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HISTORICAL INSTITUTIONAL ABUSE INQUIRY

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being heard before:

SIR ANTHONY HART (Chairman)

MR DAVID LANE

MS GERALDINE DOHERTY

held at

Banbridge Court House

Banbridge

on Thursday, 7th May 2015

commencing at 10.00 am

(Day 117)

MS CHRISTINE SMITH, QC and MR JOSEPH AIKEN appeared as Counsel to the Inquiry.

Thursday, 7th May 2015

(10.00 am)

(Proceedings delayed)

(10.50 am)

JOHN DUFFY (called)

CHAIRMAN: Good morning, ladies and gentlemen. I start, as always, by reminding everyone to ensure that their mobile phone has been either turned off or placed on "Silent"/"Vibrate". May I also remind everyone that no photography or recording is permitted either in the Inquiry chamber or indeed anywhere on the Inquiry premises.

Good morning, Ms Smith.

MS SMITH: Good morning, Chairman, Panel Members, ladies and gentlemen. Our first witness today is John Duffy. I neglected to ask John when I was speaking to him earlier whether he wished to take a religious oath or whether he wished to affirm.

A. I'll affirm.

Q. Thank you.

JOHN DUFFY (affirmed)

CHAIRMAN: Thank you very much. Please sit down, John.

Questions from COUNSEL TO THE INQUIRY

MS SMITH: Now John has provided three statements to the Inquiry so far. The first is of 1st October 2014 and

that's at SNB-7517. That related to a specific issue that had arisen in the Rubane module about the transportation of children.

Then he provided a statement dealing with general matters for module 2 on 12th November 2014. That can be found at SNB-7526 to 7541.

Then in respect of this module he has given us a statement of 16th April 2005 , which includes appendices. That's at 7369 to 7455. Now this is the statement that you provided in respect of module 2, Rubane, and this one in respect of this module. Is that correct, John?

A. That's correct.

Q. May I take it that you signed each of those statements?

A. I did, yes.

Q. And you accept them as your evidence to the Inquiry --

A. I do.

Q. -- together with anything else we discussed this morning?

A. Yes.

Q. Well, in paragraph -- sorry. The preliminary to this statement, at 7369 you set out your background and you have been involved in statutory children's services for over 33 years. You came to Northern Ireland in 1995 and were responsible in the Southern Health & Social

Services Board for the implementation of policies and procedures relating to the Children Order 1995. Is that correct?

A. That's correct, yes.

Q. You are now the commissioning lead within the Health & Social Care Board with responsibility for, among other things, children's residential care and you have come to the Inquiry in that capacity, and on behalf of the Health & Social Care Board you have provided the statements that you have, and this statement that is on the screen represents the Board's positions -- sorry -- position on matters you address.

A. That's correct.

Q. Now the statement was based on consideration of papers given to you in relation to complaints about which the Inquiry has heard and seen a lot of documentation. I am going summarise them. There are four issues. There was the -- what's become known as the NL157 complaint of 1984; the HIA210/NL145 /NL97 complaint of '85/'86; the NL260 complaint in 1993; and the NL164/NL168 complaint in '94 to '96.

Now the details of those come complaints, you discuss the details of them in Appendix 1 to your statement by reference to the documents and you refer to matters that you considered to be relevant in

paragraphs 2 to 4 of this statement.

A. That's correct, yes.

Q. In 1.5 of your statement, if we could just scroll down to that, please -- it is on the next page, 7370 -- you refer back to the statement that you provided for module 2 and you refer to paragraphs 23 to 26 of that. Essentially you are referring to the respective roles of those charged with the responsibility for the care of children in Northern Ireland from 1950 to 1995. In your previous statement after paragraph 23 you set out the details of that, but in this paragraph 1.5 you are essentially saying that the three main responsible bodies were the Welfare Authorities, who later became the Health and Social Services Boards, the Training School managers and voluntary organisations.

You say that:

"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. The Ministry of Home Affairs, which later became the Department of Health & Social Services, had the legislative responsibility for registration, certification, regulation and inspection for the three responsible bodies and for a general

oversight of residential care."

So --

A. I think I would now make a slight amendment to that, because I do think at some point the Ministry of Home Affairs I believe split into probably DHS and the Northern Ireland Office, and I think the training schools went to the Northern Ireland Office, but I'm not sure, but I think that would require clarification later on.

Q. Yes, but certainly the field that you are looking at, which was children's residential care --

A. Yes.

Q. -- this would have been the oversight body?

A. It was my way of trying to explain, trying to interpret what I read, yes.

Q. Okay. I should say, John, that your work prior to 1995 was in England. It wasn't in -- you weren't involved in any way in any of the homes that we had in Northern Ireland --

A. No.

Q. -- up until then. You refer in the next paragraphs to two departmental circulars, the 1983 circular, which was circular 10 of '83, which was entitled "Monitoring of Residential Childcare Services", and it largely refers to homes operated by the Health & Social Services

Boards, which became known as statutory children's homes, but it did say in paragraph 17 of the circular that the Boards had to satisfy themselves about the standards of care being provided for each child placed by them in a voluntary home. It then goes on to confirm that Boards are not involved in monitoring the overall standards, either professional or material, for voluntary homes.

You then -- sorry. I am not going to read through every aspect of your statement, John. You can be assured that the Panel and the Inquiry have looked at it and considered it in detail, but in paragraph I think it is 1. -- you go on to talk about the 1985 circular there at 1.8. You have exhibited those circulars and we have seen them. That was regarding the provision of information to and a complaints procedure for children in residential care and their parents. It describes a complaint system to be introduced by the Health & Social Services Board and by voluntary organisations which operate residential homes for children and young people in care.

You then rehearse various aspects of the 1985 circular in the following parts of paragraph 1.

At paragraph 5, if we could go to that, please, which is at 737...

CHAIRMAN: ...4.

MS SMITH: ...4. Thank you, Chairman. In paragraph 5 you, having referred to the details of -- a summary of the details of the papers that you looked at, you then proceed to make an analysis of what you have read with reference not just to the social care documents of the children but the statements that you have seen provided to the Inquiry.

You say that essentially the social workers took any complaints that they received seriously and they informed their line management and information was shared across Boards and Trusts. That was your reading in all of those complaints of what took place. Is that fair?

A. By and large, yes.

Q. Paragraph 6 you make the point that:

"An investigation of how complaints of child abuse within the community are dealt with is very different from how an allegation -- where an allegation is made against a member of staff of a residential home is dealt with."

You talk about the inconsistencies of -- within the 1985 circular in paragraph 6.4 to 6.7. You make the point that this circular had to cover a wide range of complaints. You say that it is difficult to see how one

process could manage this range, especially as there were a number of conflicting considerations that could come into play.

If I just read there at paragraph 6.7, you say:

"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."

We were just -- when we were talking earlier, you were giving examples of the range of complaints that this circular was supposed to deal with even from the papers that you looked at.

A. Well, I think basically when you look at the papers, some of the complaints -- I think it was in NHB137's records in relation to NL164 -- is that he comments on the fact that the complaints procedures included

complaints from children in relation to other children, in relation to young people who are -- were dissatisfied with their clothing allowance or other issues in relation to home, but then also included quite significant issues in relation to staff treatment of individual children and young people, which could be considered abusive.

Q. The point is that each of those types of complaints would need to be dealt with in a different way.

A. They would, and although I haven't commented on it in here, I did see after I completed the statement a complaints procedure for one of the Boards which was a -- seemed to be a very complex document, which tried separate out the different levels of complaint and, to be honest, it was a very complicated way of doing it. I think it highlights the fact that it was -- the complaints procedure was trying to cover a very wide range of different issues of different complexity.

Q. You were talking to me about the difference between what was happening in Northern Ireland and what was happening in England. You were saying that in England amendments to the way complaints were dealt with happened much more quickly than it did in Northern Ireland.

A. Well, one of the -- one of my tasks when I first came over to Northern Ireland was around the implementation

of the Children Order and as part of that I drafted the Children Order Representation & Complaints Procedure, for which I used an experience base from England, and that was very clearly separated out: child protection, staff disciplinary and general complaints within children's homes. So my experience in England was that that separation had occurred some years previously.

Q. Although you say that there would be still difficulties with regard to issues that were open for debate, such as greater professional openness, even today.

A. I think it's a complex area, you know, in terms of young people who have -- you generally go into children's homes because you have a difficult background. You may have suffered trauma. You have a range of emotional and behavioural issues. It is sometimes very difficult working out the nature of a young person's complaint and the severity and the method in which you deal with it, you know, but there have been a significant range of improvements over the years that put a range of different measures in place that can assist in achieving a better outcome.

Q. You would say that the lines of responsibility are now more clearly defined?

A. Well, since the Children Order came in and what in terms of the way we use residential care has changed

significantly since the time I've been in Northern Ireland -- in fact, probably more significantly in the last ten years -- is our homes are now much smaller. We don't -- the current policy is that children and young people should not be placed in residential care for any great length of time unless in exceptional circumstances, so, for example, it's for a specific purpose. We operate a family-based looked after children placement service largely. The idea is if you are in residential care, you are there because we can't meet your needs within a family-based setting. So the ultimate aim is to return you to a family-based setting at some point. Now that might take a number of years, but it would be the exception rather than the rule that children and young people stay in residential care for any length of time.

Q. I think just to complete that we were talking about the fact there is a maximum of eight currently in any children's home in Northern Ireland.

A. We are currently reducing from children's homes that were either six or eight places down to four and six places, depending on the nature of the home and what its purpose is.

Q. Coming back to your statement, John, at paragraph 7 you discuss the differences of opinion that were disclosed

in the HIA210 complaint between the Eastern Health & Social Services Board and the Department as to the nature of the complaint under consideration. We have looked at that in depth in the Inquiry, but at 7.3 there you say that:

"The senior professionals and officers within two key statutory organisations, that they could seemingly hold such strong, conflicting views as to accountability and responsibility around matters as important as the investigation of childcare 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."

I wonder if we might expand a little bit on that. As we were discussing earlier, when we heard from Robert Moore, his point was, "Look, this was -- yes, this was a spat between the Department and the Board, but generally we worked together extremely well and, you know, this was just one time when we disagreed", but you are suggesting that that spat was of wider significance?

A. Well, it's difficult for me to say it's of wider significance, because I haven't seen all the issues that are there, but I do think that when you look at any

system, it's when it becomes under pressure that it actually shows up issues in relation to the system. If everything is burbling along quite happily, you don't need to go back to the original legislation, to go back and say, "Well, actually who is responsible for what?"

So I think just looking at it from a systems analysis is that, you know, it is only when you put something under pressure do you see whether or not it's fit for purpose, and I would say the way the circular was written that leaves conflicting views there. It allowed those things to happen. You know, the fact that Boards were responsible for the care of individual children but weren't responsible, had no role or no apparent role in the general professional material standards of a children's home is an issue.

Then if you go to the further aspects in relation to the '85 circular, again Boards were responsible for the investigation of individual complaints in relation to individual children, but they weren't responsible for investigating the wider aspects of a children's home. That came under the administrative authority or the Management Committee overseen by the Department.

Q. I think you were you talking as well about the development of legislation in Northern Ireland as well on a wider point. You mentioned to me and I think you

do make mention of it in your statement of a paper that was written by Pinkerton & Kelly about a particular culture in Northern Ireland that pertained at the time of the introduction of legislation here as opposed to the introduction of legislation in England and what we would accept here that (inaudible) legislation.

A. When I first came over, one of the reasons why I found the Pinkerton & Kelly is that I became aware that the legislation was significantly different to what I had been used to in England for most of my social work career -- in fact, for all of my social work career.

So I looked at the legislation, what was around at the time, and then looking at -- in doing my first statement, realising that in terms of the care of children who were placed out of home the legislation didn't significantly change for 45 years from 1952 to 1996 I think is an issue in terms of how professional practice and the challenge function comes into social -- children's social care.

Q. You make the point that in that period of time in England things had moved on considerably in terms of --

A. Well, there have been a number changes in legislation. You can argue whether or not they had an impact in the protection of children in certain circumstances in children's homes. We have had our own -- in England

they had their own inquiries in relation to children being abused in children's homes, but I think the general thrust of the openness of arrangements and responsibilities was clarified over that period of time and --

Q. The same was not true of Northern Ireland?

A. Well, I think -- again this may be a personal view rather than a Board view, so I need to be clear about that -- is that if you don't have experience of change of legislation, you develop things on a professional basis and you get your ideas from perhaps legislation that's in a different jurisdiction, but you don't actually understand the context. So you're looking at professional practice without having the legislative base to implement the legislative practice in the manner in which it was there, plus you haven't got challenge function of the course. So I think you end up with various things coming into the system which are custom and practice rather than necessarily based upon the legislation.

An example would be the belief that there was a statutory duty for social workers to visit children in children's homes is widespread or was widespread but, in fact, it didn't exist until 1996 as far as I could see from the legislation, but it became custom and practice

and then it became referred to as a statutory visit, even though it wasn't. So I do think there are -- there are possible things that could be explored in that area partly from my own experience, partly from reading the things preparing the reports.

Q. One of the things that you -- one of the points you made to me about the Pinkerton & Kelly article was that there was legislation coming in 1969 in England. In order to pre-empt that, as it were, the government in Northern Ireland passed its own 1968 Children and Young Person's Act.

A. That is basically largely the thrust of some of their arguments within their paper is that the nature of the government within Northern Ireland at the time -- and they refer to it as the Protestant government -- did not want the welfare approach that was being developed in England to happen in Northern Ireland. So, therefore, they pre-empted the 1969 Children Act in England, replacing it with the 1968 Act or Order here -- I can't remember whether it is an Act or on Order -- Order here, which was actually based upon the 1963 Act in England.

Q. So --

A. So I think, yes, their supposition is that they didn't -- the kind of much more welfare approach and the State's involvement in the overall welfare of children

and young people was not something that was an issue for the government at the time.

Q. Coming back to your statement at paragraph 8, you talk about the length of time that it took to carry out investigations, and you make the distinction between the time it took to investigate the NL168/NL164 complaint and HIA210, and whenever there was a specific child protection issue in respect of an allegation of sexual abuse, that that was investigated by the police and that took a very short period of time between a social worker and the police to investigate that to a conclusion.

A. I think it is partly -- it is not necessarily just the length of time. It is the length of time by which an investigation was started. In one in relation to child protection procedures there were clear procedures to follow, which took place quite quickly. I think in relation to the investigation of complaints, because of the nature of the system, it was more difficult to actually decide who was going to do what when and within what time frame.

Q. The fact that -- we have been looking, for example, at the HIA210 and how long that took to resolve. That was because people simply didn't know who was responsible for doing what.

A. I think there was a lack of clarity around

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.

For example, the investigation of the subcommittee, their role -- their investigation was limited and effectively brought to an end by SR18's acceptance, but it is not obvious how that subcommittee reached its conclusions, for example.

A. There's nothing in there. Basically there's just a record of the outcome both either in the minutes that were sent through to the Boards or in the papers I saw later, which related to the actual allegation and investigation. It just basically says whether it was substantiated or partly substantiated with no rationale explaining how they reached that conclusion.

Q. You also make the point that the role of the independent person in the subcommittee was not defined and he seems to have effectively been sidelined after the subcommittee reported over to the Management Committee.

A. Well, I think again in looking at it from again a slightly systems analysis is there didn't appear to be anywhere in the paperwork a discussion as to what the role of the independent person would be and what was expected of them. It seems from reading Alan Chard's statement that he went along and was part of the investigation, but it is not clear as to how assertive his role would have been, and then it would appear he wasn't involved in any subsequent discussions.

Again they took the term "independence" to mean not -- from a Trust that was not involved in placing children there, whereas I think you may have looked at "independent" as being independent from the Management Committee and the administrative authority, and it may well have -- again possibly have been better to actually have the independent person being from a placing authority so that you had someone who had that responsibility for the placement and care of children as per the regulations.

Q. When we look -- we know that the subcommittee actually included two members -- one member of the Management Committee and the Mother Regional as well as Mr Chard.

A. Yes.

Q. Yes. So, I mean, how independent that subcommittee was in itself is perhaps an issue.

A. Well, I think I raise that later in the statement, that I think there are -- the way the thing was set up is if you have an organisation that's largely responsible for investigating itself, you can -- there are lots of other responsibilities that may impact --

Q. Yes.

A. -- upon the independence or the way things are approached.

Q. In paragraph 10 you talk about whatever the outcome of

the investigations, whether it was in the case of NL164 that certain things had been substantiated, whether it was in the case of HIA210 -- and I am using that in summary for that whole three-person complaint -- that they weren't borne out, and in the case of NL157 , for example, SR2 was told not to put soap in a child's mouth again, but the wider implications for the home in terms of childcare practices does not appear to have been identified or addressed. Each investigation seemed to address the individual complaints and deal with them as individual complaints and not as part of a wider systems issue. Is that fair?

