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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 Tuesday, 9th June 2015

commencing at 10.00 am

(Day 123)

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

Tuesday, 9th June 2015

(10.00 am)

CHAIRMAN: Good morning, ladies and gentlemen. May I just remind you that any mobile phones should either be turned off or placed on "Silent"/"Vibrate" and that no photography or recording is permitted anywhere within the Inquiry chamber or indeed on the premises.

Yes, Ms Smith?

Opening remarks by COUNSEL TO THE INQUIRY (cont.)

MS SMITH: Good morning, Chairman, Panel Members, ladies and gentlemen.

Yesterday I dealt with a number of pieces of material that we have in the bundle in relation to the home at Fort James. Now I did also when I was in my opening remarks make the point that one of the issues for concern for the Inquiry was the fact that there had been an allegation against a member of staff in that home by a resident, an ex-resident at the time the complaint was made. I am going conclude my consideration of the material and the paper by looking at what the material shows us about that.

He has been given the designation -- that's the staff member -- FJ5, and the police material relevant to the matter is at FJH30351 through to 308... -- ...388 and there is further material at 30832 to 30855.

The Inquiry received some further material from the Board on Friday last, which can be found at 30911 to 31070.

There is a statement from Shirley Young, which is at FJH478. Essentially Miss Young has examined documents in respect of the homes in question and has ascertained that the personnel file of FJ5 no longer exists.

Now I am just going to show a few documents which are not in terribly great condition, but hopefully I will be able to explain what they show.

If we can look, first of all, please, at 30913, you will see that this is a memorandum from Mr Newman to Rodney Carroll, the Director of Social Services, on 30th October 1980. It says that -- sorry. I think it is maybe -- just bear with me for one moment. The document I wanted actually to show is a different page reference to that, first of all. Actually it is this.

This is a document from Peter Newman to Rodney Carroll providing him with details of a dispute that FJ5 was having with , who were his previous employer. It sets out FJ5's employment record.

I am just going to remind everybody that while these documents do show the names of F... -- show FJ5's names and the documents will show the name of the child in question as we look at them later, those names are not

to be used outside the Inquiry chamber.

If I can read this, it is quite difficult to make out, but it says that:

"I am now able to provide you with further details relating to the dispute with FJ5 that FJ5 is experiencing with his previous employers.

His employment record with is as follows.

September 1972 - commenced employment with worked at a place in

July '74 - moved to at -- in

September 1978 - commenced a two-year" I think that's course at" -- I can't make out. I think it might be ".

MR LANE:

MS SMITH: . Thank you very much.

"... He was seconded by for this two-year period and the course ended in July 1980.

31st July 1980 - FJ5 terminated his employment with having given the required statutory notice.

31st August 1980 - FJ5 was interviewed by ourselves

for the post of -- at and he was no longer an employee of at that time."

For reference purposes his date of birth is given.

If we can scroll on down, please, it says that:

"FJ5 gives his reason for terminating his employment with as due to the fact that, despite advanced notice of almost one year, were unable to offer him a post in the field of therapeutic work with children, which he felt was commensurate with his experience and training.

He has explained this to on a number of occasions, but despite this, they have asked for a refund of the course fees and expenses amounting to approximately 2500.

I understand that the present position is that the situation has been referred to the Legal Department of I would be grateful if you would discuss this situation with the , who I understand is a Mr , to see if this matter can be resolved."

Then we see the follow-up to that at 30912, where Mr Carroll writes to on 10th December 1980 and says:

"You will remember some time ago that I telephoned

you regarding the above named. If you recall, the issue concerned his secondment agreement with your authority.

At the time of our conversation you agreed to consider my appeal to release him from his secondment agreement and to waive all fees, etc, which you may feel are due to your authority.

I wonder if you have had time to give consideration to this matter and I look forward to hearing from you in the near future in the hope that your decision will be sympathetic to FJ5's position."

Now it is clear that this must have had some effect, because FJ5 was, in fact, employed from 2nd September 1991 to 31st July -- sorry -- 1981 -- I beg your pardon -- until 31st July 1983.

We have asked the Board about what the selection procedures and so forth were with regard to that and they can certainly advise us of what the current selection procedures are, but if we look at the submission to the Hughes Inquiry at 16845, they append the "Selection and Appointment Procedures for Staff in Health & Social Services", which date from August 1978.

If we could just scroll down through that, please, you will see that the -- there is an introduction; the definitions; general principles; there is a panel of assessors; the procedures; and a vacancy arising;

constitution of shortlisting/interviewing panels; monitoring by the council; and breach of procedures. These would have been the procedures that would have applied in 1981. One can assume there, despite the fact we don't have documentation in respect of it, that these procedures would have applied to the employment of FJ5.

One further document is at 7500 to 7504. This is a document which is not directly relevant to this module in that it relates to the planning for the Hughes Inquiry. There were -- there was -- if we just scroll down, please, to -- you will see that a Kincora statement had been made setting up the Hughes Inquiry.

Then there were notes for supplementaries, that if there were any criticisms of the Secretary of State's proposal, various questions were suggested and the answers that should be given to those were prepared by the civil servants in preparation for any criticism that there might have been.

I think it is at 7504. If we can just scroll down through, there is you will see -- sorry. Just there at 7502 it says that -- it is asking whether the case of FJ5 was included in the Hughes Inquiry terms of reference and the answer to that was:

"No. I understand that the case stands adjourned until January (1984) and since the case has not yet been

heard, the terms of reference, which take in homes where there have been convictions or disciplinary proceedings, do not relate to it. It would be for the committee of inquiry to consider what action to take in relation to any convictions which arise during their inquiry and I can't comment further on the Fort James case, since it is sub judice."

So clearly this was in the media at the time and would have been -- was being thought about in terms of the Hughes Inquiry.

With regard to the actual complaint about FJ5, the background is that the child, who I will call FJ30, was admitted to care under section 93 of the Children & Young Persons Act 1968 by Limavady Juvenile Court on 22nd April 1980, when he was almost 15. We see that at 30851. He was there until he was discharged from care when he reached 18 on 12th May 1983. That's the Court Order committing him to care.

At 30834 we see his discharge from care. At that time he had obtained accommodation in the community and his social worker, a TL9, continued to visit him in the community after he was discharged.

He was resident in Fort James from 17th April 1980 until 11th May 1980, so before the Order was made of the Juvenile Court until after he was -- the day after --

the day before -- I beg your pardon -- he was discharged.

On 7th October 1983 TL 9 had called -- she called to visit FJ 30 at his home as per arrangement, and during that meeting he made allegations about FJ5 to her.

Now she created a note of her interview with him, which can be seen at 30853. You will see that she visited him at his home.

"Almost immediately after I arrived he said that he had been feel quite depressed. When I asked him why, he said, 'Have I ever told you that FJ5 would leave his mark when he left? Well, he has'. I asked him what he meant and he informed me that he thought he had venereal disease. There was a long silence.

I then asked him is he saying that he and FJ5 had had a homosexual relationship and he replied 'Yes'. I asked him when this relationship had taken place and he informed me it commenced shortly after he left school.

Before continuing the discussion I pointed out to FJ 30 the seriousness of the allegations he was making and the implications in him making it. FJ 30 said he was fully aware of this, but felt that it was important for someone to be informed as FJ5 is still employed in

the childcare profession.

I asked FJ 30 where, in fact, the sexual relationship between himself and FJ5 had taken place. He informed me that it had first started while on holidays in , but had continued following their return to Fort James Children's Home. He said he was quite embarrassed at telling me, and although he wanted to go into greater detail, he felt too embarrassed to do so.

I explained to FJ 30 that, because of the seriousness of the allegations he was making, I would have to inform TL 11 , who was then Assistant Principal Social Worker for the area from which FJ 30 came, who would have to tell his direct line manager, Mr Carey, who was the Acting Principal Social Worker. Also we would have to inform the Principal Social Worker for Residential and Daycare."

That was TL 20

"Following this, I said that it would probably be necessary for FJ 30 to be interviewed by senior members of staff and more likely the police. FJ 30 accepted this.

When I asked FJ 30 why he had waited so long before telling someone, he said that although the sexual relationship had ended some time ago (approximately one

year), he still felt confused and angry about it. On occasions while he was still in care, he had felt he would like to tell someone, but each time changed his mind for fear of the outcome.

However, recently he had seen a film on venereal diseases in the government training centre and he believed he had contracted this disease. Recognising that he must seek medical advice if this was the case, he decided he must tell someone of the sexual relationship that had existed between himself and FJ5. I asked him if he had been to see a doctor and he said 'No'. I (sic) asked if I would arrange for this. I agreed to do so and for FJ 30 to contact me on Monday, 10th October to find out the time of his appointment."

Now that statement is consistent -- that note of her interview is consistent with the statement she gave to the police, which can be found at 30377.

On 12th October 1983 FJ 30 was visited by TL 20 , TL 11 and TL 9 , and a note of what took place can be found at 300... -- I think that should be 30841. If we could look at that, please. This is a report which was compiled in respect of their meeting with FJ 30 It said:

"The following people will be referred to in this

report and their names and relevant information are given now for the purposes of clarification."

I am not going to recite them, but they are recorded there. You will see that FJ30 had a key worker. The dates are not included in this. It is clearly a draft of what was originally presented, but if we can just scroll on down through that, please, to the next page, there's -- background is given about FJ30 s time in care and how he came to be in care and the various orders that were made in respect of him.

If we can just scroll on down through the next page, please. Just if you could just stop there, please, it records that:

"During a visit to his flat on 7th October late afternoon FJ30 implied to his social worker that he had a very important matter to discuss. He went on to relate details of a relationship he had had with FJ5. Specific information on the relationship was not gone into at the time by his social worker, but sufficient inferences were made for her to conclude the essence of homosexual affair.

