th September 1994 to his line manager Vincent O'Rourke, NHB137 raises an issue of being informed of 'minor' complaints of other young people against NL164 whilst stating information is being withheld over more serious matters.

6.7 It is difficult to see how a single process could respond effectively and with an appropriate level of rigour to such a wide range of situations particularly as a number of possibly conflicting considerations could come into play. These could include the need to support staff in a very difficult area of work or protect them from untoward or possibly malicious allegations, confusion between child protection and staff conduct around professional practice or disciplinary measures, the reputation of the home or the voluntary organisation, or confusion around individual professional accountability and management responsibility.

7.0 Confusion as to organisational responsibility and accountability.

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 HIA210 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 NL168 and NL170. 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 NHB137, 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 Sister Paul outlined in a letter to Mr Armstrong, DHSS,[SNB 6952] the details of the investigation into the complaints initially made by HIA210 HIA210 and its outcome. In what Sister Paul 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 NL164 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, SR18 and Judith Chaddock but have not carried out further investigations. It seems from the minutes of the meeting (item 2) that it was SR18 '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 SR18 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

substantiated by the investigation but the proposed action following the investigation appears to have been that the HSS Board social workers would encourage the complainants to make statements to the police (letter DL518 [redacted] to Mother Paul 10th February 1981). It's not clear from the documentation whether any further action was taken regarding the on-going care practices within the home.

10.3 The Minutes of the Nazareth Lodge Management Committee dated 11 March 1996, item 3, [SNB 49406] identifies an action to be taken following the conclusion of the investigation 'in the light of the complaints investigation to review procedures for complaints and untoward events'. Again there does not appear from the records to have been a formal consideration of any wider implications for practice of the events leading to the complaints.

11. Conclusion

11.1 In reviewing the documentation in relation to the investigations undertaken in the periods 1985/6 and 1994/6 into allegations made by young people who were resident in Nazareth House or by staff working in the home, and to address issues raised specifically by the Inquiry in the Witness Request I conclude as follows

11.2 In relation to the actions of those involved in the events above, the HSCB concludes:

11.2.1 Whilst there are some gaps in the information, a brief overview of the documentation suggests to me that the social workers involved took the information shared with them by young people seriously and sought to verify the information regarding a possible complaint with the young people concerned and the staff within the Home. Where there was considered to be a formal complaint the detail was shared with their management, and investigations were undertaken in line with the requirements of the time. Board/Trust officers sought detail of the outcome of those investigations.

11.3 The Respective roles between the HSCB and the Regulatory Body

11.3.1 The primary legislation and regulation in place from 1950 until 1996 placed responsibility for the provision of appropriate care in a voluntary children's home with the Administrative Authority, in effect, the Management Committee of the home or the voluntary organisation itself. DHSS (previously MoHA) had responsibility for the registration and inspection of the home whilst Boards/Trusts held responsibility for 'furthering their best interests' regarding children in their care. The 83 Circular placed on Boards the expectation that when they placed children within a voluntary children's home they must satisfy themselves about the standards of care being provided for each child. However, the same circular also stated that Boards were not involved in monitoring the overall standards, either professional or material, of voluntary homes.

11.3.2 In respect of the investigation of allegations or complaints regarding children placed in voluntary homes, the 1985 Circular HSS (cc) 2/85 set out the organisational responsibilities as outlined in the sub-paragraphs below.

11.3.2.1 It confirmed that it was the responsibility of the Administrative Authority or the Home's Management Committee to investigate complaints. The child's social worker should be informed of any complaints, and for complaints which allege criminal activity the Director of Social Services of the appropriate Board/Trust should be informed. Whilst there was not a statutory duty to do so, the
expectation would have been that the child's social worker visited the child regularly. The voluntary organisation, and Management Committee were responsible for providing care of an appropriate professional and material standard and this was inspected by DHSS.

11.3.2.2 When a complaint was made the Board/Trust had a responsibility to visit the child and ascertain the nature and substance of the complaint being. They then should notify the chair of the management committee of the nature of the complaint and agree the follow up action required. Boards/Trusts should also have been prepared to offer assistance in the investigation of the complaint.

11.3.2.3 The Management Committee or voluntary organisation was responsible for ensuring an investigation into the complaint was carried out and to decide whether to involve the police. 1The Director of Social Services could also decide whether to involve the police.

11.3.2.4 If the police were to be involved then the Department must have been notified. The Department was to review complaints relating to voluntary homes at regular intervals.

11.4 Other systems issues identified by the HSCB:

11.4.1 There appears to me, from the records I have read as listed in paragraph1.1, to be a number of issues that could have been a consequence of the systems in operation. The primary legislation and the subsequent guidance around complaints relating to children living within voluntary children's homes placed the responsibility for the investigation of allegations, including those which could be considered as relating 'child protection' on the organisations, which in my opinion, were least competent in taking forward such serious matters, the voluntary organisations themselves. Investigating child protection concerns requires a clear procedure with a defined threshold for action, training and experience. There should also be a separation in relation to other possibly conflicting issues such as personal relationships, organisational loyalties and staff care responsibilities. The complaints procedure in place during these time periods lacked detail and clarity whilst those required to undertake the investigation were unlikely to have the necessary training or experience in this specialised area of work.

11.4.2 The guidance indicated a role in this process for other key organisations, in particular the HSSBs but it seems to me that there was not sufficient detail in the guidance to enable those other organisations, including DHSS to be confident and clear about their respective responsibilities both in the actual investigations and in progressing any follow up actions.

Statement of Truth

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

Signed _____

Dated 16/4/15