A. Well, from the items that I read I didn't see any particular outcome subsequently in relation to the wider running of the home. That doesn't mean there wasn't any, but I didn't read any subsequent outcome recorded.

Q. Just coming on then -- I will come to the conclusions that you draw in a moment, but just going back to some of the things that you have said -- I mean, for example, the Boards were supposed to be satisfied as to the -- well, in fact, this is one of the conclusions. If we just go to that, please, paragraph 11. You draw various conclusions and you say -- in paragraph 11.2.1 there you say:

"Whilst there are some gaps in the information,

a brief overview suggests to me that 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 with 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 and Trust officers sought detail of the outcome of those investigations."

Then you go on to talk about the respective roles between the Health & Social Care Board and Regulatory Board, but at paragraph 11.4.1 you say from the records -- in paragraph -- I should say in paragraph 11.3 you are summarising who was expected to do what within -- in terms of the Department, in terms of the Health & Social Care Board.

One of those things is that the 1983 circular precluded Boards from monitoring homes, yet placed on them an expectation that they satisfy themselves about the standard of care being provided in the home. The question is: well, how were they supposed to do that? What was the mechanism for them satisfying themselves as to the standard of care provided by the home? There doesn't seem to have been a particular mechanism. They

were supposed to do it, but they weren't allowed to monitor the home themselves.

A. I think that is an issue in relation to the legislation, because clearly Boards would have a responsibility for the child placed, but if they have issues in relation to the home, what avenues does they take other than removing the child? They don't have or they didn't appear to have in relation to legislation responsibility for the oversight or the management or the intervention in relation to development of a home.

Q. We know from the legislation that responsibility fell on the Department.

A. Well, I think it was the responsibility was on the administrative authority to manage its own affairs and make sure that its homes were safe and was providing effective care for children and young people, and then the Department would have had the registration responsibility in relation to that and then the inspectoral role.

Q. Yes, but, I mean, the point I was about to make to you was the Department had that inspectorial role. The only way that a Board could find out apart from asking the individual social workers who were going into the home about what they felt the standard of care was in a home -- they would have been reliant upon any inspection

reports from the Department, but it would appear that the Department was not sharing those reports with the Board.

A. Well, from what I read I'm not aware of that second point, but I think I made the point in my first statement that for Boards to meet their legislative requirement, you know, particularly in relation to the placement of children or Catholic children, they had the requirement to place a child in an appropriate home, largely appropriate to its religion and ensure that kind of the welfare of the child was -- I'm sorry. I have to quote -- my apologies for not recalling it properly. Basically they had responsibility for ensuring the welfare of the child.

In terms of my reading of the regulation and the regulation at the time is because of -- to place a child in a registered, inspected home of the same faith could be said to have met their legislative requirements, you know. I am not sure I explained that very well, but ...

Q. I think what you are saying is they were reliant on the Department to deregister a home that wasn't suitable for the care of children, if I can put it that way. You would have assumed that would have been done.

A. Yes. I think it is fair to make the assumption if you place a child in a registered, regulated home, that that

is meeting the acceptable standard of care.

Q. So they wouldn't have been pushing to see the inspection reports necessarily then?

A. I couldn't comment on that. I don't know whether they would have done or not. I think it would be standard practice now and you would -- you know, they are open to any placing authority.

Q. Just to be clear, I mean, it is clear that Nazareth Lodge, going back in time, was an industrial school and during that period in time it was inspected regularly up until 1951. There then doesn't seem to be any inspections carried out by the Department from 1951 to 1983. At least there certainly -- the Inquiry hasn't seen documentation, and there was a 1983 Social Work Advisory Group inspection. Then in a letter from -- sorry -- a memo from Kevin McCoy in the Department he makes it clear that annual inspections were carried out regularly from 1986 onwards.

So there's -- there seemed to have been a gap certainly in the inspection regime of this particular home, and I am only referring to one of the two we are looking at in this module.

So, therefore, it's possible that the Board's reliance was ultimately misplaced, because there were no inspections being carried out within that time frame.

I am not saying that the Board would have been aware that there were no inspections, but with looking at what we can gather from when inspections effectively stopped and started, there was a gap.

A. I think if there was a gap and the inspections weren't taking place, and there were no other mechanisms in place, which from my reading there wouldn't be, then I think that would be of concern, and I'm not sure from -- again going back over the information is to how much the Board officers would have felt empowered to be able to take forward wider issues in relation to children's homes or the standard of care without taking that by the Department.

Q. Certainly the correspondence between the Department and the Board in the HIA210 complaint would suggest they felt they had gone as far as they could and really it was over to the Department at that stage to carry it further.

A. I think that's -- I think that would be the Board's position in relation to that, yes. I don't think it's -- I don't think it's meant to be critical of the Department as such, because I think it's -- the basis of the circular is the circular. You could see from both arguments they could pull out different bits of the circular and say, "We are right from our perspective",

but ultimately I think the Board's view would be that if investigations have been carried out on the individual incidents, the avenue to have that addressed with the home in general would have been through the Department and the registration process.

Q. You were describing that there would have been a light touch approach, because Social Services were reliant on these homes to provide the accommodation.

A. From the information I have read in relation to preparing both statements there did seem to be a light touch in relation to intervention within voluntary homes. Obviously the Inquiry is going to look at wider homes. I haven't been able to comment on those, but there did seem to be a light touch.

I think there may have been a number of reasons for that. One would be demand and pressure on placements, in particular placements for Catholic children, because I think there were fewer. The fact that Board homes came to be known as statutory homes and voluntary homes being known as voluntary homes, even though they were actually there under the same statute, I think is an indication that some were seen as being more aligned to -- I think it is made in some statements -- aligned to the Protestant state and the Catholic children were placed within Catholic children's homes. So there was

pressure on that. I think there would have been a wider issue in relation to society at the time and the issue between, you know, religions.

Q. We have also heard that there was certainly a difference in how the homes were financed and it's been suggested effectively that the Board was able to get childcare on the cheap in comparison to the cost of putting a child in the statutory home.

A. I think in relation to information that I have read that surrounded an embargo that took place on the Rubane one, which I read through for the previous statement, issues in relation to finance were raised when the Board -- when the Eastern Board I think it was stopped placing children at the time or put an embargo on placing children. That was I think reported at some point that that was creating financial instability for the home and it would have been an issue.

I mean, in terms of the cost of children's homes and I think in relation to some of the statements I read in preparing this report -- I think it was related to it might have been Marion Simpson's one, where they were raising issues about the length of time that the Sisters were working and they were covering for deficiencies in other staffing. That would suggest there was a financial issue in relation to whether or not there

was -- effective costs were being paid or whether the church was subsidising that.

Q. You do go on to identify a number of issues which you say could have been the consequence of the systems in operation. 11.4.1 here you say:

"There appears to me from the records I have read as listed in paragraph 1.1 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."

Certainly it is true to say that -- we have looked at this with regard to the issue of independence of an investigation as well. If the voluntary organisation -- it is self-regulation effectively.

A. **Well, I think it is -- I think -- and again this is not a criticism of anybody who would be on a Management Committee, because I think Management Committees were probably there to support the general running of the**

home and to ensure that the standard -- material standard and generally that the home was operating to what the voluntary organisation considered to be an acceptable standard and obviously what the Department considered to be an acceptable standard through the registration process, but when you get into issues relating to possibly child protection concerns and investigations of serious complaints, that does require a level of skill and practice and experience that Management Committees probably wouldn't have, and at the same time a Management Committee has a range of other loyalties to the organisation, to the staff that would have to be very carefully managed.

Q. You make that clear in the rest of that paragraph, where you say:

"There has to be a clear procedure and a defined threshold for action, training and experience and there should be a separation in relation to other possibly conflicting issues such as the personal relationships, organisational loyalties and staff care responsibilities."

You say that:

"The complaints procedure in place during these time periods", and we are talking from the early '80s right through to the mid '90s, "lacked detail and clarity

whilst those required to undertake the investigation were unlikely to have had the necessary training and experience in a specialised area of work."

A. I think in relation to the -- I saw a copy of the complaints procedure for Nazareth. I think it was in Barbara McDermott's records somewhere there was a faxed copy of it. I mentioned earlier on today I have subsequently seen a copy of a Board's complaints procedure for their own children's homes and one is significantly more detailed than the other.

So I think there was an issue about the level of detail around who should do what when. I think it also goes back to the comment in relation to the independent person, because I would speculate that at the time some of those issues they would have hoped would have been addressed through an independent person there, but because there was not clarity around the independent person's role and how assertive they should be, it is not clear whether or not that could have happened.

Q. You say essentially the guidance wasn't sufficiently clear about who was responsible for what.

A. Yes. I think generally if you look at the -- again I~think the guidance was based upon the existing legislation, which hadn't changed. So it was perhaps reaching the end of its appropriate shelf life in terms

of the development of professional practice -- is that you have -- maybe I will use an example -- is if you look at the 1969 Act, which I comment on in the original statement, in England, the local authority -- all children who came into the looked after children's system became in the care of the local authority at the time.

So things like approved schools, which I think were the equivalent of training schools, or training schools the equivalent of here, kind of disappeared at that time my understanding is, but also the local authority had a responsibility for the strategic planning of all children's homes within its area whether they were voluntary or not.

There was also a requirement that when you looked at the Management Committee of voluntary homes, a third of those had to be nominees from a local authority or the local authority.

There were changes that probably from my opinion pushed responsibility in a particular direction whereas I think the lack of that kind of development in Northern Ireland may have left this overarching principle that each part of the system was largely responsible for its own management with a minimum or a light touch in relation to cross-over between that from

an accountability perspective.

Q. And the result of that is an abdication of responsibility by certain bodies. Would that be fair?

A. "Abdication" wouldn't be a word that the Board would use in relation to that, no.

Q. That's my word.

A. I think it would be that there could be a situation arising where it was possibly easier to be looking for somebody else to grasp the nettle rather than grasp it yourself.

Q. I think the words we used when we were talking earlier was the blame game could be engaged in.

A. It could be, because I think, you know, if you don't have the lines of accountability and tackling some of the issues is complex and possibly politically sensitive, then sometimes it is easier to look and see if somebody else is responsible for doing it for you. Now I can't comment whether that was the case in here -- I haven't see the evidence -- but I think the systems could have allowed that --

Q. To occur?

A. -- to occur.

Q. There was one other matter. We were talking about how the landscape has completely changed since 1995, but there are still even today difficulties with the system

with regard to -- although things have improved immensely, there is still difficulties with the system with regard to getting to the bottom of complaints. Isn't that correct?

A. **Well, I think there are, yes. As I mentioned before, you are dealing with young people who have a range of complex needs, and you are dealing with staff who are -- who are working in quite difficult situations dealing with quite challenging behaviour. So it's -- I think in relation to dealing with what would be straightforward child protection matters now is very clear-cut. That's -- that's not the particular issue, but then there will be things which are less clear, which relate to the standard of care and whether or not that standard of care leaves children vulnerable or at risk in the wider safeguarding context. That still requires discussion, and there can be difference of opinions about how that's taken forward.**

Q. Well, thank you, John. You will be glad to know that I have nothing further that I want to ask you about your very detailed statements, which have been very helpful to the Inquiry. I just wondered if there was anything more you wanted to say that we have not covered, that isn't either in your statement or anything we have looked at today, if there's anything more you want to

say that you feel would be of help to the Inquiry at this point.

A. Not at the moment. Thank you.

Questions from THE PANEL

CHAIRMAN: John, can I ask you about two aspects of your evidence today? The first is that, as I understand it, you are making the point that in Northern Ireland the development of professional practice in relation to children in the context that we are looking at became increasingly influenced by professional developments in England in the same field.

A. I wouldn't say increasingly. I think when you look to develop professional practice, you often look outside your own jurisdiction or you develop things within your own jurisdiction. So I think it was probably a combination.

Q. But the developments elsewhere in the United Kingdom were connected with a clear statutory base, which did not -- no longer represented the statutory base that continued in Northern Ireland. Is that right?

A. I think I was more commenting on the interpretation of developments that may have taken place in England and setting those in a Northern Ireland context. I am aware that we have looked at developments in England and sought to sometimes mirror them, sometimes improve them

or sometimes to implement them, but I have noticed from personal experience that sometimes we don't understand the context in which they are operating in England and the developments that have taken place prior to that or the legislation that sets things in place.

The example would be the simple fact that over there you have local government running children's services. So if you are dealing with homeless young people, the local authority is the local authority, regardless of whether they are homeless or whether they are a looked after child, whereas over here the Northern Ireland Housing Executive deals with homeless young people and we would deal with children who require to become looked after, which adds a complexity.

So sometimes it is we import things that seem to be a good idea, but are our implication may -- our application of them may be more I suppose procedural rather than conceptual, because of the different state of the legislation at the time.

Q. So one is taking developments from a different context without fully understanding perhaps the differences between the context in Great Britain and the context in Northern Ireland.

A. I think that's the case. I don't think this is entirely solely a Social Services issue, because we have done

things --

Q. No, I understand.

A. -- in early years which are completely out of context as well.

Q. It happens across a wide range of fields, but we are looking at childcare here, but that leads to a question really, which is why wasn't the legislation being updated in Northern Ireland to bring it into line with changes in practice? To put it another way, the practice perhaps was moving away from the statutory base on which it was supposed to rest.

A. I think I can comment on the second part. I am not sure I am qualified or would have the knowledge to comment on why legislation didn't change. I can make -- I can speculate that there were lots of other things going on at the time, you know.

Q. Yes.

A. The way -- the nature of government in Northern Ireland still has its complexities in relation to taking forward legislation.

I think in terms of the second part -- can I remind me what the second part was again?

Q. The social work practice --

A. Oh, yes. Sorry.

Q. -- was moving away from the statutory base on which it

was meant to be anchored.

A. I think from reading the documents and people's statements social work practice had continued to develop and evolve, even though there was no legislative change.

Q. Yes. If I can then come to a more specific aspect of practice at the time and that relates to the circular that was issued by the Department. You have commented on this at a number of points in your statement.

It is certainly open to one view, which is that you start off with different parties having different roles in the area. The Department is responsible ultimately for enforcing the statutory framework, because they register the home. If the home doesn't come up to its standards, it shouldn't be registered. Presumably if it falls below those standards and can't be brought back up, it should be deregistered, but that's perhaps the nuclear option, but it also has a role as the inspecting authority to ensure that the homes are providing a satisfactory environment for the children. Isn't that right?

A. That's my understanding of it, yes.

Q. But the delivery of the care for the child is being done either by a voluntary home or by a home provided by one of the Boards in the public sector. A Board which places a child in a voluntary home is still responsible

for that child in practice -- isn't that correct --

A. That's correct, yes.

Q. -- in the sense that it has to satisfy itself that the voluntary home which is actually providing the accommodation, food, the care and so on meets the Board's requirements.

A. Yes.

Q. So far so good?

A. Yes.

Q. The difficulty that seems to have arisen in this instance on one view of the evidence is that when there arose circumstances that led to the question of whether or not an individual complaint in relation to more than -- one child or perhaps several children in a home, whose responsibility was it then to look at all of the implications?

The Department's view appears to have been that it wanted the Boards to look at many of the things and in at least one instance the Eastern Board are saying, "No. This is not our responsibility, because it raises wider issues as to not just the care of this child or these three children, but the standard of care for children in general. That's for the Department".

Now you have pointed out that it's a matter of concern that there were two quite significantly opposing

views as to whose responsibility it was --

A. Yes.

Q. -- created by the terms of this circular --

A. I think the circular --

Q. -- or contributed to by.

A. Contributed by, yes.

Q. So if one resolves it to a rather simplistic view, the circular fell down in that respect, because it didn't make clear where the boundary between the Board looking after this child and the Department looking at the broader picture -- where the interface was to be resolved.

A. I think -- I am not sure it was the circular per se that might have fallen down, but I think the circular was probably trying to base itself upon the legislation and the regulations, which had that separation of responsibilities. As I mentioned before, there was a lack of connectedness between those apart from the Department and the registration function. So I think it was a wider context rather than just the circular. I think the circular was probably in line with the legislation, but I think that still had that issue in relation to it, that you were looking for the Boards to be assured about the quality of care being provided to an individual child, but the extent to which they felt

empowered or would have been seen to have the authority to do more in relation to the overall quality of the standards of the home is -- is lacking, you know. That goes towards the Department, you know.

Q. I am not sure whether you touched on this in your statement, but we are aware from an earlier module that there was a significant push by the Boards to have the inspection function transferred to it at one stage post-1973, which the Department resisted. So in a sense a decade later one is seeing the outworking of that tension between the two positions.