She informed TL11 when she came to work on Monday, who in turn made contact with Mr Carey. The matter was then related to TL19 , Mr Haverty, Mr Newman and eventually the Director.

FJ 33 was advised to go to a general practitioner, who referred him to a special clinic at Altnagelvin. However, he decided to go on Tuesday. He didn't tell the doctor there all the details and hence a thorough medical was not carried out. A further appointment was made.

It was felt appropriate for TL 20 TL 11 and TL 9 to visit to ascertain more specific facts and a meeting was arranged for Wednesday, 12th October at FJ 33 flat.

Before embarking on the subject the seriousness of what we felt FJ 30 was saying was explained to him. He recognised this but decided to share his experiences.

He told of a close relationship that had built up between himself and FJ5, one which was noticed by other staff and children at the home. This FJ 30 felt resulted in him being ostracised by the others.

He stated that the children implied FJ5 was queer or gay and that they called him . FJ 30 himself was referred to as gay by some of the other children, although at the time he believes nobody else knew that a homosexual relationship was being carried on. He thinks their statement related more to the closeness of contact as demonstrated openly in the home.

For example, FJ5 involved FJ 30 a lot in

decision-making and gave him a key to the staff bungalow. Also he took a keen interest in his hobbies in a way that was not experienced to the same extent by other children.

Around the time FJ30 was 16 years old -- he was not sure of the exact date -- an offer was made for him to accompany FJ5 to FJ30 found this an unusual request, so he suggested other boys should go. This offer was accepted by FJ5 and so himself and one other boy travelled to staying from ...",

and there is a gap with regard to the dates.

"More offers followed until FJ30 agreed to go on his own. While at FJ5's -- while in one evening he felt tired and went to bed early. He remembers waking at about 2.30 in the morning to find FJ5 in the nude in the bed beside him. This shocked him, and being away from the residential home in a country where he knew no-one, he decided the best thing to do was go downstairs in the hope of sleeping there. He went to the kitchen where he pulled two chairs together and tried to sleep.

Shortly afterwards he was followed down by FJ5 and tea was made. The offer was given for FJ30 to go back upstairs, but this he initially refused to do, saying he preferred to remain where he was. He claims FJ5 said

that he should respect his wishes. FJ30 consequently returned to the bedroom to find FJ5 already there. FJ30 asked him to leave, but he refused saying his bedroom was cold. FJ30 found it difficult to get over to sleep again. So FJ5 offered to rub his back. This was something that he did on occasions at Fort James, stating that such massaging helped relieve tension and result in the person being more relaxed. According to FJ30 FJ5 started rubbing his back, then moved to his feet, legs and then to his bum.

FJ30 paused when telling us the story at this stage. However, because of the seriousness of the matter, we asked him to elaborate further.

Continuing, FJ30 then -- continuing, he stated FJ5 then touched his privates and finished by putting himself 'inside me'. FJ30 s attitude to this was one of annoyance and possible anger and he gave his reaction as resulting in not allowing FJ5 to get away with it. So he in turn had anal intercourse with FJ5.

We asked FJ30 if he could tell us how often such a relationship took place, suggesting maybe ten or twenty times. He could not be specific, but said -- stated more than ten. He told us intercourse had taken place in Fort James Children's Home when he was in the flat there as well as in his room in the home, which was

a single room.

He was of the opinion no such relationship had taken place with any of the other children and that he had not told any of them about this situation.

Bearing this in mind and taking the standpoint there was no-one to collaborate his story, we asked if he could give us any other information.

He went on to tell various other incidents, one, for example, where FJ5 was seen by other children going through his bungalow in the nude. Apparently there is a window leading to a passageway off which there are a number of rooms. This window did not appear to have any curtains or ones that were pulled across.

He told how FJ5 on occasions walked about in what was described as a small square tablecloth which covered from his waist to his knees. He said there was one night when another staff member shouted with fear. She saw what she thought in the light was a mother of one of the children upstairs in the home. FJ30 claims that it was FJ5 with only the tablecloth to cover him.

He also said FJ5 walked from the bungalow in this attire and open sandals at 7 o'clock one morning to waken him. Additionally, that FJ5 took walks at night with a dressing gown over his tablecloth in the grounds of the children's home. This event was stated to have

been witnessed by other children to came into FJ30 bedroom to view.

There were stories of telling children the facts of life at 11 o'clock at night and in his own case being told them in the early hours of the morning in one of the rooms downstairs in the home. This he claims was also known by another staff member.

FJ30 decided that he had had enough of the relationship and refused FJ5's advances. He claims that around this time the situation in the home became very difficult. He was dependent on the home for a roof over his head and so he felt he could not tell anyone, although he seriously considered telling his key worker. His behaviour deteriorated considerably, resulting in instances of him being destructive. As mentioned earlier, he was discharged to live in the flat on 11th May 1983.

His reasons for bringing this matter to our attention at this time were given as follows. First of all, he saw a film recently on VD and other related matters. Some of the symptoms described seemed to bear similarities to complaints he was experiencing himself.

Secondly, he expressed concern that FJ5 had gone to take up a position of responsibility with mentally handicapped boys and believes they could consequently be

in danger.

He made the following categoric statements.

He would prepared to put all he had said on a tape and sign a transcribed copy. He felt he would have difficulty writing it himself.

He would be prepared to confront any staff at Fort James Children's Home with the stories which he claimed some of them were aware of.

He was aware this information would have serious consequences both for FJ5 and himself.

He was aware that, because of his age, his name could be printed and details given in the press.

Taking account of the above, he still wanted our Department to take appropriate action.

A case discussion took place at Area Board Headquarters on Tuesday, 18th October 1983. Present was Mr Carroll, Mr Newman, Mr Haverty, TL 20 and TL 11 . The following decisions were taken.

The matter was to be referred to the police on Wednesday, 17th October 1983 by Mr Haverty.

The key staff at Fort James Children's Home to be informed of the procedure.

FJ 30 to be informed as soon as possible of the decision to contact police.

Further steeps -- steps" -- I beg your pardon -- "in

relation to others to be contacted and method adopted to be considered on advice from the police."

That's signed by the Assistant Principal Social Worker on 19th October 1983.

In fact, FJ30 according to the police material himself complained to the police on 17th October 1983. If we look at 30352, there is an outline of the police case in the matter. You will see there that the complaint was received on 17th October.

If I just go through this, it indicates that as a result of inquiries FJ5 was arrested. After interview, which took place -- the interview -- I am not going to -- I am just outlining -- pause there for a moment, please.

This is the outline of the police case and I will go through it in a little more detail from it, but just to advise you that FJ30 statement to the police can be found at 30360 to 30366. FJ5's interview is at 30367 to 30375. There is a statement from Rodney Carroll about -- and I will look at that in due course. There is a statement from FJ7 , who was working in Fort James at the time. There is also a written statement after caution at 30381 to 30387.

You will see that in the written statement after caution police indicate here that, in fact, FJ5 admitted

sexual activity with FJ30 on three or four occasions. He described it during the peak of an excessive amount of overtime when he was doing -- working 24 hours a day.

Police recommended that he be prosecuted for what was then the offence of buggery and for gross indecency. I am not sure if he was actually tried on those two charges, but I expect that he was. Ultimately a direction was granted at the end of the prosecution case and -- which resulted in acquittal for FJ5.

Just going through -- back to the police outline of the case, please, if we can scroll down through it, you will see that FJ30 -- sorry -- FJ5 was, in fact, granted bail, but the police discussion of the evidence in the case said that FJ30 at this stage was 18 years of age and had been resident in Fort James and was placed there -- he was actually placed just before the age of 15. It says that:

"On becoming -- on being placed in the home he quickly became the subject of the attention of the principal."

That is actually not quite correct, because FJ5 did not come until 1981 and FJ30 had already been in the home for a period of time at that stage. It is said:

"The attention manifested itself in FJ5 reading to the boy at night in his room, graduated to massage and

then the boy alleges that FJ5 sexually aroused him and engaged in anal intercourse with him and vice versa. This physical relationship continued in the boy's bedroom spasmodically over a period of a year."

It is said:

"In April 1981 FJ5 took FJ30 to at FJ5's expense, purchasing an air shuttle ticket from to , and FJ30 had kept this ticket counterfoil. During this trip of five days anal intercourse took place between FJ30 and FJ5."

Now again in April 1981 it is not clear that, in fact, Mr -- sorry -- FJ5 was working, because I think he started in September 1981. So the dates, if FJ30 did travel to in 1981, could not have been with FJ5.

If we can scroll on down, please, it says:

"The relationship continued on a physical level and during the next two years FJ30 alleged that FJ5 had oral intercourse with him and engaged in mutual masturbation. Over this period", it says, "FJ5 took FJ30 to and in June 1981."

Again 1981 cannot be correct for the reasons that I have just explained. It said:

"In July '81 both FJ30 and another boy went on a trip to but no allegations were made."

Then it says:

"After this trip regular intercourse took place and oral sex."

Then there was a visit in March 1982 to

FJ30 alleged that intercourse took place once on that trip.

"From then on the" --

He said:

"That would appear the last time any physical relationship took place.

From then on the contact between the two of them became fraught with dissension, frequent arguments and quarrels."

It goes on to discuss the medical evidence. If we can just scroll on down through it, please.

It discusses FJ7 evidence. She set the scene in the children's home. Can we look at her statement, please, which is at 30379? We will see that she made the statement on 20th January 1984. She outlines the position of herself and FJ5 in the home and then describes how the home functions and its layout. If we can just scroll down through that, please. She says that:

"Until Christmas 1980 a system of duty night staff was in operation."

I think -- actually I am corrected. In her

statement she says it was 1980, in fact, that FJ5 took up the position in charge of the children's home. So that has been my mistake. Apologies for that. So he would have been then in the home and taken up his position shortly after FJ30 was admitted to Fort James. Therefore the dates -- it would have been possible for FJ30 to have travelled to with him on the date that FJ30 suggested it happened. Apologies for that. I didn't mean to mislead the Inquiry.