A. Yes. I am sure there were pros and cons in relation to doing that, but I do think -- I suppose -- I think there's a wider question, which I think we discussed a little bit earlier, but not in my -- earlier today, is that I generally come from a perspective that good professionals can make a poor system work. So whilst I think there were issues in relation to legislation in the circular, I couldn't -- it would only be speculation, but I would have a question why those things weren't resolved in a more amicable way at the time, and I think that suggests something in relation to the wider context, but I haven't seen enough of the information to be able to comment on that further. It's just the second question I would have asked is: "Well,

why did you -- you know, as professionals, why did you not reach a better conclusion?"

Q. Perhaps that's a question we will have to pose at some stage. Thank you very much.

MS DOHERTY: Thank you very much. It's all been very helpful.

Can I just ask, going back to the NL170/NHB137/Vincent O'Rourke correspondence in relation to NL164, one of the issues that NHB137 brings up to Vincent O'Rourke's attention is that NL170 is withholding information and is being told to do so by her Superior in the home. That seems to be one of the issues then that gets lost along the way. There's a kind of general thing of, "Let me know how you're getting on. Raise this with the Mother Superior and the nun that's the subject of the complaint", but it doesn't seem to have raised an issue for Vincent O'Rourke about, "This information has been withheld. What does this say about the home if they are withholding information about a child and if they are being -- if a junior member of staff is being told to do that by a senior member of staff?" I mean, it is important we don't judge things that happened a number of years ago by today's standards, but that was 1994. I just wonder what your expectation would have been at that time how something

like that would have been dealt with.

A. Well, in terms of -- I think from -- if I recall, the records didn't show whether there was a particular outcome in relation to that. I do think there seemed to be -- if I recall rightly, Vincent O'Rourke had said something. There was a record of him saying, "Investigate this further" or words to that effect, but then there was no -- there was no outcome in relation to that --

Q. There was no outcome at all.

A. -- which I think I said in my statement I don't feel in a position to kind of speculate as to the whys and wherefores of things that may have happened twenty years ago based upon records, because I am not there to talk to people, but I think an expectation then and now would have been that the matter was taken up with the voluntary home and, if necessary, through the Management Committee to have the issue resolved.

Q. Okay. In relation -- I mean, when we get to the situation of SR18 and the investigation and the fact -- I think, as you rightly point, her admittance then, you know, in a sense closes the issue down. There seems to have been no consideration of the general issues that this raised about supervision of this particular nun and how these actions were allowed to happen and how did --

previous issues being raised by junior staff, how were they dealt with?

Again recognising that we can't judge from here to what happened then, in that that was 1995, would there have been an expectation that those more general issues would have had to be considered, not just the actions of the one nun?

A. I think I commented in my statement that there didn't seem to be any wider outcome. So, yes, I think there would have been expectation then and now that wider issues in relation to how things happened, not just what happened, should have been looked at.

Q. Thank you. That's what -- you essentially analyse it well. I was just trying to get your view about it and your view would be that that should -- something should have been ...?

A. I mean, I can't say whether it did or it didn't, but the assumption -- when it happened, it could have been that something was not recorded that was taken forward, but I think there would be an expectation then and now that you would look at making sure such things didn't happen again.

Q. Okay. Thank you.

MR LANE: One of the things that you said intrigued me and that was that a social worker from the Board would have

been carrying out sufficient checks just to make sure that the home was registered and regulated and was from the right denominational grouping. Was that correct? Did I understand you properly?

A. I don't think that's what I meant, no. I think what I was saying in terms of the requirement in terms of placing children based upon the regulations in the placement is the Board social worker or the Board had a duty to place a child or young person somewhere where their welfare would be -- it would meet their welfare needs -- I think it is "further their best interests" is the actual wording of it -- and that they should do that within a placement of their own denomination.

Q. So if a social worker is trying to find a suitable placement for a child, what other sort of checks on the quality of care and the atmosphere and things like that would you expect them to make that is obviously short of the monitoring and inspection that was the proper role of the Department?

A. I think the system at the time would have been that there were a range of available placements, some within the Board's own facilities and some within voluntary organisations that the Board would have habitually used, and the social worker who decided which was the most appropriate one based upon the child's needs and

availability of placements.

Q. Where would they get the information from to know whether it was suitable or not?

A. I think their assumption would have been that had it -- that the fact it was a registered and inspected home, that it was suitable.

Q. So the Board --

A. I don't think a social worker would have gone beyond that.

Q. Right. The Board wouldn't have gathered information on the functions of individual homes or the resident group at that time and things like this to determine whether a child would fit in?

A. There may well have been discussions, but I think it probably was more to do with custom and practice and the appropriateness of placements that were available. It is not -- again the context is very different to an English context, where placements would have been over a much wider geographical area and a much wider range. Here placements -- it is a small -- comparatively small, and people use the same placements on a regular basis. So ...

Q. So the custom and practice you are talking about is like the accumulated wisdom and experience of previous years?

A. Yes.

Q. Fine. Okay. Thank you.

CHAIRMAN: Well, John, thank you very much indeed for answering our questions and coming to speak to us today in such a helpful manner. You have given us in your written statement a great deal of more information than we have touched upon today and it's very helpful to us, and we are very grateful to you for coming to speak to us today. Thank you.

A. Thank you.

(Witness withdrew)

MS SMITH: Chairman, Mr Aiken is taking the next witness. So if we take a short break, I'm sure he will be ready very soon.

CHAIRMAN: Yes.

(11.55 am)

(Short break)

(12.35 pm)

NORMAN CHAMBERS (called)

CHAIRMAN: Yes, Mr Aiken.

MR AIKEN: Chairman, Members of the Panel, good afternoon. The next witness today is Norman Chambers. He is aware, Chairman, you are going to ask him to take the oath.

NORMAN CHAMBERS (sworn)

CHAIRMAN: Thank you.

Questions from COUNSEL TO THE INQUIRY

MR AIKEN: Norman, coming up on the screen -- and if you just keep the microphone towards you; pull it towards you, if that's helpful -- should be the first page of your first witness statement of 15th April 2015. If you just can confirm it looks like the first page.

A. I confirm that.

Q. If we go to 9176, please, which is the last page of your first statement. So it's a lengthy statement of 25 pages. That's the last page of it. Can you confirm you've signed your witness statement?

A. I confirm so.

Q. And you want to adopt the contents as your evidence to the Inquiry?

A. I do. Uh-huh.

Q. Attached to that statement then there is a significant amount of exhibits, which run from 9177 to 9303. That included a dissertation that you did when you were doing your Master's.

A. Yes.

Q. I know that the Panel have found a lot of that statistical information that it contains helpful, which is not necessarily easily available with the passage of time. I am not sure you knew when you were writing it it would end up being produced to a public inquiry, but

the Panel have found that helpful.

Your second witness statement then of -- it is dated 16th April. It can be found at 9545, please. Can you confirm that looks like the first page of it?

A. I do. I confirm that.

Q. You are engaging in this statement with what DL 518 has had to say in his witness statement of 3rd April. If we move to the last page of the statement, please, at 9548, and again that's the last page, and you can confirm you have signed your statement?

A. I do.

Q. You want to adopt it as your contents --

A. I do.

Q. -- the evidence? You want to adopt the contents as your evidence to the Inquiry?

A. I do.

Q. Norman, as I said to you beforehand, the Inquiry is aware that we are looking at matters that happened a significant time ago. We are asking people to do their best to remember as far as they can with the help of the documents that are available. If at any stage you have any difficulty of any kind, just indicate that and we will deal with it. That's perfectly normal for the Panel.

As I said to you, it can feel in your position more

like a cross-examination, although that is not what the Inquiry engages in. The reason for that is because we try to limit the amount of time you have to sit in the witness box pouring over material. So I try to come right to the core issues, but that's not to stop you saying anything you want to say to the Panel, who have already read the detailed material that you have provided to us.

You were born on 28th January 1944.

A. Yes.

Q. That makes you, if my maths is right, 71.

A. That's right.

Q. You have explained that you qualified as a social worker in 1966.

A. Yes.

Q. You then spent eight years between 1974 and 1982 as the Director of Childcare at Barnardo's.

A. Yes.

Q. I am right in saying that would have involved you having significant involvement in the children's homes that that voluntary organisation provided.

A. It did.

Q. Prior to '74 you had spent some time in one of the welfare authorities.

A. That's right.

Q. Then in 1982 you move from Barnardo's to work for the Social Work Advisory Group.

A. I did.

Q. Just to contextualise that, that's a professional advisory body, but part of the Department of Health at the time?

A. It was. It was. Uh-huh.

Q. But then you also have the executive part, which was the Childcare Branch.

A. That's right.

Q. So you would be doing your work and advising the Childcare Branch, but there was close liaison between the two parts of the Department as far as children's work was concerned.

A. That's correct.

Q. You went in there as a social work adviser.

A. That's right.

Q. That was the title --

A. It was.

Q. -- at the time. That involved you engaging in the type of inspections that we are going to look at.

A. It did.

Q. In 1986 then the Social Work Advisory Group becomes the Social Services Inspectorate.

A. That's correct.

Q. And at that time does your job title change or do you -- is it still a social work adviser?

A. You became a Social Services Inspector.

Q. Right. So you were a Social Services Inspector until 1991, when you become the Assistant Chief Inspector.

A. Could I just correct that? It was 1989, not '91.

Q. When you became Assistant Chief Inspector in 1989, who was the Chief Inspector at that stage?

A. The Chief Inspector then was Mr P.J. Armstrong.

Q. He had been the Chief Inspector in SWAG and then --

A. Well, I can't remember the exact dates of his appointments. He had been the Deputy Chief -- the Deputy Chief Social Work Adviser in SWAG.

Q. And then eventually became the Chief Social Work Adviser?

A. That's right.

Q. Then he became the Chief Inspector when it moved to the SSI in 1986?

A. He did.

Q. For a period of time then you were an Assistant Chief Inspector to him from 1989 until I think it was Dr McCoy took over.

A. That's right. I was there until 1995.

Q. So you have been retired out of the Department, though not necessarily retired in terms of your work. You have

spent a lifetime effectively working in childcare in one way or another.

A. That's correct.

Q. Since your retirement from the Department doing consultancy work in the same field.

A. Yes, that's correct.

Q. As I say, so that you're not spending days sitting in the witness box, the Inquiry's focus tends to come down on some very particular aspects of what was a lifetime of work. So that's the context and everyone involved is aware of that context, but you were involved in the 1983 inspection of Nazareth Lodge on behalf of SWAG.

A. That's correct. Uh-huh.

Q. And you -- the Inquiry has -- and I am just going to let you identify them. If we -- there are two documents we have been looking at. You know I talked to Victor, your colleague, about them, who was involved with you in this inspection, and you and I have talked about them. You are aware of the issues that they raise and that we will cover, but there is a document if we can look at 14316. This is the first page of the -- what I am calling document one, and if we can bring up beside that, if possible, the last page at 14322 just so that it -- Norman can see the -- 14322. Norman, we were discussing this earlier. I just want to allow you to explain to

the Panel. Looking at this document, which is obviously different from the final report which wasn't on the departmental file, where this document was found, but which was available because it was amongst the Hughes Inquiry papers, who had this, the final version of the inspection of '83, and we are going to talk about those two documents --

A. Uh-huh.

Q. -- but can you explain to the Panel from the best of your recollection what this document, which doesn't contain recommendations, for instance, at the end, what this document -- what its genesis was, how it came to be in existence? If you just explain the process if you can.

A. Yes. Initially when I saw this document around 11th or 12th February, I had difficulty in identifying what it was, because the final report of the inspection which was issued was not in the file. Indeed, I continued to have that difficulty for a number of weeks. I had difficulty with it because, on reading it, I was surprised by the harshness of some of the wording, which would not have been characteristic of the way I would have presented a report to an administering authority, and also the report was incomplete. It didn't have recommendations. It had typing errors in it and so

forth and I wouldn't have issued it to anyone in that form. So I did have some difficulty working out what this was.

To just summarise, I then came to the view, just relatively recently on a good deal of reflection, that what this was was a dictated report, which would have been dictated probably the day after Victor McElfatrick and I completed the inspection. It wasn't handwritten. I dictated it as my initial impressions. That might explain the directness of some of the speech and perhaps harshness.

Victor McElfatrick and I met the following week to discuss the inspection which we had just completed. This report is dated 18th October, and we met within a day or two of that. So we would have had a discussion. I would expect that I gave this to Victor, and then on completion of that -- our discussion I would then have moved to writing the substantive report.

When I completed writing that, the report would have been submitted to Mr P.J. Armstrong, who was my line manager. He was the Deputy Chief Social Work Adviser at that time.

So that explains what the report was, its status and the use to which I put it. It was essentially, if

I might use the term, an aide-memoire for my own purposes and for discussion with Victor McElfatrick.

Q. You mentioned -- I'm going to strip that down a little. You mentioned Pat Armstrong, and you were explaining to me earlier it is likely, given some of the things that don't make it into the final draft, that -- on reflection you think there is likely to have been discussion between you and him about the report as that process of writing it goes on.

A. I think it's likely that I would have had discussion with Mr Armstrong either before I wrote the report or in the course of writing the report about one or two issues in particular and what our view would be on them and how I would present it in the report, yes.

Q. Just to complete the process then is you end up with a final draft, which you then share with the administering authority, and you ask them for their response to it, or is it a finished report at that point when you give it to them?

A. I cannot remember exactly what our practice was in 1993, but certainly in succeeding years our practice was to submit or send the draft report to the administering authority for a factual accuracy check. In other words, we didn't wish to complete a report with obvious errors in it. We weren't asking them to respond to its

recommendations. It was just an accuracy check. Whether it happened on this occasion, that I can't confirm, but that certainly was our normal practice.

Q. Well, there certainly are documents where -- in the file where you can see the report being given. It seems to be April 1984, but whether there had already been a discussion phase with them or not the documents don't tend to answer that.

When you produced this document, you were just into the Department, as it were, a short period of time --

A. Yes.

Q. -- having spent six years in Barnardo's.

A. Eight years.

Q. Eight years in Barnardo's. This document presumably, however you might produce the final report, and we will talk about that, as you know, this is an accurate record of your impression of the home that you visited.

A. Yes.

Q. There is in a number of respects harsh language, as you have described it, but also very direct conclusions about whether something is satisfactory or not. We will look at some of the examples. Arrangements for parents were unsatisfactory. Sharing of who had access to files and a serious omission, because they weren't given -- staff weren't given access to files and that type of ...

A. Sorry. On that point I would take the view that perhaps young and inexperienced staff might not necessarily have direct access to a lot of the child's file, which --

Q. We'll come to the -- I am going to come to the specific examples --

A. Yes. Okay.

Q. -- but I am just giving you a grounding --

A. Yes. That's okay.

Q. -- of the type of harsher language that you are talking about --

A. Uh-huh.

Q. -- in order to say to you: was this a home you would have been wanting to send a child to, the one that you characterise in this first document?

A. I think that has to be seen in the context of the time. The Eastern Board was the main user of Nazareth Lodge. They would have known the home quite well over a period of time and they considered it appropriate to place children there. Like many homes at that time, perhaps they had outlived the purpose for which they were originally brought into being. That is very often for the rescue of young children for long periods of time. Other homes were in a similar position, particularly in the voluntary sector. They had been in existence for a long period of years and perhaps hadn't moved on, but

at that time the Boards would have had limited choice in where to place children. That problem existed well into the '90s. I remember many occasions where I would have had concerns about the suitability of a placement in a particular home. The reality was that the Boards had to find placements and they did the best that they could.

Q. I am not asking you, Norman, about the Boards. What I am asking you about is you have gone in as the Inspector - and we can look at some of the examples of the harsh language -- and the test that you are applying from the legislation is about whether this home is being suitable -- being run in the best interests of children --

A. Uh-huh.

Q. -- the well-being of children. I am just asking you: given what you have read and as you reflect back on the first document, is there somewhere you would have wanted to place a child in care?

A. I find it difficult to give a kind of simplistic answer, if you don't mind. If I look at the experience of this home over a period of even five years and look at the evidence of the service that the Board said they were receiving from it, that is in terms of the care of children, I don't think I could have taken the view that

I would not have placed a child here, because Boards were saying that children were being well cared for. I am looking particularly at reports that we received in the mid '80s, 1987 in particular.

Q. Norman, I am talking about 1983 and this document and what it characterises. Let me break it down a little. What you describe in this first document is three children's units within the home and one of them has a head that seems to be doing things pretty well. That's SR148. You explain why you say that in this first document. She is operating a key worker system, which, when we get to the final report, you explain in detail how that should work, no doubt as a teaching aid to help the parts that weren't doing it, but you are finding she is doing this well. She is involving staff in reviews. She is involving them in the children's files.

You find in respect of the other two units one is, it seems, better than the other, but not doing those things that SR148 was doing, and the third one not doing them at all.

Is that a fair -- from your first document --

A. I think the -- it's the final paragraph, final sentence would indicate that, as you put it, yes.

Q. If we look at that last -- if you look at the last

sentence that's on the page:

"It must therefore ..."

"While one of the Sisters clearly has the ability and another has been in post for only one month and has undoubtedly a lot to contribute, the third Sister had little understanding of residential social work and her ideas are largely irrelevant to the statement of aims and objectives, and the fact that no staff are substantially involved in carrying out the aims of the home is a serious indictment of the regime."

The nature of the language is very stark here. One of the messages I take it that you were recording was that one of the heads of this unit -- one of the units had a head who was not really up to the task.

A. Uh-huh.

Q. That obviously -- being critical of a particular member of staff doesn't feature in the final report, but how would that have been taken forward, because you have got one of these three units and at the time having three units was a large -- the homes you would have preferred would have been much smaller in size.

A. Uh-huh.

Q. You have got this home that has three parts to it. One of the parts has a head that's not suitable, if that's fair on what you've written.

A. Uh-huh.

Q. How would trying to get that remedied be taken forward?

A. Well, in the final report, which would be a fairly open document, I certainly would not normally have identified an individual member of staff, but how would it have been taken forward? It most certainly would have been discussed with the head of the home and my concerns would have been made known to her, and she would have been expected to do something about it, whatever that was considered -- whatever was considered to be necessary, but it would not have been ignored, because it wasn't -- at least the person wasn't identified in the report.

I mean, the purpose of the inspection, as I said earlier, was broadly speaking two-fold. One was about enforcement of regulations and the other part was to develop the service provided by the home. That is a highly critical comment of one group head that existed at that time. So that would have been discussed.

Q. We can't find in the file anything showing that being taken -- because that's obviously a serious issue --

A. Yes.

Q. -- because you've got twelve or fourteen children being looked after in a unit with an unsuitable member of staff at the head of it. You don't have a memory

yourself, but your belief is there would have been discussion to make the head of the home, which was SR143 at the time, aware that that was the inspectors' view. Is that fair?

A. Yes, it is. As you know, I didn't actually take forward the implementation of these recommendations. Chris Walker did. So that would have been an ongoing process, but a very important factor in the life of that home.

Q. Mr Walker wouldn't -- the final report doesn't tell you this story.

A. Uh-huh.

Q. The recommendations don't -- don't tackle this issue at all. Mr Walker, unless you have told him, won't know about it, and in the material I have seen of Mr Walker engaging with the home it is on the recommendations that are in the final report.

A. Uh-huh.

Q. It's -- what you're explaining -- and correct me if I've got this wrong -- is you wouldn't have tackled this type of issue in an inspection report, but you would have expected to tackle it by communication with the home itself?

A. Most certainly.

Q. You can't say at this remove whether that happened or not?

A. Certainly I don't remember --

Q. You don't remember, no.

A. -- thirty-two years ago individual discussions.

Q. But would you expect there to be -- had it happened, there would be some record of that being taken forward in the file?

A. Had I personally had a meeting with the head of the home to discuss this inspection in some detail, I would have expected at the time to have made a record of that, because that would have been an important discussion.

Q. One of the things we did find on the file, and you were getting the opportunity to see it again, was your handwritten notes from the inspection itself --

A. Yes.

Q. -- that run over ten or twelve pages. They do contain the type of -- you talk about the rigid hierarchy --

A. Yes.

Q. -- that you talk about on the first page here, but you talk about the communication with the head of the home. In fairness to you, it appears from the Hughes Inquiry report -- if we look at HIA915, please -- that SR143, who was the head of the home at the time you are inspecting in 1983, didn't even have the regulations that they were to be complying with. I am sorry. I should have made the operator aware. If it is

possible if we can have HIA915 --

A. Yes.

Q. -- on the screen. Thank you. While -- you give her a copy of the regulations.

A. Yes.

Q. Is the fact that the person who is supposed to be the head of the children's home doesn't have -- there we are. We can paragraph 9.24, and you are recorded:

"Mother Regional should have ... separate written report on the inspection",

and so on.

"We noted that the current , SR143, said in evidence that she had been unaware of the 1975 regulations until SWAG drew her attention to them in October 1983."

So from that what she seems to be saying is not only did she not have a copy; she didn't know of them.

A. Uh-huh.

Q. You effectively were teaching the head of the children's home about what statutory requirements were upon her as the person in charge of the home. Is that not a major issue?

A. Well, it was an issue which I dealt with it would appear by giving her the regulations and presumably discussing them with her. Might I say that it was not unusual in

going round voluntary children's homes and might I say some of the statutory sector for staff not to be aware of the detail of the regulations. That's where they were at that time. In the process of the programme of inspections obviously that changed through time, but the fact that the head of this particular home didn't have them to hand, shall we say, that in itself was not unusual, important as it was.

Q. I am not talking about staff now. I am talking about the person in charge.

A. Indeed, yes.

Q. The legislation imposes on the person in charge of a home a series of mandatory requirements --

A. Yes.

Q. -- and according to this this person didn't know about them and found out about them from you.

A. That's right.

Q. Is that not something that would normally find itself, however -- whatever the language in the final version, that, "There's a serious issue here about understanding what one's responsibilities are"?

A. Well, it's certainly a very pertinent issue. It would seem -- I have no doubt that I did -- that I addressed it with her. Yes, it was important.

Q. It doesn't feature in the actual reports, the first or

-- the first version or the last version, about the need for there to be greater understanding in the home of what their statutory obligations were.

A. I agree that it didn't feature as a recommendation, but in a sense it had been dealt with while I was with SR143. I had no reason to believe that she would not take the matter seriously.

Q. The -- if we can look again -- if we can move to the split screen, please, and bring up on the left side 50504 and then on the right screen, if it's possible, if we can have 14321, please.

Now you can see here on the left side from the final report you are making the point that:

"The Sisters are available in the home at all times",

and there's reference to the 40-hour week that the staff were supposed to work, but on the right-hand side, which is the earlier document, you can see reference to the fact that they were working much longer hours. They were doing between 56 and 70 hours per week.

In addition, if we can look at the first page again, if we just bring it up on the left-hand screen as well, 14316, and then I'm shortly going to move on to 14317, because at the bottom of 14316 you make the point that you found that the staff had this perception of the

Sisters in the home, that:

"They perceived them as authoritarian background figures who absent themselves from the group particularly during periods when their help is needed."

Then as we scroll down on the left side:

"The Sisters do not socialise with the staff. They are separately -- they eat separately and have their own living quarters. The need for the Sisters to attend to religious duties throughout the day is considered to be intrusive, and while it is understood that they may occasionally be late for offices, their religious duties are considered to be paramount."

So that -- these two passages that we have on the screen at the moment, Norman, are a reflection, along with some others -- because you can see on the right-hand side the third paragraph down refers to:

"As a staff group they appear to get along well. They seem to enjoy working with the children. However, their relationship with the nuns is very poor and none of the staff is content. Their principal grievances are to do with salary levels, split shifts and living conditions. While these are important considerations, we would be equally concerned about the professional development, which is virtually non-existent."

So there is strong language in these pages that we

are looking at about the difficulty there appears to be both in what you're being told and what you yourself have found about the relationship between the Sisters and the lay staff.

A. That's correct. Uh-huh.

Q. When one then comes to the final version, this criticism on one view of the perception of the Sisters absenting themselves at important times and their religious duties interfering with their role looking after the children, it's not in the final version. Is that likely to have been the type of thing that you and Mr Armstrong will have talked about and --

A. It's extremely difficult to -- I don't wish to speculate about that. I'm sure there was some acknowledgment of the fact that team work in this home didn't really happen, that only one group was really switched on as far as the development of the key worker system. I have little doubt that we could have -- that would have been acknowledged.

The underlying problem in terms of relationships was that the care staff -- sorry -- they, care staff, saw themselves as somewhat subservient to the Sisters who made the decisions. Now that was an unhealthy environment from an employment point of view and that was a feature of living and working in a religious

community at that time.

What needed to be developed were core principles to do with management of staff, to do with the professional development of staff and the development of care practices, such as the key worker system. I have little doubt that we would have gone over that ground.

Q. In addition to it being a healthy or not a healthy environment for staff was the phrase that you used, presumably what you are articulating is not a healthy environment for the children either?

A. I think inevitably -- well, I would take the view that if there is not effective team working, which results in consistency of practice in the handling of children, in the understanding of their needs, in the outworking of care plans, that is an empowerment which is deficient.

Q. What you find at least in a third or two-thirds of the home in terms of two units is that the files are not either seen by or contributed to by staff, that there are staff meetings only between the three Sisters who head up the units once a month, not recorded, and that one third or two-thirds were not involved in terms of staff taking part in the reviews that were taking place. That was something that received strong words from you in the first document.

A. Uh-huh.

Q. Is that fair?

A. Oh, it most certainly did, yes.

Q. When it comes to the final document on those issues, it is not painted as starkly and it is more front foot some review staff are coming to -- it is not as critical. We can look at the examples if you wish --

A. No, I don't --

Q. -- but you probably know the contents of the documents.

A. Yes.

Q. It is certainly not as clearly critical as these remarks are in the first version.

A. Yes.

Q. Why would -- why would you have not been as direct with the home about these childcare practices? These aren't issues about individuals per se. They are childcare practices that you are not happy about. Why not be direct about those so there can be no equivocation over them?

A. I think in writing the report there needs to be a balance between criticism and encouragement, between pointing of weaknesses and pointing of areas where there needs to be development. I think in the second report -- in the final report, as you have said, I spelt out in a bit of detail what I expected to see in terms of the key -- well, as an example of good practice the

key worker system. Obviously what I chose to do was to be circumspect in my criticism, but point up what I expected to see happening in three groups. Obviously one could bombard an organisation with heavy criticism. It is not my view that that is the best approach. The report is a basis for discussion and a basis for planning further development. There's quite a lot to say about the need for staff development, the need for training. That is where the emphasis lay as far as future development was concerned.

Q. The point you made to me earlier as well was that the final report wouldn't in any event have been easy reading for the home you were writing to. That was a point you were explaining to me earlier that, well, yes, it doesn't contain the strength of language, but it still would not have been a palatable read for the administering authority.

A. I think it would have been quite an uncomfortable read for the head of the home and her senior staff, especially for her to see in black and white how their staff were feeling about their employment and how they were being treated.

Q. Just if we bring up on the left side of the screen, please, 50511 and 14317. On the left side is the final version, Norman, that touches on the issue of parents at

8.4. What you say there is not as strong as when you look at the last paragraph of the first version, where you say:

"Arrangements for parents to spend time with their children in Nazareth Lodge is very unsatisfactory."

Now I have had a running discussion, Norman, with social workers about they tend to use more gentle language than perhaps people in my profession do, but for you in your context to describe something as "very unsatisfactory" --

A. Uh-huh.

Q. -- is there a higher adverse finding than "very unsatisfactory"?

A. I am sure one could find a more extreme form of words, which I wouldn't choose to use.

Q. In the terms of what you would put in a report is "very unsatisfactory" not pretty much the bottom of the scale?

A. I think it would be, yes.

Q. When you look at the final version at 8.4, what you are saying by describing something as "very unsatisfactory: "This really is not good enough. It is not right. It needs fixed". Why not give them that stark message, because in the end this report is designed -- it is going to them perhaps at this stage, or shortly after it the Trust will start to see the report as well, but in

order for them to realise how serious matters are if you were saying things to them, "This is very unsatisfactory", would that not in all likelihood cause potentially a greater degree of reaction than --

A. SR143's response to this particular recommendation was virtually to reject it. She said that they made parents very welcome, and I think she accepted that perhaps more could be done, but she was I think very uncomfortable with the final version as she read it. I don't know whether it would have caused a more positive reaction if I had expressed it in more stark terms.

Q. So what you describe at least in that respect is that even a gentler version wasn't met with acceptance on that particular issue?

A. Well, I think she probably found this rather insulting.

Q. You -- if we -- on the left side of the page, please, if we move on to 50512.

CHAIRMAN: I think it is after 1.15. Perhaps this would be an appropriate time to take a break. We will try and sit again as soon after 2.00 as we conveniently can, Norman.

A. Thank you.

Q. If you need longer than that, don't hesitate to ask.

(1.15 pm)

(Short break)

(2.30 pm)

MR AIKEN: Chairman, Members of the Panel, before lunch we were looking, Norman, at the two documents. I am only going to show you a couple more examples. I want to just talk to you about the food. The first version is on the left-hand side of the page, which is SNB-14320, and then the final version of the report is at 8.9, which is the version on the right-hand side of the screen.

In the first version, Norman, you -- in addition to explaining that the staff -- the Sisters don't eat with the children, which you thought was something that shouldn't be the case, and that the staff don't eat the food and their view of it is that it is unappetising, in the first version you explain that you actually had this experience, because you say in the penultimate paragraph:

"One meal we had was tasteless and unappetising and most staff complained about the food they receive."

So you and Victor -- if that's a "we" for the two of you or at least you -- your actual experience was to bear out what the staff had been telling you, although the children didn't seem to be complaining, but that was your experience.

Whenever you have that direct experience like that,

which would be telling, as it were -- you may agree with me -- to the person reading it: "Well, the person who is writing this to me, they actually experienced this themselves", when you come to talk about the food then in 8.9, you don't refer to your own experience of it. I presume you are not going to remember this specific incident, but I am asking you on a general level can you remember why, you know, that type of direct experience that you had wouldn't feature in a final version of the report?

A. I think the purpose of the report was to reflect what was general practice in the home rather than my one-off experience. Our experience was -- in having meals in children's homes during inspections was that things were a bit laid on because we were there. What I was reflecting in the final report I think was what staff I think consistently were saying to us.

My greater concern would have been the fact that what happened at meal times did not resemble what one would thirty years ago expect or wish to have seen in a normal family, where people sit down together and eat, where parents serve their children, look after their children and where they communicate with one another.

What we were being told by staff was, "What happens in here, the Sisters don't eat with us, nor do we eat

with the children -- we are there and serve them -- because we don't like the food".

Now the significance of food, the emotional significance of food in a child's experience, is very important. So what we were being told, and I think this was rightly what I described, was something which I would have felt was not acceptable and not good practice in terms of the emotional well-being of children. I think there always was a danger or a tension between what I, given my background, might have considered to be good family practice, which others might have said was middle class, and what might have been the normal experience of children in the care system, but what I was -- I think what I observed and what we were told was what I reflected in the report.

Q. The fact that -- if I parse what you have said there, Norman, one of the fundamental issues for you was that meal times did not resemble in their structure -- never mind the quality of the food -- they did not resemble in their set-up the way an Inspector considered they should.

A. Well, key if I might say -- the key people at this time in the care of the children were the Sisters, but they were not there.

Q. What I was going to say to you, there is

a recommendation at 13. I will not bring up the page, but it is at 50523. It says:

"Management should take steps to satisfy itself that the meals provided for children are appetising."

That's obviously a hark to the fact the quality didn't appear to be great --

A. Yes.

Q. -- according to the staff and your singular experience, but the recommendation doesn't tackle that more fundamental structural issue.

A. May I ask you to read the preceding sentence, please?

Q. Sure. In fact, we will bring it up and that will be easier. 50523, please.

A. I'm afraid I can't read it on this screen.

Q. If we make it full size, if we could, 50523, if we can do that. It's the second of the three recommendation pages in the hard copy, Norman, if you have it, or that's it blown up on the screen now, which might be easier.

A. Thank you.

Q. If we just scroll down, number 11 deals with parents, and 12 about the volunteers, and then 13 deals with the steps taken about the meals, and then it moves on to ...

A. At paragraph 8.9, please, of the report --

Q. Yes.

A. -- could you read the preceding sentence to the recommendation?

Q. You mean on the actual --

A. On the report itself.

Q. You want to go to the report. Could we go back to 50513, please? So you are saying -- you have said in the body that it would be -- if we scroll down to 8.9:

"It would be preferable if" --

A. Thank you.

Q. -- "the Sisters and staff on duty were to dine along with the children in order to create a more family-like environment."

A. Yes. That to me was an important statement which I -- perhaps it could have been formulated as part of the recommendation, but really the need for the staff -- the staff, being the lay staff, and the Sisters obviously needed to work as a team, but they needed to be there at meal times there with the children.

Q. As I understand it, any report should be taken as a whole --

A. Yes.

Q. -- but the purpose of the recommendations at the end are, "These are the things I want you to get on with".

A. Yes.

Q. This was -- this is deeper -- in the way you are

describing it it's a deeper thing than, "Sort out the quality of the food" --

A. Yes.

Q. -- but it doesn't feature as something you want them to do in the recommendations.

A. It's not a recommendation, but, as you have said, I mean, the report need to be taken as a whole. I mean, central to this report was the -- were the tensions which staff were expressing as between themselves and the way they were being used. They were being used primarily to tend children and to do cleaning. I mean, the report is very much about addressing that dichotomy. I agree that this could well -- perhaps should -- have formed a recommendation in its own right.