She indicated that:

"Until Christmas 1980 a system of duty night staff was in operation which in practice meant that a person would be employed on waking duty whilst the manager slept in the unit. Whenever the officer in charge slept in the unit, he would occupy a room on the third floor known as the sleeping room. After Christmas 1980 a houseparent always slept in and the room used would be on the second floor and the west end of the passage."

She had been in Fort James for eight years at that point in time. She recalls FJ30 and she said that:

"He mostly lived in his own room on the second floor at the east end of the passage and at various times he was placed in a group of rooms known as 'the flat', which was a training scheme for children leaving the

home for independent living. This would give him experience of self catering and a certain amount of independence."

She said that:

"A day to day log of events was normally kept recording unusual events. There is no set pattern to what is recorded and it is left to the duty officer to decide on what entries are made."

She produced the log books covering the period September '80 to September '83 and she said that each child had a set of day cards.

We know from the statement that she gave to the Inquiry that, in fact, FJ7 stood bail for FJ5 when he was charged and released on bail.

Going back to the outline of the police case, please, which is at -- if I can just get the actual page reference here -- yes. It is at page 30354 I think we have been at and then 5 -- the bottom of that and then 55. There is evidence of the arrest, and then from paragraph 19 onwards the police talk about the interview with FJ5. It says:

"Initially, although shocked about his arrest, he appeared confident and denied the allegations. His conversation with us relied heavily on sociological terms and stressed the attention he showed to FJ30 was

simply that of a caring person. Denied being a homosexual and during the second interview refused to agree to a medical examination.

During the third and final interview FJ5 alleged that this refusal was because he had been the victim of a homosexual rape as a child and was afraid that this would be detected. He eventually admitted that the allegations were in part true.

He verbally stated that on three or four occasions during 1980/1981 he engaged in acts of buggery and mutual masturbation. He said that FJ30 penetrated him anally each time, but he did not on any occasion bugger FJ30

He then elected to make a written statement, which is virtually a case history of FJ30 , again using language", as the police describe it, "much loved by Social Services. Eventually FJ5 got round to the subject matter of an admission."

They also talk about the statement of Rodney Carroll, which can be seen at 30376. This is a statement from January 198... -- it's hard to make out when exactly that was. I think it might have been 1984. He said -- he gives the details of FJ5's employment and said that:

"His function was both managerial and professional,

being responsible for day-to-day management of the home, including the supervision of subordinate staff. He was also responsible for implementing agreed caring programmes for the children in his charge. The temporary removal of children in care from the province (for holiday periods, etc) is at the discretion of the District Social Services Officer. It would have been possible for FJ5 to take a child on holiday to GB provided he had official permission to do so. In the event that a child is taken away without such permission the member of staff concerned would leave themselves open to disciplinary action."

The written statement after caution, as I indicated, is at 30381 to 30387. As police have indicated, a lot of this relates to FJ30 s time in care, but he talks about FJ30 being anxious in the home.

If we can just scroll on down, please, he said that -- he talks about FJ30 being -- living amongst an aggressive and threatening group of teenagers in the home. If we can scroll on down, he said -- he talks about -- again throughout all of these pages he is talking about FJ30 and his position as he perceived it to be.

"On occasions" -- if we can just -- there -- "on occasions he never slept at all. He would go for walks

in the garden during the early hours of the morning. I felt strongly that he should not be encouraged or allowed to do this and on the first occasion when I had remained on duty I insisted that he remain in his bed with the light off, but the door ajar to enable sunlight to enter the room."

We can scroll on down:

FJ30 persisted in getting out of bed and also in switching on the light. I attempted to explain to him that he must consider the other person in his room and leave the light off, and also that he if could relax during the night, he may find the following day more tolerable."

He goes on to talk about his efforts. He agreed to leave the light on for the night:

"... and I would provide him with a bedside lamp."

He then goes on I think to talk about the night cover. He said -- yes.

"It was decided that in order to help the residents to settle at bedtime more particular attention should be paid to the process of going to bed. This included individual bath times and bedtimes for those who most required it. In addition, hot water bottles and reading books were purchased. FJ30 responded particularly well to this. It was felt that not only would he gain

from the experience of reading and listening to stories but that also he may use the opportunity to discuss some of his fears. It was on one of those -- these occasions when I was reading to him that he stopped me and asked if it was possible that his mother and father were not his real parents."

He goes on to talk again about conversations with FJ30 and so forth. If we can just scroll on down through this, he said that:

"... resulted in" --

He said:

"Because" --

If we just scroll back up to the last page, please, he said:

"Due to the fact that there was a heavy burden in terms of time and effort needed for FJ30 and the fact that there was a severe shortage of senior staff available, my contact with FJ30 and the implementation of his programme increased to the extent that the vast majority of the work became mine. This resulted in me becoming exhausted and over-important in his life. He came to see me as a constant figure and could be morose and difficult during the periods of my absence."

If we can scroll on down, he said that FJ30 refused to go to the shops with his key worker, wanting

to go to the shops with him. He said:

"The alleged offences I believe occurred during the peak of this period of my excessive amount of overtime, which consisted of 24 hours a day, 7 days a week. The offences FJ30 alleges occurred on three or four occasions. They involved mutual masturbation on one occasion. On the other occasions I masturbated FJ30 I did not insert my penis into his anus, although he inserted his into mine on two occasions. These offences occurred in his bedroom in Fort James. I regret deeply these incidents and have made every attempt to do what was in FJ30 best interests before and since. He has not always agreed totally with the action taken by myself and my former colleagues and indeed at times, because of his affection for me, he has tended to regard most of the shortfalls in his life and his expectations as being totally solvable, but despite his considerable progress, he has not been able to cope with reality."

He goes on then to talk about the fact that when he was in the community -- if we can just scroll down to the end of this statement, please, he said:

"I have not made any contact" --

He talks about:

"He became over-identified with me. I believe this continued right up to the day before my departure from

, when he delivered a gift bought with his only spare money. Along with the gift was a card expressing thanks for what help he claimed he'd received and gratitude for what he considered was my help in settling him in his new home. I have not made any contact with FJ30 since leaving except to thank him for his present and kind words."

That statement then was signed by FJ5. If we can just scroll down to the end of that, please. That statement was recorded over a period of some three hours, just over three hours.

The police, as I've indicated, did prosecute, which ultimately resulted in acquittal, but the question for the Inquiry will be: what did the Board do as a result of this?

One thing I should say is that there was a warning given to TL9 , the social worker, for not reporting the matter. We can see that at 30359. That was by police. You see here that -- this is:

"I have considered TL9 statement and her failure to supply information of an arrestable offence and I suggest that this should be left until after proceedings have terminated, at which stage she should be told of her obligations and the possible consequences should she fail to take appropriate action in the event

of any future incident of a like nature coming to her notice."

The Board, as I have shown, met FJ 30 themselves in the persons of TL 11 , Mr Carroll and TL 20 -- TL 20 TL 11 and TL 9 . I beg your pardon.

Then there was a management review into the matter. Tom Frawley has given a statement to the Inquiry. He refers to this at page FJH602.

Now there is a bundle of material in -- that was provided last week by the Inquiry which show that there were notes on the review. That's -- if we look at 30990, these are "Notes on review into the management of Fort James internal/external during the period that FJ5 was officer in charge to examine the details of FJ 30 period in care".

The membership of the review group was Mr Haverty, who was the District Social Services Officer, Mr Newman, who was the Assistant Director of Social Services and Childcare, and Mr Thompson, who was the Assistant Chief Administrative Officer for Personnel and Management Services.

There then follows a series of interviews with those members of staff who were in the home at the relevant period in time.

You will see that on 7th December 1983 FJ7 , who was then acting officer in charge, was interviewed. It is quite clear how the interviews were conducted, because at the beginning of the interview Mr Haverty explained to her that:

"This review into the management of Fort James during FJ5's period as officer in charge was being set up following his recent appearance in court as a result of an allegation made against him by a boy who was now discharged from care.

Mr Haverty explained that the review was concerned with management issues, in order to identify any weaknesses that may exist, so that these could be put right and that lessons may be learned during this exercise which may be of help in the management of other children's homes throughout the area.

He further explained that whilst the group would examine details relating to FJ30 period in care, they were not investigating the accusation made against FJ5, as this was in the hands of the police and legal services."

So this explanation was given to each member of staff in turn as they were interviewed by this review panel.

Just to be clear, there are rough notes of what was

said at pages -- I don't need to go to these -- but they are pages 30913, 32... -- sorry -- 30913 through to 30977.

If we can just scroll down, FJ7 discusses the staff rota book.

"She explained there was a repeat rota system existed for staff whereby they could produce periods when they were off and on duty. Those rotas were normally made out by the deputy officer in charge, but any problem, she shared them with the officer in charge."

She goes on to talk about the various staff members at the time:

"... and explained that the staff in establishment for the home prior to recent increases was the officer in charge, deputy officer in charge, a senior houseparent and six houseparents."

In terms of staff cover for the home she discusses that at night from 10.00 pm there was only one houseparent and one member of management staff on duty.

"She cannot recall a situation where there was only one staff member on duty at night.

She recognised that the home was understaffed and that staff were under a lot of pressure as a result.

As regards management staff during the period that

she was on the CSS, communication between management staff suffered to some extent, as there were no handover periods.

She pointed out that FJ5 was very tired and on a couple of occasions he fainted whilst in the home.

Overall she felt there was a good level of communication, which was facilitated by staff meetings and more informal contact between staff and during this period she was anxious to point out that considerable development took place in the home with the introduction of the key worker involvement in fostering, visitation by staff to potential foster parents, development of greater contact with social workers, etc, etc.

Overall she felt that during FJ5's periods there was a very considerable development in the field of childcare protection at Fort James. She referred to the new system introduced by FJ5 for getting children to bed and providing them with a certain amount of attention during this period, such as reading to them, provision of hot water bottles and staff generally making some time available to give some personal attention to the children in order to enable them to settle down.

When discussing this further, she admitted that no discussion took place with the Senior Social Worker, as this was seen as an internal change in the home. In any

case the Senior Social Worker at that time was new to the job and there was a gap before TL 4 was appointed.

In relation to additional staff recently made available she said this would mean shorter duty periods for management staff and less work directly with children.

She also said that the home felt isolated and that other people did not understand their problems. She referred to the fact that the Principal Social Worker had no residential experience and this applied also to other more senior management staff.

In relation to management support to the home, she said that TL 4 now visits the home every Monday, Wednesday and Friday, but when he took up the post first, he normally visited every Wednesday. She said that management staff had the feeling it was difficult to get things done for the home through their line management and that in order to get things done quickly FJ5 bypassed the recognised organisational structure and went directly to supplies for various pieces of equipment, as he felt this was a more effective approach.

She said that TL 20 was normally in the home four or five times a year and that he was always

available by phone and that it was easy to get an answer to problems brought to his attention.

In relation to other management staff visiting the home, when questioned she said that her impression was that Mr Newman visited the home mainly to deal with development and planning issues and that she would see him at area childcare training groups.

The District Social Services Officer mainly visited at Christmas before he went on holiday and the Director of Social Services visited to carry out an inspection or wanted to drop a child at the home.

She indicated that she felt TL 4 role was in no man's land, as his authority was nil, and that both he and his predecessor pick up management problems and feed them back to TL 20 ."

She talked about the records which were kept in the home.

"She pointed out that she had a lot of respect for FJ5, that he was a capable and professional worker, and she had no suspicion that there was anything going on between him and FJ 30 and indeed found it hard to accept there may have been."

If we can scroll on down, please, these -- you will see there are other members of staff then who were interviewed in relation to what records were being kept.

If we can just scroll down through this:

"She said that all three staff members would only meet at staff meetings and in relation to support from outside the home she was aware that the Senior Social Worker visited weekly and that TL 20 visited much less."

She talks about who she would contact.

If we can scroll on down, I am not going to go through all of this, but she said -- if you see there:

"In relation to reviews, she said these were carried out regularly and that absences from the home and holidays for children may be raised at them.

She said that FJ 30 absences from the home as far as she knew were recorded in the book and would have assumed that permission was obtained for him to go on holiday.

She saw no weakness in the system that would prevent an incident like this from happening. She thought the home was well managed. She would like to see the Board member meeting staff and children when he visits in December '83."

The houseparent is interviewed. We can scroll down through that.

Again there is -- this is -- the next person is FJ 30 key worker. She was appointed in 19... --

November 19... -- she was working on a temporary basis, first of all, as a temporary houseparent from May '80.

"Staffing.

In relation to staffing she said that between '79 and '82 the staffing rate was very low in the home and that sometimes there was only one member of care staff and one member of management staff on duty. She felt that staff were under a lot of pressure.

She said that she felt that FJ5 did a lot of overtime and he was always very caring towards the children. She only became a key worker in early April '82 to FJ30 and she felt that she had good support and supervision from FJ5."

She talks then about FJ30 and in relation to his absences from the home she believed that he went on holiday accompanied by FJ5 in March '81 and that they may have stayed at a house in She says:

"Prior to the trip FJ30 had shared a room but following the trip this other boy moved out of the bedroom and left FJ30 on his own."

So she was believed this was done for professional reasons.

"She felt that in July '81 there was a group of five children went on holiday with FJ5. She said that FJ5 felt an issue that FJ30 could not go on this trip,

because he was not behaving himself, but he eventually did go and his behaviour improved.

She said the two trips were discussed with FJ30 social worker and that meetings took place in the home to make the necessary arrangements.

In relation to permission for children leaving the home, she said that she was aware that social workers should be involved about these trips, but also felt that FJ5 was aware of this.

She said that in May '81 FJ5 took FJ30 on a trip to for an interview at Community Service Volunteers' office. She said that the social worker was heavily involved in arranging the trip and they both decided that FJ5 should accompany FJ30 , because he was more familiar with the situation than the social worker. They were away for a couple of days and she believes they went to for a couple of days.

She believes that trips to -- would have been mentioned at reviews and recorded in the log book.

She recalls FJ5 taking a holiday and spending some time before coming back to work. Before leaving he promised FJ30 that he could visit him in She recalls that there had been tickets purchased before FJ5 left the home, because she saw them. She said that FJ30 took money out of his savings book to buy those

tickets. She is convinced that FJ30 did go to on that occasion, because she spoke to him on his return and he said that he had helped FJ5 to paint some sheds attached to his property in On return FJ30 was in bad form and quiet. He showed her some trousers with paint marks on them, which indicated that he did, in fact, help with the painting of the sheds. She concluded that FJ30 s mood was in response to the personal situation he was going through.

She said that she was disappointed ..."

Sorry. Just ...

"She indicated she felt it difficult to talk to him about it."

Sorry.

"She mentioned to FJ5 that FJ30 was in bad form after returning from his holiday in and his response was, 'Well, FJ30 had to work on the holiday painting sheds'.

She said that after he left FJ30 to came to her house on a couple of occasions. She thought that -- in July '82 she thought that a trip was arranged, but FJ30 didn't go on that particular one."

She goes on to talk about, if we can scroll down, talking to FJ30 about sexual matters. Scroll on down to the next page, please.

EPE OPERATOR: There is no next page.

MS SMITH: There ought to be I think, because they do go on up to 30977. In any event, I am not going to go through the rest of this, but it is clear there was a review being carried out into what took place in around the home. Although they were not investigating the allegations, they were seeking details of information about FJ30 being taken out of the home and whether permissions were properly applied for and granted in respect of that. Sorry. I beg your pardon. It's 30... -- 31087 I think is the last page.

But if you can look at 30988. Yes. I think -- turn that round, please. This is a memo from Mr Haverty to Miss Watson on 30th April 1984, saying:

"The review identified a range of difficulties created in the home due to lack of secretarial/clerical staff. You are aware that we looked at the possibility in the past of the lack of" -- I have lost my place -- "lack of secretarial care and where looked at the possibility in the past of appointing a part-time secretary to Fort James, but unfortunately due to a lack of resources this was not possible.

I wonder if there is any possibility of making monies available towards the appointment of a part-time secretary in the home."

There is, however, another document at 30986. I think it is just two pages prior to that. This is a note -- it is headed "Notes draft. Review into the management of Fort James Children's Home during the period that FJ5 was officer in charge. Follow-up action to be taken".

So, following the review, this document is created. It says:

"1. Understaffing in the home, especially lack of management of staff during this period. Although the staffing situation has improved recently, it is still necessary to review the staffing levels, especially in light of the independent living units coming into operation.

2. Decision-making within the home by management staff. Changes in the systems for management of the home and changes in the routine in respect of the care of children were not shared with district management, one example being the changes in the bed routine introduced by the officer in charge and reading to children in bed. It is important for middle management at district level to be kept informed of changes in practices in the home."

They talk --

FJ7 in particular said that management

staff in the home felt isolated."

They didn't have residential care experiences, which added to the sense of isolation.

"This raises the degree and quality of support offered to management staff in the home."

It talks about the --

"It would be helpful at least to have an annual review on children's homes carried out by Mr Haverty, Newman and TL 20

Staff in the home felt TL 4 role was not clear. Action needed to be taken to clarify his role and ensure that it is seen as a management one.

The practice of returning diary cards to children, thereby depriving the home and management staff of ongoing records on the children. Action has been taken to rectify this.

Reappraisal of the recording system kept in the home. Action has already been taken in respect of this. It is now necessary to review the effectiveness of the new system that has been set up.

Staff should write frequent progress reports in the child's file. This now takes place.

District management staff should ensure that new members of staff appointed to the children's home should be clear on their responsibilities and authority and a

period of induction training is essential.

Communication between ... during the time period was limited owing to the staffing problem. This has now improved, but steps should be taken to ensure that a system is set up whereby management staff have an opportunity to meet on a regular basis, at least once a week, to examine care practices in the home and to identify and modify strategies for the care of the children in the home.

Necessary to clarify the role of Board members.

Support/training for staff outside the home. At least one junior -- member of junior staff felt it would be a good idea for counselling opportunities to exist from outside the home.

In discussion with Mr Brangham", who would have been involved in the Central Services Agency, "it was recognised that it was important for all new staff entering to have training sessions.

Permission for children leaving the home. Although action has already been taken on this particular issue, we should review how effective it is and whether greater authority should be delegated to the officer in charge.

Although reviews were regularly carried out, it would seem that absences of children from the home were not normally considered and this should now be taken --

now take place.

Action has now been taken to examine books in the home on a regular basis and sign log books. Urgent need for secretarial support at Fort James.

It was evident during our review that staff are not receiving the level of supervision they required. With the improving -- improved staffing establishment this should now take place. It is, however, necessary to monitor on a regular basis the level of and effectiveness of this supervision."

You will see that there is a handwritten note at the bottom:

"All older children should have a key worker at all times."

Now it would appear that Mr Haverty had circulated this draft to the other members of the review panel and these handwritten notes are of one of those members.

The one other thing that I haven't quite highlighted was the fact that it became clear in the course of this review that FJ5 had not been, in fact, attending the review meetings in respect of FJ30 that were taking place in the home and that is -- that can be seen in the course of that review document that I mentioned.

You will see that at 9... -- 30986 -- sorry. That is the document we have just looked at. Apologies for

that. There is just one other piece of material in the bundle relevant to this matter and this was subsequently -- you will be aware that this investigation was all taking place after FJ5 was no longer employed in , and there is a memorandum at 31070 from Mr Newman to Mr Carroll and he says that he is:

"... writing to advise you of two recent telephone conversations I have had with the principal officer of concerning FJ5. She indicated that he had applied for a post of 12 months' duration for an She was aware of the court experience" -- sorry -- "court appearance, and he had applied -- unsuccessfully applied for a fieldwork post at the end of 1984, and she was asking whether he would be a suitable candidate for interview.