Q. The -- I am not going to go through it. The Panel have the reports and have read them in advance of today and are seeing them again today. You touch on the subject of case files and record-keeping and access to files, and the two reports are there to be read as to what's in them.

A fundamental issue wanted to ask you about -- and I will just cut straight to it, because it is not in either of the two documents -- is the fact that the home, the Management Committee, the administering authority, the Sisters were not complying with

regulation 4(2) of the '75 regulations.

A. Yes.

Q. So there was no voluntary visitor and no monthly report for you to see that was required to comply with regulation 4(2).

A. Uh-huh.

Q. Yet that -- why is that not in the report?

A. Well, I have acknowledged in my written statement that that should have formed a recommendation, but the fact that it didn't -- and I can't diminish the need for it -- doesn't alter the fact that we tried to get the -- understand the hierarchical -- the system of governance, however you describe it, in the Sisters of Nazareth, and they seemed to have four levels of -- in their hierarchy and reporting. There was Mother General in London, Mother Regional in Dublin, Mother Superior in the home and then there was a council for the community. They didn't have a Management Committee.

I think in practice the Regional -- the administrative authority probably was based in London and the responsibility for routine -- for monthly visiting would have been delegated to Mother Regional in Dublin.

When we asked about this, quite apart from the fact that there was some discrepancy between what we found as

to the frequency of her visits --

Q. Yes.

A. -- when we asked about her reports, they were told reports were written but they were confidential. The Mother Superior didn't see them, that they went to London.

So we were trying to sort out that, and in that context I think clearly we did discuss the regulations, and I can only assume we discussed -- drew attention to regulation 4(2). We gave Mother Superior a copy of the recommendations -- sorry -- the regulations, and I think there was evidence within the next year or so that there was some improvement. At least they were moving in the right direction. They appointed a monitoring committee who, we were told, were providing reports.

Q. But coming to it, Norman, is that really how the regulator, who has a statutory obligation and to ensure that others are fulfilling their statutory obligations, should approach it?

Just before you answer that, if we look at the terms of regulation 4(2), if we can bring up HIA-445, this is the statutory obligation on the administering authority:

"To ensure that each home in its charge is conducted in such a manner and such principles as will further the well-being of the children in the home."

The legislation then sets out how part of that duty is to be discharged --

A. Yes.

Q. -- in 4(2):

"The administering authority shall make arrangements ..."

So it is a mandatory requirement:

"... for the home to be visited at least once in every month by a person who shall satisfy himself whether the home is conducted in the interests of the well-being of the children and shall report to the administering authority upon his visit and shall enter it in the record book ..."

A. Uh-huh.

Q. Then Schedule 2 in terms of the records that were to be kept is also in mandatory terms. You do make reference to the fact that the events of importance, which was the second element in the schedule, was not being kept.

A. Uh-huh.

Q. But what I want to show you -- you touch on this in your statement in a different way about what the consequences were of not being registered. I was talking to you about the 1968 Act.

A. Uh-huh.

Q. You were saying it wasn't necessarily something

inspectors would walk around with in their briefcase, but HIA-379, if we can look, please, at what is section 127(4), which says:

"Where at any time it appears to the Ministry" -- now the Department -- "that the conduct of any voluntary home registered under subsection (1) is not in accordance with regulations made or directions given in that behalf under this part or is otherwise unsatisfactory, the Ministry may, after serving ... notice ... remove the home from the register."

Then subsection (5) deals with the penalties for when someone carries on despite not being on the register --

A. Uh-huh.

Q. -- but the legislative framework is this must be done --

A. Yes.

Q. -- and not only does it seem it wasn't being done, but no reference is made by the regulator about the fact it's not being done.

A. Uh-huh. I have acknowledged in my statement to the Inquiry that this should have been covered in the recommendation. I am saying that the importance of the regulations was discussed with SR143 and within a year we saw evidence of compliance, maybe not to the full extent, but certainly they took on board the

recommendations that we did make and matters discussed with them.

I think subsection (4) would seem to me to refer to circumstances where there was consistent refusal or unwillingness to comply with the regulations, and we did not -- we never found that attitude in the home.

Q. Well, I will leave it to the Panel to decide what subsection (4) says.

A. Yes.

Q. It's regulations not being complied with. They are not being complied with here. You have explained that there were improvements thereafter. Indeed, you mention that further on.

Was there no thought at the time about in addition to recommendations imposing conditions? By that I mean, "If you do not put in place a voluntary visitor, if you do not have that voluntary visitor providing reports, if you do not make those reports available to us as part of our inspection function, then it is not going to be possible for you to continue to be on the register, because we can't properly satisfy ourselves that you are properly running this home".

A. We tended not to wield a big stick. What we did was we issued reports in final form, asked the administering authority to confirm they accepted the recommendations

and to indicate to us the time frame within which they planned to implement them. That was subsequently followed up with them.

Now it was not our experience -- well, it was not our experience that the recommendations were not accepted in principle, and generally people made a reasonable effort to comply. Certainly conformity with the regulations was an imperative. There is no question about that.

Q. You make 19 recommendations in the report, Norman. Those are at 50524 and the following two pages, but they don't appear to -- in your first document you are very clear about this need for team work and the need for appropriate access to be given to files, appropriate contribution to be made to files, appropriate contributions to be made to reviews. We have dealt with the voluntary visitor aspect, which isn't there either.

Why do those type of things that would have then perhaps forced the home to react -- because you have got this list of recommendations. Simply put, "You have got to let the staff contribute to the case files". It would be very easy then to check: well, are they doing that? So why did those type of things that were of concern for you in the body of the first version not in the end form part of your recommendations?

A. One -- I mean, given where this home was at the time we visited, there is no doubt one could have multiplied the number of recommendations that were made, particularly in various areas of the practices, the childcare practices within the homes.

My own view then and later was that one should confine recommendations to matters that simply had to be complied with. I would have taken the view that in addition to that one can then make other suggestions, matters for consideration. I found that it was overwhelming and intimidating to be constantly producing lengthy lists of recommendations year on year. So my own preference was to focus on the critical issues and beyond that seek to encourage good practice, and I think that was more acceptable to people.

Q. Norman, I am not -- whether it was acceptable to people or not, is it not a disservice to the people who need to run the home properly for you not to tell them all the things that you consider to be needing dealt with?

A. What I am saying is that the imperatives must be contained in recommendations and other matters which will potentially contribute to good practice need also to be contained in reports and become the subject of ongoing discussion.

Q. I am going to move away from the 1983 report --

A. Okay.

Q. -- and I am going to deal with this next aspect very briefly. That is that you did -- were involved at least at the start of the 1984/'85/'86 correspondence that went on between the Department and the Eastern Board about going in to investigate child practice issues versus individual complaints.

You I think were involved -- was it the NL157 complaint you were involved with?

A. My only involvement in that connection was in relation to NL157 , which was a relatively straightforward issue.

Q. That was using the soap in the mouth?

A. Yes, and a couple of other -- the use of food that had been donated at the end of trading.

Q. I think that was three complaints that had come from --

A. That's right, and the use of the cloakroom for time out.

Q. -- that were looked into. Were you aware then of the various further individuals and complaints that were referred --

A. I don't believe that I was and certainly I wasn't involved in the discussions and deliberations and correspondence which took place subsequently. I didn't have any involvement in that.

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 --

A. Uh-huh.

Q. -- this gentleman, NL269 , who worked for a short period in the Nazareth Lodge, the reason for him coming forward -- it's in another document -- is explained as he raised his concerns in the home with the Superior, felt he didn't get anywhere, his concerns about the well-being of children. He then decides to resign. There is an inspection going on. He gets in touch with the Department, talks to Marion Reynolds, who takes a detailed note of what he had to say, and the point you make, and you go over this in considerable detail in your statement, that he rises essentially many of the matters that Marion Reynolds herself had discovered as part of her inspection process --

A. Yes.

Q. -- but you identify three areas in particular where he's raising things that Marion had not necessarily --

A. Uh-huh.

Q. -- for whatever reason. They didn't come to her attention or she was not aware of them or whatever.

In particular I am just going to show you, because we know then it presents a problem beyond this date, and that's in (iv) in the top right of the page on the right-hand side of the screen:

"One of the ex-residents, NL165, according to

another member of staff, had previously sexually abused a child while in care. He now frequently visited the home and had the run of the house."

So that's one of the three that Marion had not herself come across as part of the inspection process. The issue that arises here, it is referred to you and your handwritten annotation is:

"We need to get this from him in writing."

A. Uh-huh.

Q. Just cutting right to it, you know that subsequent to that I think Dr Kevin McCoy, who is going to give evidence later today, has made the point in his witness statement at paragraph 36 at 9144 that things didn't need to be in writing in order for them to be taken forward. If it was a serious matter, it should have simply been investigated.

A. Uh-huh.

Q. Before I get you to respond to that, the 1985 complaints document dealt with anonymous complaints. 19085, if we just can look at that for a moment, please, and then we will come back to the memo. 19085, paragraph 45. If you just scroll back up the page for me. Keep going a little. Yes. Just stop there, please. Norman, would you prefer that -- if we make that full screen --

A. Uh-huh.

Q. -- please, if we can, and just -- thank you. Now this is taking about the individual complaints of children and the mechanisms. There has been much debate before the Inquiry already about this particular process, which is to do with children's complaints, but:

"Anonymous complaints may be received. The fact that they are anonymous may reduce the weight attaching to them and the way in which they should be followed up ..."

So there's nothing in this document either that talks about the need for things to be in writing before they can be progressed.

If we go back then to the memo at 19071, please, do you want to explain -- can you explain to the Panel why you were coming from where you were coming from when you were saying to Marion, "Look, we can't do anything with this in effect unless he puts it in writing"?

A. The paragraph --

Q. Scroll down, please.

A. -- the paragraph that's just disappeared, which you read out a moment ago, I think it said it was a matter of judgment for the body receiving --

Q. Yes.

A. -- the complaint how it should be followed up.

Q. And a matter of weight.

A. Yes.

Q. Yes.

A. Where I was coming from was that a very detailed, thorough inspection report had been produced, which I assume I would have read before it was sent to the home. While -- there's absolutely no question that -- and this wasn't an anonymous complaint, but a complaint received from whatever source, which had child protection implications or implications for the welfare of children in the home, would have to be -- must be followed up.

It was clear to me a number of things. One is that a qualified member of staff, who had recently left the home, should have known that any complaint that he wished to make while in employment in the home had to be recorded. As a matter of good practice, therefore, he should have known that. I am quite sure he did.

For complaints to be followed up, they need to be specific, they need to be evidenced, and, if possible, corroborated. Now had he produced such a report, it would have added enormously to the weight of the complaint and potentially added another dimension to Marion Reynolds' already very substantial report.

So that is where I was coming from. That to me is not a matter of protocol. It's a matter of standard

practice. The police will not act on a complaint that has not been made in writing, or they will assist you to make a statement and sign it. If you choose not to, they will still take the information and presumably use it for intelligence purposes. The Commissioner for Complaints will only receive complaints in writing so far as I'm aware.

But in terms of the impact of this, it seemed to me that it was important that NL269 **, who had been there recently, should do so. Now had he done so, I think it would have brought to light matters which came to light a few years later when a member of staff did write a written report, which led to an investigation.**

So I am in no doubt now, quite apart from what I thought then, that this report should have been made in writing.

Q. I understand that.

A. Thank you.

Q. What I am asking you about is then the information that's conveyed, because for whatever reason someone mightn't be prepared to put it in writing, but he raises amongst many other issues which --

A. Yes.

Q. -- and there is on one view your corroboration, because

they are the same things as Marion has been finding, but he raises this issue, one of three, about NL165 and having the run of the place. This is late 1992 he is phoning or his work period is late 1992. He is phoning early 1993.

What was there to stop the Department in its regulatory role investigating whether what he had to say about an ex-resident coming back in, whatever "having the run of the place" meant --

A. Exactly.

Q. -- investigating, "Is that boy in the home? If he is, why is he there? If he is there, there had better be good reason for him being there". Why not have that question asked of the Mother Superior at the very least?

A. Perhaps you are inferring potentially or otherwise that nothing was done about it. My assumption today is that, knowing Marion Reynolds, she would have done so. She was exceedingly thorough in her work as is evident from the report.

Q. What we do know is that another month after this she wrote a letter to NL269 , telling him that unless he put it in writing -- essentially following what's in your note -- unless he put it in writing, it wouldn't be possible for her to take it forward. There is nothing on the Department files to suggest that it was taken

forward.

A. Yes.

Q. On one view she obeyed what she had been told.

A. Yes. I personally would have written the letter to

NL269 **a little differently. I would have explained to him why it was important that he provide some detail in writing of some of the things he was saying.**

Whether she was saying to him that she couldn't take it forward formally as a complaint on his behalf or that simply her hands were so tied that she couldn't discuss it with the Mother Superior, I do not know. My confidence in her would have been such that had she been concerned about this, she would most certainly have discussed it in the home.

Q. You were involved then, Norman, in the 1995 Judith Chaddock inspection. She is the -- you were the Inspection Manager, which -- I was checking with you this morning. That doesn't necessarily mean you would be there when she is doing the inspection itself, but you would be her point of contact and would check the report and so on as she produced it. Is that --

A. That's right.

Q. -- what the Inspection Manager role involved?

A. That's correct.

Q. As you know, she raised six issues as part of a series of trains that took off after her inspection through three different Trusts with different children and then her writing a letter of 11th December to the home itself. If we just look at 49392, please, she writes -- sets out to the Regional Superior the issues that she wants addressed. If we just scroll down to the bottom, please, you see she asks that you investigate --

"I ask that you investigate these matters further and that a report is sent to me in due course."

Now you say in paragraph 5.3 to 5.5 of your statement -- I will just show you that -- it is at 9167, please -- that she did -- it is essentially in 5.5 -- she did everything that she should have.

A. Uh-huh.

Q. It doesn't appear from the material that's available that a reply was ever received, or that the lack of receiving a reply was ever pursued, or that any consideration was given -- after this was dealt with through the Management Committee and the investigation that led to -- such as it was -- SR18 resigning --

A. Uh-huh.

Q. -- that there was ever any consideration then about, "Well, as the regulator in terms of the home being run in the best interests of children, do we now need to

have a look at this whenever a unit head has had to resign?"

A. Uh-huh.

Q. Did that type of analysing, thinking not go on within the inspectorate?

A. I can't comment on that, as you know. I left SSI shortly after this. So I wouldn't have known how the whole thing unfolded. All of the information in this connection I am quite sure was fed into the Childcare Branch of the Department, which was also the recipient for annual monitoring reports and all inspection reports. I would find it astounding if between the Childcare Branch and senior staff in SSI that they did not meet to look at the implications of this, but more than that I am unable to say.

Q. I am not sure -- I am just checking to make I am right about this -- I am not sure we found any documentation that suggests that happened. It is something we can take up with Dr McCoy.

A. I can assure you that I didn't see it. In fact, I don't actually have a vivid memory of Judith Chaddock having discussed this with me, though I take some credit for the correct action that she did take.

Q. I am not going to get -- the Panel has heard much evidence about the different mechanisms that seem to

have involved the thing being dealt with by the Trust rather than the Department investigating. I am not going to deal with that with you in respect of that today at any rate.

What I will do, if we just look at paragraph 6.4 of your statement, please, at 9169, you say this:

"It may be noted that overall Nazareth Lodge had made significant strides in promoting and developing residential social work practice during a period when the behaviour of many children and young people was becoming increasingly challenging."

Now do I take from that and the tenor of what you are describing that while it might have started from a low base, efforts were made to improve it and there is evidence that it did improve?

A. Well, what I draw a comparison in paragraph 6.4 and 6.5 is between the Mother Superior's statement that discipline problems do not arise to any significant degree -- that is in 1983 -- and then in 1994/'95 monitoring statement she lists behaviours which they were then having to deal with, which I would suggest did stretch the staff in the home considerably.

So here you had a home which moved from dealing with relatively straightforward children, perhaps not in the way we would necessarily have liked all of the time, to

coping with very difficult children. During that same period the level of funding increased. The commitment to the investment in staff training increased. There's a whole range of improvements which took place, and also, as I said this morning, when inspectors asked the Unit of Management for their views on the standard of care being provided prior to each inspection, they got fairly glowing reports most of the time, as recently as 1987 I think it was, when one Unit of Management actually went to the trouble of providing a statement in relation to each child.

So I do think that there were significant improvements over that ten-year period in what this -- in the way the home was operating, their attitude to social workers. The relationships with field social workers seemed to be supportive, mutually supportive, and so forth. So, yes, I do think it's fair comment to say they made progress.