I advised her that they would have to decide whether he should be interviewed on the basis of their own criteria. She enquired about the allegations made concerning him and my response was the fact that he had been found not guilty by the court. Apparently already had a reference from Mr Haverty in respect of his unsuccessful application at the end of 1984. I advised Mr Haverty that this lady would

possibly be contacting him.

I received a second telephone call in July 1985. She was ringing out of courtesy to advise me that FJ5 had been interviewed the previous day and had been appointed to the post. A new reference had not been sought from Mr Haverty as considered the reference provided in 1984 was sufficient, since there had been no contact with -- between the Board and FJ5 since then."

Now that is all the material relating to the incident involving FJ5 that is in the bundle. I think it might be an appropriate time for a short break.

CHAIRMAN: Very well. We will take ten minutes, ladies and gentlemen.

(11.15 am)

(Short break)

(11.35 am)

MS SMITH: Chairman, Panel Members, I am now going to turn to look at what papers we have in the bundle relevant to the second home under investigation in this module in the Inquiry. That is Harberton House.

Again I would make reference to the general statement of Ciaran Downey filed on behalf of the Board, which can be seen at FJH771 in respect of this home, which provides a good summary of the matters relevant to Harberton House.

As I showed yesterday, maps, plans and elevations of the home can be found at 18962 to 18970. If we look at 21... -- sorry -- 20198 -- I should say I am just going to look at some general documentation in respect of the home before going on to consider the issue of inspections and the circumstances surrounding the investigation about peer abuse in the home.

This is a statement of principle for Harberton House Childcare Centre. I am not clear from when it dates, but it sets out the statement of principle, the mission, what Harberton will do -- if we can just scroll on down through it, please -- and how it will achieve its mission, and in support of its mission it will -- sorry. Can you just scroll back up slightly there?

"Provide a clear statement of the role and function of the centre.

Carry out Board policy, including those on:

Care and control.

Complaints.

Health and safety.

Access to personal records.

Confidentiality."

If we can scroll on down through it, there is then I think -- sorry -- yes. This next document is, in fact, a booklet of information for visitors. Now this

seems to have been prepared in and around 1995, right at the very end of our period of investigation. It may well be that that statement of principle dates from the same era, but if we can get some clarification on that, that might be helpful.

Just scroll on down through this document quickly, please. You will see that:

"Harberton House is one of two residential units within the Foyle Community Unit of Management providing for children considered to be in need of care, protection or control. One of these is provided by a non-statutory organisation."

It talks about the geographical area.

"Harberton House is a purpose-built facility opened in September 1980 and accommodates", in 1995, "20 children."

It talks about the resources that the unit provides.

You will see here that there is a:

"Medium stay unit providing ten places for children who require residential care of up to 12 months."

Then there's Chez Nous, which I mentioned yesterday:

"... which is a small independent unit accommodating three young people who are involved in a programme geared to help them prepare themselves for living independently in the community."

There is also the cottage:

"... which is a bungalow which is located in the grounds of Harberton House and which can accommodate up to four children. At the moment this is being used as part of a transitional change which is taking place in residential childcare, which will enable children with adequate support systems to remain in the community."

Then there is a video suite/medical examination room, which is obviously something that is added later in the course of Harberton's life and at the end of our period of reference.

Then it talks about the background of the children admitted to Harberton. If we can scroll down through this, please. I am not going to go -- to read through this, but you'll see it discusses the type of children in 1995 and so on.

There is a document at -- I'm not -- as I say, I'm not -- because there is such a sheer volume of material, I don't want to suggest for one moment there is not information here which is of relevance to the Inquiry, and I just reiterate that all of these documents are considered by the Inquiry when we look at it, but it would be simply impossible in the time frame that we have to open every single document in the level of detail that is included in it.

There is reference at 10014 to the fact that in -- this is in March 1990 -- there is a crisis situation in foster care in 1990, which then obviously would have had a knock-on effect with relation to the number of children being admitted to care at that time -- into residential care, given there was this shortage. If we can just scroll on down, you will see there that children were in short-term foster care. There were 19 of those. There were 17 children in Nazareth House, 11 in Harberton House, 8 in Fort James, 3 in Coneywarren and one at home. Of the children there were 162, the highest number ever of children, were in foster care.

"As we know you appreciate, there is an unrelenting pressure on and from children's homes to place children, some of whom are very disturbed or abused. Also there is pressure from a large group of our short-term foster parents who are holding on to children who should no longer be with them. In fact, in some instances foster parents and children are at risk and we will also certainly lose some of these very committed and overburdened carers as a result."

I am simply highlighting this document to show that while we are looking at residential homes, the whole picture in regard to childcare is such that what is happening in residential care is obviously affected by

what is happening in the general childcare environment. If there is a backlog and a crisis situation where children cannot be placed in foster placements, then obviously that has a knock-on effect on their stay in residential care with regard to the length of time in the homes before moving on and also as to whether or not they, in fact, do leave residential care.

Some general documents in relation to the home. There are admissions and discharge book registers similar to those that I showed in respect of Fort James. They are at 10836 to 10959. That's the admission and discharge book register from 1980 to 1988. Then '88 to July '95 can be found at 10675 to 10835. There is a register from '95 up to 2000, which again falls outside most of our terms of reference -- sorry -- most of that document falls outside the terms of reference. That's at 10663 to 10674.

At 11058 to 11173 we can see complaints by residents. If we just have a look at 11082, that's just an example, again making -- a child making a complaint about another child who is always shouting at her and then thumps her.

"This really hurts me. He always says he is going to tell staff things about me and he doesn't care if I tell or not. I wanted to tell now because he won't

shop annoying me and thumping me.

He used to keep asking me to go with himself, and I never would."

Then there is an entry added:

always steals things from my room and when I say I will tell, he pokes me in the back with his finger. This really hurts."

That is recorded by the social worker, the care worker in the home, and it is signed by the child in May 1994.

I just was going to give an example of a children's meeting from 1993, which can be seen at 11082. You will see that on 25th August 1993 there was a residents meeting held. The agenda included the reasons for the children's meetings, bullying, supporting each other when things were difficult, transport strike and any other business. Just scroll down through that. I am just not going to read it out, but if we can just scroll down through it quickly:

"Each child present was asked about bullying and were they bullied here. At some stage they said they'd been bullied and they all felt really desperate."

Talking about loyalty to friends being discussed and about children being bullied, that one should intervene and say, "That's not fair", etc.

There was obviously a transport strike which was having an effect on the outings or trips. A child expressed annoyance at that.

"It was agreed to hold another meeting in two weeks when all the children had returned."

This is obviously during the holiday period in August 1993.

There is also records of how the complaints were being investigated at 11088. This is a record of an interview with one child in March of 1992. The interview was conducted after the child forwarded a contact card requesting that she would like someone to call and see her.

"It materialised that she wished to discuss an incident involving herself and another resident which occurred on 15th March. She informed me that a resident and she were sitting in a child's room. They had been smoking. A staff member had already known about this incident and taken the cigarettes from them. At that point the boy came into the room and started to taunt the girl about her smoking. She told him to shut up and he subsequently went away."

He then -- it goes on to talk about:

"However, he kept taunting her and he then kicked her. She retaliated by kicking him and the incident led

to him punching her on the lip and the side of the face. He cut her upper and lower lip. Since then things have settled down and are all right. She wants to forget about the incident but tells me that he continues to bring it up.

When asked why she sent in the contact card, she told me that she would like to know if he was talked to about this incident in an attempt to make sure that it would not happen again."

So the officer in charge of the home is then informed about what the child has said. He said:

"The situation did not happen exactly as she had said. She accused of telling staff about herself and the other girl smoking. This, in fact, was not the case, but words were exchanged and she struck the first blow. didn't retaliate and struck her. Both have been spoken to very severely about it and warned of the seriousness of striking other residents and the situation will not be tolerated within Harberton House. I explained to the content of my discussion with She was satisfied that the matter had been handled correctly and was satisfied that both and herself had been spoken to about the incident.

She stated that she was happy with the way the incident was handled at the time and subsequently.

Finally, she states that she is happy in Harberton House."

Now clearly this was a child who elevated the complaint about what she said had happened to her to the Acting Locality Manager in Childcare Services at the time. He had come into the home and investigated, spoken to the child and to the officer in charge. That's just an example of how complaints were being registered.

There is a complaints register from 11100 to 11153 which covers the period from 1992 to the end of 1995 and an examination of that shows that the complaints largely relate to bullying by other children.

At 10223 to 10254 we see an admission booklet for children. You may recall that this was brought to us by the witness HH 5 when he came to speak to us in Module 1. This was something that Harberton had devised for the benefit of the children. I am not going to open it, but it is in the bundle at those pages.

One document that we have not seen before at Fort James is at 11540. Yes. If we could just rotate that, please. Now you will see this -- when I spoke yesterday about the fact that a number of documents had come to our attention that ought to have been destroyed, you will see here that the last date of entry in this was

July 1996. It was due to be destroyed in January 2012, but it is an extract from the sanction book relevant to 1994.

It talks about -- names the resident, the staff member, the reason for the sanction, the nature of the sanction and any comments. It is just this one page seems to be all that remains of this kind of material.

We will see that he:

"Received a sanction for his verbal -- verbal abuse and aggressive behaviour. He was prevented from going to the cinema. I explained to him the reasons for the sanction and he accepted this."

Then the same child is again sanctioned in July -- about a week later.

"Received sanction for ..."

CHAIRMAN: "... disruptive behaviour in the unit" --

MS SMITH: Yes.

CHAIRMAN: -- "and abusive attitude towards staff."

MS SMITH: "... towards staff. Lost privilege of going to Ulster final on Sunday."

Then again the same child is disciplined on 15th July.

"Received sanction for [something] back at staff and continued verbal abuse."

It sound like "throwing back at staff".

MS DOHERTY: "... throwing book ..."
MS SMITH: "... throwing book at staff ..."
It may well be.
"... and lost cigarette after dinner time. He had received several opportunities to remove slogans he had written on a hut but had refused. The incident occurred when he was again challenged after removing these slogans."
CHAIRMAN: "... over removing them ..."
MS SMITH: "over". Sorry. Yes.
"... challenged over removing them."
Apologies. I'm not very good at reading some of this.
Again the same day he also:
"Received a sanction for being aggressive, banging doors and shouting. He lost going up town but staff bought him cigarettes and the Derry Journal."
Again the same child has:
"Received a sanction for smashing windows on the fire escape and breaking into staff sleeping room. He was fined £2 for both, boys breaking Board property."
It must have been with -- sorry. There was himself and another boy.
"Explanation given and sanction accepted."
So that's the only example that I could find in the

bundle of a sanction book, but it is clear that punishments were being recorded certainly in 1994.

One other thing that we did not see in the Fort James material is a medicine book. That's at 15637 to 15709. That's relevant to the period 1988 to 1993. You will see that this is incoming medicines and medicines for disposal. The way this book appears to have operated is that incoming medicines were recorded at the front of the book and what would happen to them at the back.

For example, if we just look at a random page at 15642, you will see here the name of the child, the name and form of the medicine, the quantity received and date it is received is recorded. So all incoming medicines are at the front of the book.

Then if we go to 15655, there is part 2 of the book, which is medicines for disposal, and at 15659 you will see that the name of the child, the medication prescribed, name and form of medicine for disposal, the quantity to be disposed of, the reason for disposal and the method, and most of it was:

"Flushed down the toilet."

Some other documentation show excerpts from minutes of meetings of the Personal Social Services Committee. These can be seen at 16266 to 16271. I am not going to

open these, but what they do show is that reports were given to the Personal Social Services Committee -- we will maybe just look at one, 16266 -- by the member who visited the home.

You will see this is an extract of the minutes held on 15th December 1988. If we can just scroll down through it, you see there that it is, in fact, highlighted:

"Draft minutes of the Community Care Committee.

Minute report of a visit to Harberton House, Londonderry.

In response to a question from Mrs Burnside, SND 502 advised that the level of resources for fostering had been increased and that proposals in relation to special fostering would be placed before the Community Care Committee in the coming months. She also went on to elaborate on the difficulties of fostering children with special needs."

I think further on in these documents you see that -- yes:

"Report of a visit to Harberton House, which took place on 4th November 1988, had been distributed to members in advance of the meeting.

Mrs McGowan drew members' attention to her comments in relation to blocked places at Fort James Children's

Home which she had alluded to during an earlier discussion.

The Chairman thanked her for her report."

So the visiting member of the Personal Social Services Committee was, in fact, reporting back to the Board at meetings.

Just in respect of the minutes of '79/'80, if we look at 16569, again this is an extract from the Board minutes, but you will see here the report on capital building schemes. If we can just scroll down through that, please.

"Short stay accommodation -- short stay residential accommodation for children (Harberton House), Londonderry."

It said -- it is reported:

"He stated that it was envisaged that the facility would be used on a short stay basis where the needs of children could be assessed before making decisions about their future care. It would also be used to a lesser extent to provide placements on a emergency basis. He confirmed that the facility would be available for use by the whole area. It was heard that the officer in charge had already been appointed and was presently engaged in the detailed planning of the operation of the facility."

That just is an example of an update with regard to Harberton before it opened.

There is an evaluation -- I know I am jumping very much between time frames here, but there is an evaluation of 6th April 1995 which talks about the evaluation of Chez Nous, which, as you recall, was set up in December 1984 as an independent living facility. That can be seen at 20280. I don't know that we really need to look at it, but it is an example of how constantly the facilities that the Board were using were being kept under review.

There was talk in the statements of core evaluation teams and we see minutes of the core evaluation team meetings. I will just look at the first one of these at 19481, which is 17th April -- sorry -- 17th November 1980. So from the outset this core evaluation team had meetings. We see here the team was attended by Mr Newman, HH 5 , Mr Burke, Mr Donaghy, and apologies were received from the deputy officer in charge, Principal Social Worker and Senior Social Worker.

Just the headings here clearly show the core evaluation team discussed administrative matters. They had case discussions that had followed on from the last meeting in respect of individual children. They then

talked about referrals for planned admission to the home and they talked about the present position with regard to six children at Harberton, and then they set up the date for the next meeting.

You'll see those statements -- those core evaluation team minutes can also be found -- I think the preceding one is actually coming up next, which is at 1... -- yes. That's from 13th October 1980. There are a number of them in the bundle for 1983.

There is another, 22nd October, at 19487 and from 11174 to 11539 there are the 1983 minutes in reverse order. Again 1987 -- we have the minutes for 1987, 1988 and 1989. I can give the reference pages for those if you wish, but they are all of a similar pattern.

If we can maybe just look at an example from 1989, which is some nine years into these meetings at 12288, you will see that again administrative matters are recorded. At this stage there is only three people attending these meetings, which is the Assistant Principal Social Worker, the officer and deputy officer in charge of the homes. There is an apology from the Assistant Principal Social Worker, who would have been the fieldwork social worker, who would have responsibility for fieldwork.

"Administrative matters.

Most of the children in the medium stay unit are on holiday."

It talks about the admissions and gives -- as you will see here from this, it is giving more detail about the reasons for admissions than in the previous earlier days in 1980.

If we can just scroll on down through this document, there are no children being assessed for admission. The assessment reviews, details are given there. Summaries of those reviews are being detailed in this minute.

If we just scroll on down, please, it goes right on for a few pages. Then there's residential reviews. Again there are details in respect of those in some considerable detail for a summary. These continue for a while in respect of the children in the home. Then you see the recommendations are also included as to what is to happen to the children.

Just keep on scrolling, please. This goes on up I think until -- there should be about three more pages.

You see there were referrals. There were none. Outreach. Not quite clear what that involves, but work was ongoing on it.

Then "Any other business" is recorded. There's -- you see there's an incident recorded about one of the children who was on holiday. These were essentially

untoward incidents that are being recorded there.

One child is being made aware that there is no other option but to seek a Training School Order in respect of her.

A child who has absconded.

Again these are all -- the "Any other "business seems to have recorded the untowards incidences.

Then also it is recorded that:

"A residential placement in Foster Green had been confirmed for a child."

That's signed by the Assistant Principal Social Worker, TL 4 . So those are examples of the core evaluation team meetings and the kind of work they were carrying out in respect of the home.

There are daybooks which can be seen. There is a number in the home from 12543 to 15312, which cover the period from October 1992 to March 1996. Just by way of example, at random if I take 13853, which is 25th September 1993, and you will see:

"Number of residents: 10.

Number of admissions: Nil.

Number of discharges: Nil.

Number on leave."

Three children are out of the home at that time. Then there is a note made in respect of each of the

children at the time. If we can just scroll down through that. As I say, there are many, many pages of these daybooks in the home.

There are also daybooks relevant -- you see just at the end of that there is a night report also recorded.

"All children slept well."

There are daybooks in respect of the cottage, which can be found at 15868 to 16209 covering the period 1990 to 1991. Again it was a document that was expected to be destroyed in January 2012. It opened -- you see there, if we can just scroll down through that page, that it opened to accommodate four children under 6 years, overspill from other units. If we just scroll down through that, please, you will see that the number of residents were 4, and there were no admissions or discharges, and it talks about the children in the home.

So those were daybooks that were kept in respect of the children. You see that:

"The doctor examined one child today. Said his chest was clearing up and he had to finish his course of medicine.

All children ate well at dinner time."

It talks about:

"Recorded grandfather of one group of children ringing to ask for a visit. Told to go through the

social worker."

So those -- there is those daybooks are included there.

Just at -- we had talked about the circular, the 1985 circular. If we look at 10546, this is a letter from the Social Work Staff Joint Council to the General Manager of the Health & Social Services Board of 12th January 1990, which without opening it up shows that agreement was finally reached to incorporate various amendments in the complaints procedures in respect of residential care that was acceptable to the Joint Staff -- Social Work Staff Joint Council. So this shows the ultimate resolution of those negotiations that had taken place before the circular effectively came into effect in 1991.

At 10548 this is -- this is then the complaints procedure and this goes through to 10563 that accompanied that letter that indicated what was accepted. Just scroll down through that briefly, please. You will see it's a procedure for dealing with complaints about the care of children. It talks about the circular and goes on through that. So that's the ultimate outworkings of the difficulties there were about the 1985 circular in that document.

There was a workshop held by the Western Health &

Social Services Board about developing an integrated approach to childcare held in September 1989. I am not going to open that, but there are some documents relevant to that at 10601 to 10621.

There are also minutes of team meetings between 1987 and 1991 -- sorry -- 1993, which can be found at 15710 to 15748.

I'll just give one example at 15685, please. This is from 29th May of 1991. An assessment team meeting held at Harberton on 25th May attended by residential social workers, who had discussion about problems within the unit, guidelines for sending children to Training School, the role of the Training School, restructuring of Harberton, working as a team, and so forth.

With regard to untoward incidents we did look yesterday I think, but I will just to be sure look at 19954. Maybe we didn't actually look at this, but this is the definition of untoward incidents and how they should be dealt with, the categories of untoward incidences and the procedure of what should happen when one occurred.