Q. You will be very pleased to know, Norman, I am not going to ask you any more questions, but it is not over just yet.

A. Thank you.

Q. If you remain where you are, the Panel Members may want to ask you something.

A. Thank you.

Questions from THE PANEL

CHAIRMAN: Norman, I would just like you to turn to a topic Mr Aiken has not explored with you today, but which you have dealt with in your statement and also in your illuminating and helpful thesis, which I read parts of with great interest. If we could look at 9153, please, paragraph 1.6, where you say:

"Comparison of economic costs of voluntary and HSS board homes respectively indicated that in most cases the voluntary homes represent between a third and a half of the cost of homes in the statutory sector."

Do you see that passage?

A. Yes.

Q. Then you refer to a departmental circular HSS15(S)1/74. Do I take it that's a 19... -- it's the first circular of 1974?

A. I think so, yes.

Q. That would tend to indicate to me that there the Department was recognising there was this very significant disparity and saying there had to be some attempt to redress the imbalance. Without going into the detail, that's the thrust of what they point out?

A. Yes. There would have been a range of tensions between the two sectors, that being one of them.

Q. Yes, and then you continue:

"During the late 1970s the Eastern Board initiated a review of the per capita payments made by the Boards to voluntary homes. In 1982 the same Board made a deficit funding of £45,000 to Nazareth Lodge Children's Home and in 1983 the per capita payment was substantially increased."

That would suggest to me perhaps that whatever was being flagged up in 1974 by the Department, there still was a major problem nine years later.

A. Yes. I think that is what I am pointing out, yes. I mean, £45,000 at that time might have been the cost of employing three residential staff. The system at that time was that in the early part of the year the Board would have agreed a per capita payment based on a number of factors, one of them being average occupancy. The home then had to wait until the end of the financial year in the hope that if there was a deficit that out of slippage funds -- that was the system of public funding -- that they might get a final grant.

Now personally I think that the Eastern Board genuinely gave preference and consideration to voluntary children's homes that were in that position, but nevertheless as a mechanism for funding a business, which is what running a large children's home entailed, that was a weak position to be in financially, to run

the business in the hope that if you'd made a big loss, at the end of the year everything would work out well.

Q. Well, it reminds me of Mr Micawber sometimes.

A. Something like that.

Q. Yes. Then if we look to 9211, which is part of your thesis, you return to this question. You are now writing in a private capacity I appreciate entirely, but from the perspective of somebody who has worked in this sector and clearly has given a lot of thought to this particular issue, because that's one of the issues you are dealing with in your thesis. You say at 9211:

"It therefore appears that voluntary organisations are disadvantaged both in terms of their ability to finance the development of their services and that even the level of recoupment of their direct costs from Boards is insufficient."

Then you refer again to the same circular and you quote from it:

"'Boards will normally meet the cost of any services provided under any such arrangements -- under such arrangements. A prime example is the provision of places in voluntary homes on a contractual basis'."

Then this is your expression of opinion:

"It is therefore disconcerting to find such a disparity between the costs incurred in the two

sectors and that some organisations are still unable to recoup the total cost of the service they are providing."

So it would seem, looking at not just this home but the whole range of payments in voluntary homes, that eleven years after the circular there's still a significant disparity, which in turn creates problems about staffing and indeed the viability of these homes. Isn't that right?

A. Yes. I think that's -- that is what that statement indicates. It seems to me that in the Eastern Board and in relation to Nazareth Lodge in particular from about 1983 onwards -- and I think I say this in my statement -- that there were substantial increases. Then when one reads the reports in the late '80s and early '90s, it seemed to me by then they were -- they were adequately funded.

Q. Well, if we turn to 9248 of your thesis, you say:

"Weekly charges by voluntary homes in 1983 varies between £42 and £198 a week while the average weekly cost in three Health & Social Services Boards was £250 per week. The average cost of maintaining a child in homes in the Eastern area was £185."

Now you have just mentioned yourself a few moments ago that by I think it was certainly the early 1990s or

thereabouts there was a very significant increase in the per capita payment.

A. Much earlier than that. I think '83 onwards probably.

Q. Well, it went up by about nearly 60% to £450 a week in somewhere between 1988 and 1992 or thereabouts according to Felicity Beagon. I can't remember the exact figures, but it is something of nearly that order.

A. Yes.

Q. Now one way of looking at it is to say that if it happens in, say, 1992/'93 or thereabouts, nearly twenty years has gone by since the Department identifies this problem of underfunding in terms of per capita payments to voluntary homes, and it takes nearly twenty years before the gap ceases to exist. Is that a fair way of putting it from a broad perspective? I appreciate there are all sorts of issues along the way. There's a very striking passage you have about limitations in public funding in 1983, which sound all too familiar thirty years on.

A. The 1970s, when inflation was very high, was obviously a very difficult period for all public bodies, and I think the Eastern Board, like all others, would have been constrained in the additions they could have paid during that period, but yes, there was a gradual progress. I do think that the Eastern Board, they did

commence looking at this, because it was a very confused situation I think in the '70s, but they did set about trying to rationalise it and gradually in the 1970s into the early '80s and then in the '80s substantially increase payments.

Q. Yes. Thank you very much.

MS DOHERTY: Thanks very much, Norman.

A. Okay.

Q. I just wanted to ask -- I mean, clearly you came to SWAG with experience of residential childcare.

A. Yes.

Q. What was your induction into the role of being a social work adviser?

A. As far as inspections is concerned, I remember shadowing a couple of experienced inspectors in the early months that I was there.

Q. And is that when you moved over to SSI as opposed to being the --

A. That transition was I think in 1986.

Q. But the shadowing, was that in relation to the SSI role or to the --

A. Oh, that was in the first months when I joined the Social Work Advisory Group.

Q. Okay, and subsequent to that, I mean, did you get -- you know, just thinking about regulations and things like

that, were they handed over to you and said, "You know, this is what you need to be inspecting against" or ...?

A. Rightly or wrongly, there might have been a presumption that I knew about them, but yes, when we were -- when I was going out with other inspectors, we would have been -- we would have been well aware of the regulations, and I think we probably had a pro forma that we referred to in that connection.

Q. Okay. Just if you could explain a bit about the supervision of work. So you have got the inspectors doing inspections. There's a Managing Inspector, who may or may not be part of it, but will look at the recommendations and look at the report. If there's a difference of view between a Managing Inspector and Inspector, was there a procedure for dealing with that?

A. I don't know there was a procedure as such, but the lead Inspector, the Managing Inspector, would have gone through reports in great detail. If they were unclear about something or if they had concerns about something, that would have been discussed. Personally I don't remember ever the substance of my own reports being challenged and changed as a result of discussion. I'm not saying that I didn't receive assistance at times.

Q. We heard from Marion Reynolds. I mean, she was pretty clear that she didn't agree with your advice about the

complaint had to be put in writing. When I asked her could she have escalated that up, her response is, "That wouldn't have been done". Would that be your view as well, that within the organisation differences of opinion would be kept to the immediate manager?

A. I would have hoped she wouldn't have had to do that. Had she said to me, "Norman, I don't accept that. This is not good practice" or whatever, I would then have probably discussed it -- what year is this? '93 -- I would then probably have discussed it with Dr McCoy. I mean, I would have taken it to him or we would have taken it to him and we would have looked at it.

Q. But you can't remember any of that --

A. I don't remember that having happened, no.

Q. Okay. Thank you.

A. Thank you.

MR LANE: We have heard Castle Priory being quoted as something to calculate staffing by. Was that ever formally adopted as the criterion, the set of systems to use?

A. I don't remember it being formally adopted. It was what I had been brought up on, as it were, in Barnardo's. So I was familiar with it. I think it was also the formula which the Eastern Board would have used as their guide. I don't also either remember any discrepancy in the

Department's attitude to the use of it. I don't remember that ever being an issue.

Q. So in inspections that's one of the things that would have been used as a tool to test whether the staffing was adequate?

A. Yes. Even by the 1970s that was the gold standard, as it were.

Q. Okay. Thank you.

A. Thank you.

CHAIRMAN: Well, Norman, thank you very much indeed for coming to speak to us today. That has been very helpful, and, as we have perhaps clearly indicated, there is a great deal of material in your statement and in your thesis which is very helpful to us and which is not easily found elsewhere. So we are very grateful to you for drawing this to our attention. As Mr Aiken said, I am sure you didn't think when you were writing it thirty years ago that you would find it brought up again in this context, but thank you very much for coming today.

A. Thank you very much.

(Witness withdrew)

MR AIKEN: Chairman, Members of the Panel, there is one further witness today. If we take a short break, it probably won't be too long before I am in a position to

commence with him.

CHAIRMAN: Yes.

(3.30 pm)

(Short break)

(4.00 pm)

DR KEVIN MCCOY (called)

MR AIKEN: Chairman, Members of the Panel, the next witness today is Dr Kevin McCoy. Kevin is aware, Chairman, you are going to ask him to take the oath.

DR KEVIN MCCOY (sworn)

CHAIRMAN: Please sit down.

Questions from COUNSEL TO THE TRIBUNAL

MR AIKEN: Kevin, coming up on the screen in front of you will be the first page of your witness statement at 9136, please. If you just can check to make sure that is the first page of your statement.

A. That's correct.

Q. If we go through to 9146, please, which should be the last page, can you confirm you have signed it?

A. Yes, I can.

Q. And you want to adopt the contents as your evidence to the Inquiry?

A. Yes, I do.

Q. You have explained in your statement you were -- if you just give me your date of birth first so I have it for

the record.

A. 1940.

Q. 1940?

A. Yes.

Q. Okay. You worked in Down County Welfare between 1963 to 1972.

A. That's right.

Q. Then you went into SWAG in '72. Was that when SWAG began, in effect?

A. More or less, yes. It was just around the time of reorganisation from local government into the Health & Social Services Boards.

Q. You were a social work adviser for a year and then became a senior social work adviser --

A. That's correct.

Q. -- in 1973. Then you did that role for thirteen years until SWAG became the Social Services Inspectorate --

A. That's right, yes.

Q. -- in 1986, and then you became the Assistant Chief Inspector. Does that mean -- the senior social work adviser, was that effectively the same job title as the Assistant Chief Inspector?

A. It was basically the same grade and the same roles were carried forward into -- the roles changed as we became an inspectorate, moving from an advisory role more to

an inspectorial role.

Q. Then in 1989 you became the Chief Inspector, replacing Pat Armstrong --

A. That's right.

Q. -- of the SSI. You did that for eleven years before retiring in 2000.

A. That's right, yes.

Q. Then you were involved in an equivalent or a similar process to this one in the Republic of Ireland.

A. That's right. I was there for two and a half years on the Confidential Committee of the Commission to Inquire into Child Abuse.

Q. As you know, in order to -- you have many years spent working in the field that we are looking at. In order to reduce the amount of time that you spend in the witness box being questioned by me I will try to go straight to the core issues. The Panel have had the opportunity to read your statement.

What I wanted to do was to cut right to the chase with you and give you the opportunity to say what you were saying to me earlier. In very brief terms you explained the context of moving from a more informal approach to inspection to a more detailed approach to inspection post-Kincora. Do you just want to articulate to the Panel how that developed?

A. Yes. Prior to the developments around the Kincora institution the approach to inspections and visits had been a rather informal one. Sometimes there were reports; sometimes there weren't. When the Kincora issue broke, then the Department decided to mount a more formal approach to inspections and decided to have every children's home inspected. It wasn't until 1986 that -- after the Hughes Report that it was decided that every home should be inspected every year. So we had a round of inspections first and then annual inspections thereafter.

Q. It appears -- and Dr Harrison has set them out for the Inquiry -- there are missing files unfortunately -- it appears that the type of inspections being carried out by Miss Forrest and Ms Wright and Dr Simpson may well have been conducted in Nazareth Lodge, those type of more informal type inspections as you are describing under the 1950 Act and then the '68 Act, but the change in approach really came in the aftermath of Kincora and the Sheridan Report and the inspection -- or the development of a more rigorous inspection system began at that point.

A. That's correct, yes.

Q. The -- one of the matters that -- again you explained it in a particular way to me and I will ask to do that for

the Panel. Just cutting right to it, one of the things that cuts across a lot of the homes we have looked at so far, and which is prevalent in the particular report we were looking at with the last witness in 1983, is the fact that the regulations imposed a mechanism of a voluntary visitor system with a person appointed to check specifically was the home being run in the best interests of children and to provide a report to the administering authority on a monthly basis, so that in theory that would be available to the inspectors every time they came to look at the home.

That mechanism doesn't seem to have been either operated at all or well operated, but it also doesn't seem to have been a feature at this point in time of the regulator saying, "Hold on a minute. You're supposed to be complying with the regulations in the following way. You are not doing it. You need to sort that out".

You were saying to me that at the time it was not necessarily using regulations to force people to do things, but just trying to get them to. Can you just explain in your own words that phase of not necessarily using regulations as a weapon, but trying to get homes to improve?

A. Yes. I think clearly the homes were registered on the basis of the regulations at the particular point in

time. Our inspections post-Kincora actually began to focus more on the practice issues and trying to ensure that the practice was improved within the homes and that in turn benefitted the children who were resident in those homes. I think there was less emphasis on the regulatory activities or the regulatory sort of functions of the Department as such and really didn't feature very highly in terms of whether a home was confirmed as being registered or its continuing registration.

Q. Did your part of the Department feature in any registration reviews? Were there registration reviews you know of and who was doing them? Was that more in the Childcare Branch, if they were happening, or had you a part to play in that?

A. Well, our part would have been to conduct the inspections and to produce the reports and then submit those to the Childcare Branch for their consideration. I cannot recollect whether, in fact, there were any formal discussions about continuing registration of a home based on our inspection reports.

Q. So there was no mechanism -- you don't have a recall yourself of having done them even informally, but there was no formal mechanism for, "Right. We are going to reconsider, look again at, reflect upon in light of your

report and a discussion with you about whether registration remained appropriate or not"?

A. No. There was no formal mechanism once we had conducted an inspection to go to the branch and say, "You know, there are issues here. You had better sort of look at the registration of this home". That mechanism really didn't exist.

Q. You were explaining to me earlier, Kevin, that that thought of deregistration was not really part of the mindset of the Department in this period of time we are looking at.

A. No. I think I would describe the approach of the Department to the voluntary childcare sector as very benign in the sense it was attempting to be very helpful and supportive and ensure that it developed in an appropriate way in accordance with modern standards at the time. That was partly because of the high dependence on these homes by the Boards who were placing children.

Q. We were talking earlier -- just cutting right to it, you looked at me and said "Necessity". These homes were needed, because places were required, and not having them would have meant Boards having to find provision that they didn't have themselves.

A. Very much so in the sense that if you take Nazareth

Lodge with its 30-odd places, as it were, if it was to be closed, as it were, very rapidly, then it would have left the Boards with a massive problem in terms of how do you sort of find placements for 30 plus children in a short space of time? That I think would have been a major problem for them.

Q. In addition to that -- something that the Chairman was discussing with Norman a short time ago -- presumably it's a voluntary organisation. It is used to provide this service and the Boards then choose to avail of it, but the cost of providing it themselves appears to have been significantly more than it cost to pay the voluntary organisations to provide the care.

A. Indeed, yes.

Q. Is that what lies at the -- you are aware from listening to what I was asking Norman you have got a first version of a report, which I understand you didn't know about until today --

A. No.

Q. -- which is much more obviously critical, without being unfair to him, than the final version of the report, and he was explaining that it was more about encouraging along, and you have said it wasn't about deregistering, using a stick as such. Is bound up in that the -- that there wasn't much alternative -- there wasn't an easy

alternative to these homes existing, because to remove them and provide the alternative was going to cause a major time delay and cost a major amount of money that just wasn't necessarily available? If I am not characterising that in a fair way, I want you just to explain it to the Panel --

A. Sure.

Q. -- as you saw it.

A. I don't think it was as explicit as that in a sense. It wasn't really thought through in that way. We were certainly conscious of the fact that the voluntary sector were making a massive contribution to residential childcare services at that time, and because of that contribution and our wish to ensure that the service to children was improved over time, then we would have been encouraging and supportive, helping them in whatever way we could. Rather than sort of, as I said earlier to you, using the big stick we were trying to use the carrot to help them along.

Q. On that subject -- I am not going to get into the detail of the funding -- you were talking to me earlier about how -- the way Boards were funded was essentially a block grant of a certain figure and what they then did with it to provide the services they had to provide was a matter for them thereafter.

A. Yes.

Q. Was the Department directly funding in your time the likes of Nazareth Lodge or was it money was only coming to them really via the maintenance fees that the Board were in a position to pay and any -- we saw a 45,000 lump sum being put in by the Board for what they called deficit funding. Was the Department themselves paying in a particular way into the voluntary home?