There are examples of untoward incident reports between 15749 through to 15794. Again just looking at an example from 1991 at 15759, you will see here that this is from July 1971 (sic), approximately 11.15 pm:

"On Saturday at approximately 11.15 pm a child aged 13 was asked by staff to go down to bed. She refused to do so and became verbally abusive and threw a glass of orange at the resident social worker. She then became very physically aggressive and began hitting out and kicking out at staff. She had to be restrained for approximately fifteen minutes, during which a resident social worker was kicked in the stomach and fell, sustaining bruising and carpet burns to her left elbow. The resident social worker", another one, "was also bitten on the hand.

The child eventually calmed down and was escorted to her room, where she remained unsettled until 12.30 am when she eventually got into bed and fell asleep."

Then it is recorded that:

"She was spoken to about the incident by staff the following morning. The social worker from the NSPCC was informed of the incident on Monday, 8th July 1991."

There are other examples throughout that section of the bundle.

There are monitoring statements. If we look at 15793, this is a 1986 monitoring statement in respect of Harberton House. Just scroll down through that, please. You will see this would have been done in preparation for an inspection. I believe the -- I am not going read

it all out in detail, but if we can just scroll down through it, please, it talks about the adequacy of the physical accommodation, the reception or assessment unit, the medium stay unit. If we can just scroll on down through that, it talks about the decoration of the home, the adequacy of staffing levels. Then it talks about the staffing structure, and it goes on. There is a similar statement for '88/'89 at 15819 to 15840.

There are example of minutes of placement meetings. At 19967 you will see that this is a placement meeting held at Harberton House on 19th September 1990 and it records again who is present and it talks about the occupancy level of Harberton House:

"It was noted that there are 27 children on the books including two children in Training School on Place of Safety Orders. There are currently 25 children in residence. It was noted that over the next couple of months one may move to foster care, one may move home and one may transfer to Fort James when another child in Fort James moves to semi-independent flats."

The occupancy of Fort James there is 19. Nazareth House is being used also at the time.

So these meetings were taking place between the Assistant Principal Social Worker, the Senior Social Worker and the officers in charge to essentially see

what the occupancy levels are in the homes and where beds might become available essentially. Then there is also the issue of foster care there discussed.

If we can just scroll down through that, you will see that these were regular meetings being held in the background in the Social Services office.

Just going to -- I mentioned yesterday some documents in relation to finance with regard to Fort James. If I turn to look at what documents there are in the bundle in relation to that subject in respect of Harberton House, we can look, first of all, at 10090. You will see here this is a memo from Mr Haverty to Mr McLaughlin talking about the childcare budgets in 1990. If we can just scroll down through that, please, it says:

"It is difficult from the information extracted to analyse expenditure over automatic/mandatory payments and discretionary payments as the expenditure subpayments (sic) are too vague."

He says:

"I hope this information will prove useful in qualifying the growing demands on childcare services and will be a help in resource planning."

Then at 10454 this is a memo from the Childcare Branch about the 1991 PES. It is about child sexual

abuse. It says:

"Branches are required to submit bids under the 1991 PES for specific service developments. Mr Kearney has identified child sexual abuse as a contender. His minute of 8th February 1991 to Miss Gilpin, which has just been copied to you, emphasises the need for a carefully constructed and justified need for realistic resources. The purpose of this minute is to enlist your assistance in obtaining the information to enable such a bid to be made."

This is obviously not just in relation to residential childcare, but it says that:

"In '89 we obtained a total of 500,000 for child abuse. This was paid in 1990/'91 in two allocations: 350,000 specifically to implement the guidance and 150,000 following the publication of the Child Sexual Abuse Incident Report. We have been made aware at various times within the last year or so that Boards do not consider their allegations -- allocations sufficient to meet requirements, the most recent indication being the statements by the Northern Board as reported in the press."

It talks about:

"The Northern Board's response to incident report also emphasises the need for extra resources to

implement the child abuse guidelines and to develop" -- Sorry.

CHAIRMAN: Can I just interrupt? When it says, "We received half a million pounds", is this a departmental memo we're looking at or a Board memo?

MS SMITH: Chairman, I am not exactly clear. I think it is a departmental memo, because it talks about the Childcare Branch.

CHAIRMAN: Yes --

MS SMITH: If we just scroll back up, Mr Kearney --

CHAIRMAN: -- which I think is a departmental branch.

MS SMITH: Yes.

CHAIRMAN: There is a reference further down to individual Boards, which would suggest it's the Department.

MS SMITH: Yes. So clearly, I mean, the Department are planning for the year ahead and looking at what kind of funding is going to be needed and resources that are needing -- needed, and it is also talking about putting in a bid for specific service developments within Childcare Branch essentially.

If we can just scroll on down through that, it says: "I should be grateful for guidance from you about the use which the Boards have made so far of the 500,000 which they have already received and how much more in terms of extra staff, treatment facilities and training

is needed to enable them to fully implement the guidance, especially in the light of the heightened awareness of child sexual abuse."

Then it talks about dealing with those who commit abuse.

"I am conscious that the information I am asking for is not easy to produce and you will probably have to consult your contacts at the Boards. However, the deadline for our bid imposed by Finance Division is March '91. So please respond by 22 February '91."

So it is clear that -- yes, that's from Mr Forde of Childcare Branch to others within the Department.

There is a memo at 16346 of 15th March 1991, and again this is a departmental memo, because it is addressed to Mr McCoy from Mr Kearney of the Childcare and Social Policy Division:

"I have only three comments to make at this stage."

He makes the point:

"I have no money to offer towards the suggested assessment and treatment unit. I have, as you know, put forward a PES bid for child sexual abuse covering prevention, protection and treatment (for victim and abuser). Even if this succeeds, resources would not be available under it until 1992."

At 16343 we see a minute of a meeting of the Social

Services Inspectorate about resource allocations for 1991/'92. That's from Mr McCoy to Mr Hunter:

"We met today."

You see this:

"Report on the circumstances surrounding incidents of peer child abuse which occurred within residential care."

Now I will come back to look at that report in much more detail this afternoon hopefully, but this is just about the financial implications. It said:

"Following a review of the activities to date, we noted that the Board:

Are continuing discussions with the Unit of Management.

Are meeting today to consider the resource allocation proposals. These include?

£35,000 to improve childcare services generally.

30,000 to provide greater support for existing foster parents.

45,600 for Nazareth House Children's Home.

Additional resources to employ two houseparents in Coneywarren where there's a shortfall in staffing.

£99,000 to develop an area-wide child and adolescent psychiatric service.

They are proposing to hold a seminar to enable the

lessons from Harberton House to be shared with other residential childcare staff."

It goes on to talk about what was agreed at that meeting, but you will see that there are resources being applied to deal with the issues that arose from the peer abuse matter.

There's a memo from -- about the staffing of a post -- regarding -- sorry. If we could just look at it, 20088. This is 26th October 1993, and it is a memo from TL 4 to John Doherty. He talks about:

"... making payment to staff for additional hours worked in the interim and received information from Salaries & Wages Department. Enclose the information summarised below."

So there's -- this was following arrangements regarding Hughes. It is simply a back payment, as I understand it, for the increase in hours that they did work before the actual recommendation from Hughes was implemented.

There is also at the next page, if we can just scroll down to it, please -- you will see there are documents here about the payment for accumulated annual leave post-Hughes. That title is backdated because again there was a delay concluding local negotiations. So if we can just scroll down through that, please. Can

we just scroll on down? Sorry. I don't think that's -- that's not the relevant document.

There is at 19319 a comment -- this is in a minute of a Board meeting, that's a Western Health & Social Services Board meeting -- that from 1988 onwards there has been a departmental shift of finance towards the Western Board that took place in August 1990. I think it is contained on this page somewhere. If we can just scroll on down, please, talking about --

"He stressed that another landmark worth noting" --

Sorry.

CHAIRMAN: What is the date of this?

MS SMITH: This comes from August 1990. Now if we can scroll back up, we may see the preceding page. I think I probably -- yes, this is the Chairman's concluding remarks --

CHAIRMAN: It looks like 1990.

MS SMITH: -- yes, from 1990. This is at a meeting of the Western Health & Social Services Board. He talks about -- I moved -- obviously this is a speech that he gave.

CHAIRMAN: Yes. I'm sorry. I just wanted to find out, but if we could then scroll down to the passage you are drawing our attention to.

MS SMITH: Yes. If you could scroll down to the next page:

"He stressed that another landmark worth noting was that during this period the Board had finally convinced the Department that the system used to allocate finances made available to the province for healthcare was unfair to the Western Board. The result of these negotiations led to a welcome shift of finance towards the Board from 1988 onwards."

It is that final paragraph on that page that is relevant and not just to the issue of these two homes that we are looking at but also Module 1 and what was considered there.

CHAIRMAN: Well, a number the witnesses in this module have commented on what some regard as serious underfunding for the Western area for many years.

MS SMITH: Yes, indeed, Chairman.

CHAIRMAN: That would seem to be a contemporary reference to a change being achieved after a very long time --

MS SMITH: Yes.

CHAIRMAN: -- making the representations to the Board -- sorry -- to the Department.

MS SMITH: To the Department. He then goes on to make other comments that are not relevant to the issue of finance.

Just two other small pieces of material about finance and that's at 20205. This is just simply a memo about the holiday budget, and you see that Mr Doherty as

Acting Programme Manager had to request money from the Invoice Department for the sum of 1053.35 -- 39 -- sorry -- for the 1993 holiday budget for the 21 children currently resident in the home and asked for a cheque for the deposit to be forwarded to the team leader at Harberton House.

There is a request for Christmas money for children at 20291 for 1995. I don't know that it is necessary to look at it, but it is just an example again of how these things were funded within the homes.

I am just going say something generally about inspections in the homes. I have already looked at a couple of monitoring statements, but if we go to 15313, this is just an example of the report by a member of the -- sorry -- the visit of a member of the Personal Social Services Committee from 1991. Again we looked at these documents in respect of Fort James yesterday, but the same document was used in respect of Harberton House.