A. The Department -- certainly at one point in time the Department provided capital funding --

Q. Yes.

A. -- to the voluntary sector. Now how long that continued for and if it ceased, when it ceased, I don't know.

Q. I think we might have found that in one of the files that unfortunately isn't available --

A. Right.

Q. -- much to my frustration, if it's not apparent.

The inspections that were taking place in the '80s before the SSI and indeed after the SSI began, the concept of recommendations at the end as opposed to conditions, which I think would be more what's done today with RQIA --

A. Yes.

Q. -- and you used the phrase to me a few times when we were speaking earlier about "the blizzard of

recommendations" when I was saying to you, "Well, why didn't it say this, this, this and this as opposed to the much more shortened version than might have been capable of being produced out of what was actually being found?" Can you just explain to the Panel the approach to recommendations and why they were perhaps shorter in number and not perhaps as in your face as I was suggesting they might have been?

A. Yes. I think it's this balance between being extremely critical of an organisation and, as I said, hitting them with a blizzard of recommendations, you know, a long list of recommendations, as opposed to giving them a shortened -- a certain list of recommendations, which one would hope would make a difference to the care that children were receiving. If they were able to implement the recommendations that we had made, which were the most significant ones, then the care of children would improve through that mechanism.

Q. The point you were making to me earlier was that in the -- the home would also know that if they got 15 in this year, that you were coming back and there'd be, you know, the next 15, and they'd essentially improve over time, which I think was what Norman was trying to explain, this idea of -- you and I were debating the appropriate word for it -- encouraging along --

A. Yes.

Q. -- the organisation to get better as opposed to constantly striking them on the head for failing to do something.

A. That's correct, yes.

Q. Is that an accurate summary of the general approach that was taken to the issue of problems that were identified and recommendations to improve them?

A. Yes, I think it was. It was this very supportive approach that we were adopting and helping the organisation to improve rather than sort of I suppose being so critical of them that, you know, they reacted to it in a negative way.

Q. I think you said to me you weren't yourself involved in the 1983 inspection --

A. No.

Q. -- or being a Management Inspector in relation to it. I was saying to you, given the difference between the two documents, I would like to see the drafts of all the other inspection reports, which unfortunately aren't available either, but when you look at the two documents, the message between them -- I am just going to deal with it at this general level -- there's a major disparity on one view in the message that you get. One is, "This is really not in good shape with significant

issues, including one of the three units not having a suitable member of staff at the head of it". When you come to the final version, the message it conveys is on one view very different.

Is there not a danger in that approach that if you're not sharing with the home that you're looking at what you really feel about it or see about it or are concerned about, that the chances of them improving as quickly and as well as perhaps they should or you would want them to is diluted? Do you understand what I mean by that?

A. Uh-huh. Yes.

Q. By not telling them it straight, as it were, as directly or in as fulsome a way that their opportunity for getting better is or their understanding of where they're getting it wrong is perhaps less than it should be, if the regulator isn't saying explicitly what it's finding. Do you understand?

A. I do. I appreciate the point you are making. I think it is this striking this balance of being ultra-critical and making recommendations which you know that can be worked upon by the organisation and improved in that way. You have got to think of this process as a bit of a journey for the homes. They had a very informal approach up until 1980. We became much more formal in

our approach and that in itself was quite a difference of approach that they had to absorb, and as with most of the childcare services, both statutory and voluntary, there was a journey undergoing in terms of improvement of the standard of care for children.

Q. Well, you had the opportunity to read that raw version, if I can describe it in that way, of what Norman actually -- his first go at expressing what he found when he walked through the doors for these three days of Nazareth Lodge and what he found in respect of the three units.

When you read that now, today presumably those type of findings would be dealt with in a very different way from they were dealt with in 1983 --

A. Yes.

Q. -- or even looking towards the end of your time, they would have been dealt with very differently at the end of the '90s than they were dealt with in 1983?

A. Yes. Just as homes were on a journey, we too in terms of inspections were on a bit of a journey and our methodology and our approach improved and got better and at times got stronger, yes.

Q. I suppose the question that flows out of that first document, as it were, and I asked of this Norman, when you read it, is that somewhere that, you know, is

satisfactory, you know, that you would have wanted to put children? Have you a view on that, having read it? I appreciate you are only reading it today. As you read the content of it and the type of difficulties he is expressing, is that a satisfactory set of circumstances that were having children placed in?

A. My reading of it -- as I say, I have only had an opportunity to read today --

Q. You have just read it today.

A. -- certainly there were highlight -- certain practice issues were highlighted which indicated that practice was not up to scratch in some respects. That said, I think I did say to you that there was no indication that this was a wholly abusive regime that was in place within Nazareth Lodge --

Q. Yes.

A. -- you know, and I explained to you what I meant by an abusive regime.

Q. Yes. I am going to show you -- you deal with that in paragraphs 18 and 21 of your statement at 9139 and then it moves on to 9140. You make the point that in none of the reports:

"On neither occasion ..."

This is the reference to '83 and '86, and unfortunately the '86 version we don't have either the

draft or the final one to my knowledge:

"On neither occasion was there any adverse comment about the harshness of the regime."

I think you were able to say, "My reference to the '86 report comes from a memorandum" that you wrote "as opposed to having access to the report" --

A. Uh-huh.

Q. -- "in June of '86". The record is the Sisters rejecting corporal punishment.

Then in paragraph 21 you talk about the Department not being aware from its visits and inspections that there were major concerns about the type and quality of care being provided.

Now the first aspect certainly, paragraph 19, you are talking about the attitude towards punishment for behaviour --

A. Uh-huh.

Q. -- and, as I understand it, when you are talking about "harshness of regime", that's what you're meaning in that corporal punishment wasn't approved and you weren't getting complaints of children being physically abused in the way the Inquiry has heard at times prior to this and indeed unfortunately subsequent to it.

A. Uh-huh.

Q. But in paragraph 21 you are going a little further about

raising concerns about the type and quality of care. Now obviously you wrote that without being aware of the document you got to see today, which was that first version of the 1983. I asked you just to have a look at that to reflect on what you had said here.

A. Uh-huh.

Q. As you look back on it now and having reflected on that document, was it not showing that there were major concerns about the type of care being provided or the quality of the care being provided, albeit there was not harshness of regime in terms of the punishment mechanisms that were in place?

A. Yes. The report -- the initial report, which was produced following that inspection, did indicate that there were certainly concerns about the practices -- some practices within the home. As I said, when I was writing this, I was not aware of that report. So ...

Q. In fairness I was just drawing your attention just before you came in -- we have been pouring through the departmental files that there are. Something that we are coming on to is the -- it is a proper blizzard, the blizzard of correspondence between the Department and the Eastern Board over individual complaint versus Department investigation. It is probably something that will continue beyond this module, but if we look at

52240, this is a memo I didn't have to my hand when I was dealing with Norman, but it is written to you, but from Norman, as we will see. It is 4th April 1984 he meets with DL 518 . This seems to be over the complaints or practice issues that were emerging to do with various children in the 1984/'85/'86 phase. We will look -- you have a memo that summarises that -- shortly.

If we move to the second page of this and the last paragraph, in fairness to Norman Chambers he is recorded as saying:

"Mr Chambers has made DL 518 aware of the major concerns about the home following the SWAG inspection of October 1983. These do not include unacceptable methods of discipline."

So it appears -- I was asking you -- it is very difficult at thirty years' remove -- but it appears he was making him aware that there was a major concern about Nazareth Lodge, but that major concern, such as it was, didn't include a discipline issue in terms of how staff were disciplining children. Is that -- do you have any recall about that now when you see that document?

A. No. I sort of -- wouldn't sort of say I remember the document at the time, as it were. Having seen it now,

it is clear that it didn't include the unacceptable methods of discipline. I can't recollect now the major concerns which Mr Chambers had identified about the home, but I think they were relatively small in number. It wasn't an extensive list of concerns identified at that time.

Q. You may have been talking to him about the type of material that's in that first --

A. In the first report. That could well be the case.

Q. -- first report or indeed characterised differently but in the second report, but the point that seems to come out of this is such -- whatever those concerns were, it wasn't -- it hadn't been findings about difficulty with how the staff were disciplining the children.

A. No.

Q. Then begins a -- I will just set the scene for it. In 1985 the Department issue what becomes known as HSS(CC)2/85. I presume "CC" means circular of some kind?

A. It could be "Childcare", something like that.

Q. Childcare. 2 of 85. So there's some missive that has come before it, but it is "The Provision of Information to and a Complaints Procedure for Children in Residential Childcare and their Parents". It begins for the Panel's record at 19080. There is a copy of it.

You didn't have any involvement in the drafting of it that you can recall?

A. I can't recall. I may have been, you know -- had an opportunity to make some input into it, but I can't recall being involved.

Q. It would have been more in the Childcare Branch that it was developed and dealt with?

A. Yes. The Policy Branch would have taken the initiative in moving this forward.

Q. I think you address it in paragraph 15 of your statement, if we look at 9139, please. You begin and you refer to how it has come about and you refer in your statement to various paragraphs of it, but what I want to have -- you to have a look at with me, Kevin, is you write a memo in -- it was June of 1986 --

A. Yes.

Q. -- the typed memo. If we can bring up, please, 6957, and you are setting out in considerable detail a summary for Pat Armstrong of how this issue over the course of two years has played out between you and the -- not you -- the Department and -- although it might have been you to a significant degree -- but you and your colleagues and colleagues in the Eastern Board, and the various issues that have arisen.

I think that first part is about NL157 .

Then if we scroll down a bit, there's the problems with HIA210 and SR62. I was explaining to you today we are now aware of things that you wouldn't have necessarily known at the time --

A. No.

Q. -- which is that she came to be moved as a result of or taken away from childcare as a result of a member of staff talking to another Sister, who talked to the Superior, who then moved SR62. That's not something that seems to have ever been communicated by them to the Board or to you.

You have got the HIA210 complaint. Then if we scroll down, I think there's the NL145 complaint. Of course, one of these initiated with a former member of staff, , speaking about it. Here in paragraph 7 you are talking about Bob Moore submitting reports relating to NL157 and again it involved SR62. Then the toing and froing of correspondence that there is.

If we just scroll down a little further, please, on to the next page, that's then in paragraph 11 in April of '86 Mr Moore raising the issue of NL97, who was another person who claimed to have been assaulted by SR62.

Then it seems that there was communication to the

Mother Superior of the home, asking her to let you have some indication of the progress of her investigation. So a step being taken in terms of writing to the home and saying, "What can you -- what can you tell us about these things?"

If we scroll down then, I think it records that the reply from her ultimately was to say SR62 had rejected the allegations against her; that the policy of the Order, which doesn't permit any physical abuse of children, is rigorously adhered to."

So even in that reply it wasn't telling you -- this is a different issue that the Panel will reflect on -- the reply wasn't explaining, "Oh, yes, in fact, we had to move this lady from being in charge of the unit because ..." You are being told, "No, there's no issue here".

Then you sum up the -- in paragraph 14 there's three children in the care of the Eastern Board placed in Nazareth Lodge and what they allege.

"The Board 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. Instead they are calling for an investigation by the Department and the administering

authority."

If we just scroll down, you then set out the potential way ahead, if we just scroll down a little further, where you are giving them the options that are available as to the types of inquiries that could be conducted.

You then conclude at 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."

If you just scroll down, we can see the date of that.

So this toing and froing has gone on over the course of two years. Trying to cut through it, as you look back on it now, why not just -- they are complaining to you and saying, "There's a problem here. We're concerned". Obviously the thought process must be, "It is not just confined to this child". The Department is replying, "It is confined to the child. Just deal with the complaint".

Did the thought never occur, "What if this is happening to more than just the child who is making the complaint? Should we not have a look at this?"

A. There were three children who made complaints against one member of staff. As I said, we had conducted an inspection in 1983 and we did not find any sort of serious concerns about the regime that was applicable within the home, and our view was that the Board who had placed the children there should then make sure that the standard of care the children were receiving was of a good enough standard and should have looked into that themselves. That was basically it. It didn't -- it didn't trigger off in our mind that there should be some other form of investigation, as you -- well, the Board certainly didn't make any -- give us any indication as to what sort of investigation or what the outcome of an investigation they were expecting to obtain over and above our annual inspections or inspections which were taking place.

Q. Did nobody at any stage -- I think you were in two buildings on the same site. There was Castle Buildings you were in I think and they were in Dundonald House or vice versa.

A. Not at that time.

Q. Not at that time.

A. We were all in Dundonald House.

Q. Right. You were all in Dundonald House?

A. Uh-huh.

Q. Did nobody get together, get round the table, "What's going on here?"

A. Well, I did speak to Mrs Brown, who was the principal officer in the Childcare Branch at the time, and we agreed that this was the way forward.

Q. No, I know that, but I am saying the Eastern Board clearly --

A. Ah! Sorry.

Q. -- wanted the Department to do something.

A. Uh-huh.

Q. You are saying you weren't clear about why they wanted you to do it. At no stage did everybody not get round the table and have it out and get a -- I think Norman postulated this, not having been involved in it -- get everybody around the able and find a solution, because the Eastern Board clearly for some reason you are unclear of wanted the Department to act in a way they felt they couldn't act. On the other hand, the Department is saying, "No, we don't want to act in that way".

A. Uh-huh.

Q. Ultimately what's at the core of this is your point that the Board have a duty to make sure the child is appropriately placed. On the other hand, they are relying on you as the regulator who has registered the

home to take at face value that, therefore, it is a suitable place for the child to go. The only people who can deregister is the Department.

Rather than all the correspondence was there no thought to, "Right. Is there something we could do here or should you do?" beyond the batting backward and forward that was -- that's recorded as going on?

A. Yes. I think in this memo I did indicate that there should be a discussion with Mr Moore further up, if you can scroll up a bit.

Q. If we scroll up again. I am sure that's probably right in one of the options that's ...

A. If you can go further up again.

Q. Keep going up further. Yes. Just stop there. In paragraph 17.

A. 17. Mr Armstrong did offer to meet him to discuss the way ahead and -- yes, I was recommending that we meet Mr Moore and discuss the situation with him and take it forward from there.

Q. Is that -- can you remember is that ultimately what -- what became of it?

A. I can't remember.

Q. You can't remember. We will have to look a bit further into that to see.

Did that question that I was posing to try to

describe it in various ways to you earlier, and I am going to describe it again now, of -- so a complaint is made by a child who says, "This Sister hit me" or in this case you are describing you have got three who say that. Was there no-one in the Department saying, "I wonder are they hitting anyone else and I wonder should we find out even to satisfy ourselves that, well, they're not"?

A. Well, to some extent that was done in a sense. We had the '83 inspection. Then there was another inspection carried out in '86, and again that inspection did not find any sort of major malpractice within the home. That was recorded in the inspection report.

Q. So the answer -- what you are saying to me is, "Well, the set inspections served that purpose and it wasn't necessary to go beyond that". Is that --

A. Yes.

Q. I don't want to be unfair to you. You tell me if that's what you are --

A. I think I have difficulty in conceiving what additional information an investigation as such would have achieved over and above the inspections that we were doing, which were becoming much more comprehensive as we went along.

Q. You -- in 1993 you are aware this issue has arisen over the note that NL269 wrote to Marion Reynolds.

A. That's correct.

Q. You have just been very clear in your statement that that is something that should have been taken forward. In fairness to you you have highlighted that. There's a letter in March of '93 that, if correct, would suggest it wasn't taken forward.

A. Yes. That's correct, yes.

Q. Your point is, writing or not writing, if it's a serious issue, you investigate it.

A. I would take that view, yes.

Q. I was asking you earlier how that would have -- you know, Norman Chambers' point was, "Better to have his statements so you're able to say, 'Aha! This man says this is what you did'". Obviously that would be preferable, if possible. So if that's not happening, which is this position, where we can't get out of him a signed statement for whatever reason -- correspondence not arriving at his door, not prepared to answer, whatever it be -- you have got a series of corroborative issues from him that matches what Marion has already found. You have got these three issues, one of which stands out because of subsequent events in terms of NL165. How would you have seen that being taken forward without his statement being something you could push across to the table to the home or the administering

authority? How would that have been done in practice?

A. I think, having looked at the record of the conversation that Marion Reynolds had with NL269 **, it was a very comprehensive note. It was very well set out, very thorough, and it clarified the issues that he wanted to be addressed. He subsequently -- she asked him to put it in writing. It appears he didn't do so, but I would have been happy enough if she had been taken -- taken the note of her conversation to the home and discussed it with the officer in charge of the home at that time.**

Q. And you regard that -- that's what should have happened?

A. I think that would have been a better way forward, yes.

Q. In 1995 then as a result of Judith Chaddock's inspection -- by this stage you are the Chief Inspector. So you are not inspection managing as such.

A. That's right, yes.

Q. You -- in paragraph 9 of your statement at 9137 you describe being brought to her attention what are said by you to be very serious complaints. The complaints that were identified by the Inspector were deemed to be very serious, and you would presumably agree with that. That's what they were?

A. Indeed, yes. I would have, yes.

Q. What then happens -- and the Panel has heard me with many witnesses going through -- a series of trains head

off, because Judith refers it to the various Trusts who had responsibility for each child and they begin their investigation. She writes a letter to the Mother Regional looking for a report back. Then you have the administering authority or the Management Committee -- there is a bit of a lack of clarity over that -- the Management Committee carrying out an investigation with a Board member pulled in as an independent representative on it.

The mechanism that it morphed into was using that complaints type approach that's in the '85 memo, and what flows out of the various witnesses, if I can just pull it together rather than bringing you the transcript to see, the various Board people were talking about it was unsatisfactory from their perspective, because they couldn't get the information that they wanted, because they didn't have the power to make the Management Committee give it to them. They didn't want to communicate it or share the report and they were chasing for material.

At the same time the Department have written and said, "Give me a report about that". There's nothing on the files that have been produced to the Inquiry that suggests a report was ever provided or that it was -- the fact it hadn't been was followed up to pursue, or

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.

Q. Is that not -- because we were having this discussion earlier about at what point do you reach the cross-over that the Department during this period of history didn't regard as having been met for it to be intervening?
I was asking you where you have a scenario where the behaviour of a member of staff is such that they have had to resign over it, is that not -- does that not cross the threshold then that would have the Department on the front foot as the regulator of this home wanting to look much more closely at, "Well, just how is this place actually being run?"

A. I think if we had -- if we had got a report from the panel which had been set up by the Sisters of Nazareth, then I think that would have triggered us into considering some issues in relation to the running of the home itself, but the fact that we either didn't receive it or we did not act upon it I can't comment at this stage.

Q. Another issue that you touch on I am just going to raise at this stage with you, Kevin. In paragraph 38 on 9145 you bring to the Inquiry's attention something that we publicly knew about, but also you raise a second issue, which the Inquiry has become aware of over recent weeks, and the question that you are raising and pointing out in your statement that you were raising at the time was,

"Why did we as a Department not know that someone had been convicted and sentenced for behaviour that included sexually abusing children in a home that we were regulating?" I don't think you ever got a satisfactory answer to why it had not come to the Department's attention sooner than you finding out in this way.

A. That's right. There was no record on file why this had happened in that way.

Q. I take it from your action, which was writing a memo saying, "Please find out", you weren't happy that, whatever mechanisms there were in place or simply no mechanisms in place, you weren't finding out something as serious as this at the time -- with an immediacy that it comes to light.

A. Yes. I would have expected that we would have been informed as soon as the allegations had been made and the investigation was underway by the -- I think it was the RUC at that time -- that we would have been informed as the regulator of the home. That would have been quite a reasonable expectation for us to hold. It wasn't until I think it was 10th August that I got a phone call from Mr Moore in the Eastern Board telling me that this had broken in the media. He didn't know about it. The home didn't know about it. We didn't know about it, and investigations had been going on for

several years. It just strikes me as being very peculiar and very odd.

Q. Just a lack of thought potentially on not considering who should be told about what.

A. But we didn't have the information. The information --

Q. That's what I am saying. You are saying that the police don't appear to have thought about telling you. There's no benefit to them in not telling you. It just appears on one view to have been it not having been considered. There wasn't a formal mechanism in place at that point in time to tackle this type of issue?

A. Well, there were police liaison officers appointed post-Kincora.

Q. Yes.

A. So one might have expected them to raise the issue with us.

Q. If they had been aware of it. So it may be --

A. Unless that means one part of the police wasn't talking to the other.

Q. That's why I say if they had been aware of it.

A. Yes.

Q. It is something we can take up, but you don't believe the police ever informed you that that was the position.

A. We had no knowledge of it until I got that phone call from Mr Moore on 10th August.

Q. Then you raise a second issue, which is the one that has come to the Inquiry's attention. If we scroll down, please, to the next paragraph, you draw attention in paragraph 41 and 42 about a second priest. That's Father Steele. It is something the Inquiry is going to look further into, but again the point you are making, this was not something that even broke in the media in terms of his connection to Nazareth Lodge. In fact, you now in terms of doing your work to come and speak to the Inquiry and looking at the inspections recognised his name as being one of the chaplains during the inspections.

A. Yes. He was recorded as being one of the chaplains -- one of two chaplains to Nazareth Lodge at that time.

Q. The fact that he has been also -- I think he is deceased as well -- that he was convicted of sexual offences against children, and the issue that that -- presumably you are raising, because that would have caused some consideration having to be given to, "Well, what effect would that have had on the home, if any?"

A. We don't know whether, in fact, any of the charges that he faced in 1996 related to Nazareth Lodge Children's Home or indeed if the later charges that he was faced with in 2012 I think it was, whether again either of those related to Nazareth Lodge or not.

Q. I am going to give a guarded reply to that at this stage to say my understanding is they don't, but it's something the Inquiry is going to look into further, but what I want to ask you is where that type of issue would have come to light -- let's say at the time it had been -- you had been made aware it might have been ten or fourteen years before there had been a four-year or five-year period where someone subsequently comes to light who was sexually abusing children -- was there any mechanism or would there have been -- what would you have done to check, okay, he is no longer in the home, but for those children who might have been involved with him during the period that he was there, how would that have been tackled, or is that something that never really arose to think about, because you didn't know?

A. No. Well, we didn't know. I suppose it would have resulted in a major discussion between ourselves, the Policy Branch and the Boards who had children placed there, as to the needs of the children who may have been abused by the individual. I don't know whatever happened to the children who had been abused by, say, Brendan Smyth, whether, in fact, they received appropriate services and counselling for the abuse that they suffered.

Q. Did the Department in terms of the Brendan Smyth --

because it obviously came to light at least to the Department's knowledge late, but not 2015. It was 1994.

A. Uh-huh.

Q. Can you recall whether there were any steps then taken about looking into those who might have been interfered with while they were in the home and connecting into them in some way about that?

A. No, no.

Q. Nowadays if that -- if this type of thing came to light, would there be that attempt to reconnect with the children who might have been affected?

A. Oh, I think undoubtedly, because the long-term effects of sexual abuse are well-known now, much more than they were in the past, and so there would be efforts made to ensure that people were receiving appropriate care and treatment.

Q. So it might have been more bespoke, creative response as opposed to necessarily having a rigid system set up to deal with this type of scenario?

A. Yes.

Q. Kevin, you will be pleased to know I am not going to ask you any more questions at this stage, although you did say to me -- and I am going to shock you publicly for this -- that -- I was asking you -- one of the points in our talk about carrot and stick was whether there had

been a home where a more forceful approach had been taken, and you were saying, in fact, that was the case in St. Patrick's Training College and I was saying we will be looking at it in June. So we may have to engage you again to talk to us about that.

A. Okay.

Q. I am not going to ask you more questions at this stage, but the Panel Members may want to ask you something. So just bear with me, please.

A. Okay. Thank you.

Questions from THE PANEL

CHAIRMAN: Can I just take you back to the events in 1986 that you were asked about? Perhaps if we look at 6960. If we look at -- scroll down so you can see 18b. As I understand what you are saying, when this matter was considered in 1986, you knew that there were three distinct sets of allegations by children in Nazareth Lodge.

The Eastern Board had said the fact that there were three had moved it from the specific to the general or the particular to the general and, as I understand it, the Department's view ultimately was, if I may perhaps summarise it, "This is a matter for the Eastern Board to pursue in accordance with the procedures in the circular and/or it may be a matter for the police, but it is not

a matter for the Department to investigate".

In that context you said, "Well, there had been reports of investigations the year before and the year after that didn't disclose any abusive practices". Am I correct so far?

A. There were two -- there were inspection reports --

Q. Yes.

A. -- in '83 and '86.

Q. Yes, that didn't disclose any abusive behaviour.

A. That's correct.

Q. Well, did the Department consider the other option -- the other inference, which was that the inspection somehow had missed these matters and that you couldn't rely on the adequacy of the inspection?

A. Yes. That is highly possible. Inspections are not the finest, shall we say -- let me put it this way. Inspection is a third line of defence in terms of the quality of the services being provided in residential centres. The first line of defence of quality is the administering authority who was running the home; the second is the Boards who are placing the children within the homes; and the third is the regulatory body, the Department, in terms of the inspections that we carry out.

Now there is very clear evidence from recent events

both in England and in the Republic of Ireland where inspections of services for people with intellectual disabilities have been carried out and subsequently there have been clear evidence gathered by undercover reporters about abusive behaviour within the homes. So the inspections -- if we take one in the Republic of Ireland, there was two inspections carried out within a year of that home. The first one was critical of management. The second one gave the home the all clear, and then several months later the television programme was aired showing thirteen -- more than thirteen staff abusing residents within the home. The inspectors could not have picked that up.

Q. Well, I appreciate the point you are making. The point I am asking you to look at is perhaps just a little bit different and it is this. Did the fact that there were three allegations, which appear to have some substance, whether they were ultimately established or not, cause the Department to reflect on whether its inspection procedures were as rigorous as they might be?

A. Well, we -- we certainly asked about it and we looked at the complaints that had been made by children and, you know, that was probably about as far as one can go during an inspection.

Q. You see, one of the things that might perhaps have been

considered was these are three complaints of the Eastern Board. Why not write out to all the Boards who may have had other children in Nazareth Lodge to say, "We have had these three complaints. Are you aware of any comparable complaints that might cause us to re-examine the relationship of the Boards as a whole and the Department with Nazareth Lodge?"

A. I think we turned -- we looked at it in a different way. We asked the Boards to give us sort of an indication about how they viewed the care being provided within Nazareth Lodge. We didn't seek information as such about complaints, but we asked them about the standard of care being provided for the children that they placed there, and generally -- I don't know whether that applied in '83, but I think from '86 onwards there was no indication that Boards were concerned about the standard of care which was being provided.

Q. Thank you.

MS DOHERTY: Can I just clarify as a follow-on are you saying you asked the Boards at the time of the inspections, '83 and '86, as opposed to when these three complaints were being considered? There was no kind of proactive at the time checking if the Boards had any other concerns?

A. Not in relation to these three -- when we got the

information of these three complaints, yes.

Q. Okay. Can I ask just when did the Department decide to let the Board see copies of inspection reports? When was that?

A. That was when we started the round of annual inspections in '86.

Q. What -- the kind of rationale for the change of approach, where previously they didn't get sight of the reports, what was the rationale for the change of ...?

A. I can't remember. It may have been on foot of the Hughes Report -- Hughes Inquiry report, and a desire to be much more open in terms of sharing the reports with the Boards, who were the users of the service.

Q. Asking the Boards -- we saw an example of a letter that went out to the Boards -- the Eastern Board asking about the -- their view of the quality of care that was given. Was that expected to inform the inspection agenda?

A. Yes.

Q. That's what I thought it was as well. The reason I ask is that the example that we looked at that Felicity put forwards to us, we had a case where there was an inspection on 12th and 13th January. This is 1988, and the letter isn't sent to the Board until 14th January, and then they send a holding reply at the end of January. Then the inspection report actually

goes out for accuracy at the start of February. The Eastern Board doesn't come back until the end of March. So the inspection report has gone without -- and the Eastern Board raised two issues which are significant. I wouldn't say they are overly serious, but they are significant. One is about the access that social workers have directly to staff as opposed to the Sisters in charge, but those issues, there was no way that they were going to inform the inspection process, given that they arrived after the inspection report went. Does that surprise you? Is that -- does that seem like unusual or ...?

A. Yes. I think the letters going out to the Board should have gone out prior to the inspection being conducted and the information then sort of considered in the context of the inspection.

Q. So that would have been a normal expectation, that consulting with the Board was to inform the process?

A. Yes, yes.

Q. Okay, and I don't suppose you have any view about the fact that it didn't happen on this occasion?

A. No.

Q. No. In relation to the difference between Mr Chambers about the whole issue about did the report need to be in writing, what we heard was a difference of view about

that, because Marion Reynolds said to us that she had the same view as yourself, that what was important was that there was a childcare issue. Would you have -- was that escalated to you? Do you have any memory of that?

A. No. I don't think it came to my desk at all.

Q. Would you have expected it to? Would that be the sort of issue -- where there's a kind of a child protection issue potentially. You have got somebody that's not prepared to put their views in writing for whatever reason, but they have identified a child protection possible issue. Would you have expected that sort of dilemma to come to you about, "Where do we go forward with this?"

A. Not necessarily. I had confidence in the staff who were there. There was no reason why they had to bring that sort of issue to me for reconciliation.

Q. Okay. Thank you.

MR LANE: You mentioned that you considered Nazareth Lodge to be on a journey I think was the phrase you used, improving stage and stage, and indeed the inspectors were on a journey as well. If, therefore, it was considered that the report needed to be toned down in some ways and focused on particular issues, because of what they could take at that time, was there a record ever of the issues you intended to take up later or not

in the report but with personal contacts or anything of that sort?

A. No. I think what we were engaged in initially was a complete round of inspections of all the children's homes in the province and then from '86 onwards we were then involved in annual inspections. So it would have been a fairly regular sort of approach we were adopting in terms of looking at the quality of the service on an annual basis.

Q. But you didn't have a note for your own personal use saying, "Next time we must follow up this a bit more, improve that area" or whatever as part of this journey you are talking about?

A. No. I can't recollect that we had a note on file that would have said -- given us triggers to include in the next inspection.

Q. Which means that something that was in this first version that we heard of, the immediate reaction to the visit as against the considered report, those issues would just have got lost, the ones that weren't in the final report?

A. Yes. They certainly would not have been recorded. Not to say they got lost, because they could have been picked up in the next inspection.

Q. But they would have been picked up if, say, you had

an Inspector who knew about the discussion before, but not if it was a new Inspector presumably?

A. True. Yes.

Q. One of the things that has been said is that while it was the Department's role to do the monitoring and the inspecting, it was for the local authority, social workers, to check that the children were getting a proper quality of care. So if that's the case, what sort of things would you have been expecting the social workers to have checked up on?

A. The social workers would have been there to conduct reviews of the children in their care and the care they were providing -- that was being provided for them within the home. They would have looked at their health, their education, their general well-being and the sort of facilities and the general ambience of the home.

Q. Would that have been through visiting the home and looking round and seeing what the facilities were like?

A. They certainly should have visited the home and talked to the children, engaged the children and the staff who were looking after them in discussions and consideration of their reviews.

Q. Thank you. In terms of the police, the discussion that there was there about whether the Department was

properly informed, did you personally as the Chief Inspector have a direct contact with the police as your normal liaison?

A. No, no, we didn't.

Q. Okay. Thank you very much.

A. Thank you.

MS DOHERTY: Sorry. Just one more question I forgot to ask. In relation -- I heard what you said that in talking to the Policy Branch, you wouldn't have had conversations with them about registration or deregistration of homes. You would give them the reports, but was there an opportunity where you came together and said, "Here are the general trends that are emerging about residential childcare in Northern Ireland. Here are some of the issues that the Policy Branch might want to look at"? Was there that sort of discussion?

A. I don't recollect having a discussion of that nature. I certainly remember that we did conduct some research into admissions of children to care and produced a fairly comprehensive report on that. That was done I think maybe in the early 1990s.

Q. Was that at their request?

A. No. We initiated that.

Q. Okay, but that's the only time you can think of where in a sense the general findings from inspection informed

the policy agenda?

A. Oh, no, no. There would have been ongoing dialogue between the professional staff and the Policy Branch.

Q. At a -- in a regular ...?

A. We worked in the same building. We were in offices fairly close together, and there would have been sort of quite a lot of informal contact.

Q. Okay, but nothing that formally sat down on an annual basis and said, "What are we finding from inspections?"

A. No, no.

Q. Okay. Thank you.

CHAIRMAN: Well, I am sure you will be glad to hear that we don't have any more questions for you, but I have to add the caveat today, because it seems from what Mr Aiken said a few minutes ago that we might very well be hearing from you again in relation to St. Patrick's Training School -- not Training College -- Training School -- I think "Training College" perhaps has implications of a clerical establishment -- because of what you have said in passing today about it being closed down, and the reasons for that are matters that we will want to look at, but thank you very much again for coming to speak to us today and for waiting to patiently for your turn to do so.

A. Okay. Thank you very much.

Q. Thank you.

(Witness withdrew)

MR AIKEN: Chairman, Members of the Panel, that concludes today's oral evidence.

CHAIRMAN: Well, because Monday was the Bank Holiday, we will, of course, be sitting tomorrow as scheduled.

(5.13 pm)

(Hearing adjourned until 10 o'clock tomorrow morning)

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