If we move on to 15316, this is a report on a monitoring exercise carried out at Harberton House in 1988 by SND 502 who was then Acting Director of Social Services, and Mr Haverty, Assistant Director of Social Services. I am not going to open it, but you see that she talks about what she did and the conversations

she had. If we just scroll down through that, we see that they talk about the staffing, admission and discharges, age range, staff leave, staff rotas, care plans, percentage of staff trained in 1988. Just pause there.

"Five members of staff have the CQSW. One is on CSS training and one on CQSW training. Six have CCRYP. Two members of staff have the post-qualifying training qualification from Queen's University and six members of staff have degrees."

There are talk about the catering:

"It is felt that only limited use should be made of cook freeze as there tended to be a lot of waste."

It goes on down to look at the recording mechanisms in the home, the fire drills, the complaint procedure booklet. If we can just pause there:

"This is not fully in existence at the moment in view of the difficulties at the Joint Council but is implemented in spirit. It was felt that we should now implement the procedures laid down by this Board on a trial basis.

Pocket money, management of drugs, personal laundry facilities and visiting facilities for parents, functional managers, aggression, contraceptive pill -- contraception/pill, and then discussion on the

monitoring programme facilities:

"The monitoring group found the exercise very productive and would like to thank HH 5 for his involvement in the exercise and both thank and compliment management staff and care staff concerned with Harberton House for the high quality of work carried out within the home."

As I indicated, there are reports of visits to the home by the visiting Board member. We can see these at 15320 to 15476. I am not going to -- there is more at 17038 to 17017.

At 15429 there is a draft Social Work Advisory Group report for 199... -- sorry -- 1986. You will see if we can scroll down through that at paragraph 4 -- again this is the Social Work Advisory carried out the report. It was Mr O'Brien. It sets out the background to Harberton and when it opened. Just scroll down. I am sorry. I should have had the page reference for paragraph 4. I think we may be getting there shortly. Yes. This is "Compliance with the regulations/direction". You will see that the -- it is clear that reports of members of the Personal Services Committee are being -- if we can just scroll on down, please:

"It is disappointing to find that there were no

relevant comments made in sections dealing with the quality of physical, social and emotional care of the children. Some observations were made about outstanding maintenance work and both reports concluded that the home was found to be clean and tidy.

Although visits should be made annually by members of the Personal Social Services Committee, only two were made to Harberton in the twelve months preceding the inspection. The direction also requires members to sign and date records that are kept in the home and this was not done."

Then it goes on to talk about the visits by the visiting social worker. Apologies. I am not going to go through that, but at paragraph 7, which is 15458, there is more reference to the non-implementation of the 1985 circular about complaints, comments and recommendations then can be found at 15462. Can we just go to 15462? It says:

"During 1985 thirty untoward incident reports, some of which were quite serious, were reported from Harberton. While these have to be set in the context of a high level of admissions to the unit, many of them children coming into residential care for the first time, they are an indicator of unsettled behaviour by the residents. The predominance of adolescents in the

group, a combination of short and long stay children, staff changes and absenteeism are identifiable contributory factors. Management can assist with moving forward quickly with the implementation of the plan to divide Harberton, by enabling more staff to go on professional training courses and through providing in-service courses which are appropriate to their needs."

This is the division into a medium stay unit and an assessment unit. It talks about staff being hard-pressed.

If we can go on down through it:

"It is recommended that the initial decision to remove a child to Training School and subsequent plans to extend his stay should be taken by senior management.

The following are recommendations.

It is recommended that reports should be prepared for reviews in accordance with Western Board policy and that plans and recommendations should be properly documented on the pro forma provided.

When future plans for children are made for reviews, the core evaluation team should ensure that tasks are allocated to the workers involved and that a specific period of time is set for their completion.

The formal division of Harberton into two units has

been agreed by the Board and it is recommended that this work should proceed without undue delay.

The Board should seek to increase the number of professionally qualified staff in the short-term and develop the expertise of all staff in childcare matters through their attendance at in-service training courses.

It is recommended that one of the senior staff is on the Harberton premises at all times.

Staff supervision sessions should be recorded and dated.

Members of the Personal Social Services Committee should be reminded of their duties under the Conduct of Children's Homes Direction with regards to the frequency of their visits, the inspection/signing of records and reporting.

A proper register for admissions and discharges.

Record should be kept of the meals provided.

Statutory records held in Harberton should be signed by the Social Work Manager in TL 4 absence.

A scheme of interior decoration suitable for a children's home should be undertaken.

Urgent attention should be given to requisitions for replacement of items of furnishing.

The initial decision to remove a child to Training School and subsequent plans to extend his stay should be

taken by senior management after a review."

Mr Carey in the statement he has given to the Inquiry has indicated that he set up another layer of supervision, as it were, by way of management audit. If we look at 20102, we see the management audit for 18th January 1989. It said that -- again:

"The following staff were on duty at the time of my visit."

It goes on to go through. Two students were on placement. It talks about the training and staff development, the children in the unit at the time, the admissions and discharges, staff sickness and that wasn't causing a problem. There was a recent bout of 'flu. Care plans, recording general information, the untoward incidents/accidents book:

"... appear in the monthly returns and both are seen and signed by the Assistant Principal Social Worker on a monthly basis."

Fire drill book, physical environment and conclusion:

"Overall I was impressed by the standard of care and organisation in the unit. The morale of staff has improved in spite of the significant difficulties with which they are faced in terms of the behavioural problems posed by children in the unit. The fact that

there are increasing numbers of disturbed children being admitted to the unit, some of whom have been sexually abused with all the risks that poses, such as sexual precociousness, does not appear to have adversely affected the determination of staff to do a good job. This I think is reflected in the staff's interest in assisting fieldworkers with certain aspects of their work and consideration is also being given to outreach programmes. This involves residential staff in conjunction with fieldwork staff offering services such as family meetings/family therapy to children and their families where this is considered appropriate ..."

I just pause there to say that is obviously what was then being talked about at core evaluation team meetings:

"... and it is envisaged that this would occur when the CET has considered applications for admission for assessment, but believe that whilst admission may not be indicated, the family could benefit from the family meeting type approach that has been developed in Harberton. In addition, I believe that the Board's proposals that emanated from Hughes recommendation number 6 have boosted", I think that should be, "the morale of staff and indeed many of the trained staff seem more than willing to take on the additional work

elements outlined in these proposals. In the long-term this will, of course, mean that management will have to look more closely at proposals for training staff and so facilitate the transition to parity of pay and the proposed extension of the residential role and the associated extension of the residential role.

The one possible cautionary note that was sounded in the inspection visit was the need to develop other placement options to cater for needs of children and young people either after assessment or when their period of stay in the medium stay unit has expired. In addition to looking at the home funding element", I think that would be, "this would also entail looking at existing resources and developing services to prevent admission of children into care or to speed up their discharge from care. All these are factors which merit attention and which hopefully can be brought to the Childcare Programme Managers Group when it commences its function. However, overall whilst I am satisfied with the standards of care at the present time, I believe that the quality of care provided will be severely tested because of the increasing number of children with very complex personal and family problems that are being admitted to care. This could obviously have an impact on the operational role of Harberton House and will need

to be monitored closely. In addition, it will be necessary to look at provision/development of fieldwork and other specialist services to facilitate the work being undertaken in the unit."

That is dated 31st August 1989. When I come to look at what was happening in the home around December 1989 and early 1990, then one might think that Mr Carey was showing some prescience in predicting the problems that might be caused for the home because of children with complex personal and family problems being admitted.

There are other management audits which I am not going to go through but which say -- the 1989 one is at 15623. There is one in January at 1... -- January '90 I should say at 15468, and another in August of 1990 at 15612.

It's -- just as a point of information it is recorded in that that HH5 during this period in 1990 and '89 was away at CQSW training. It is also noted that there were more children in the home than the home had capacity for. He talks about the -- in the conclusion about the effect on staff of the peer abuse episodes that I am going to look at later today.

In 1990, December 1990, in the management audit it is recorded that the demand for places was still an issue.

We see that the visiting social worker -- there's a bundle of material -- just moving on from management audits, there's a bundle of material from 17724 to 18423 which are the monthly reports of the visiting social worker, TL 4 , between 1987 and 1995. There is also a record of inspection dates by him in late 1995 at 10673.

I have already made reference to the monitoring statement from 1986 and to the SWAG report. There are departmental reports in respect of the home at -- the 1986 report is at 16975 to 17011.

There is then a Social Services Inspectorate report in 1987 at 18452 to 18470. You will recall yesterday that I opened a memo which indicated that the Department were then going to move to three-yearly inspections of the Board's children's homes and that next inspection report then is in February 1991. It is at 16514 to 16564 and a report in February 1994 at 16450 to 16512.

There is also a report for 1987 which is a social -- an SSI report -- sorry -- at 17184 to 17247. 17148, please. If we can just look at that, this is -- this appears to be a general report about admission of children to care inspection -- admission of children to care inspection.

If we can just scroll down through this briefly,

please, you will see there is an introduction, legislation, Departmental and Board policy, resources, a survey of admissions to care, decision-making procession and conclusions. This seems to be an overview of all admissions to care, not just obviously to residential homes, but a general overview of the admission to care of children in 1987, and there is statistics in that with regard to the matter. I am not going to open that. That's there to be seen.

In 1994 Marion Reynolds wrote to Kevin McCoy. If we look at 16435, this is a memo about the inspection of children's homes in the Western Board:

"Further to your request for a summary of the main recommendations emerging from the triennial inspection, the following issues -- highlight issues" -- sorry -- "highlights issues raised under four main headings:

Structure of service.

Staffing.

Professional practice.

Monitoring of fire regulations."

Then she goes on to talk about:

"The residential services are located in large buildings dealing with a large group of children with divergent needs. They operate at full or over-capacity for significant periods of each year. The consequences

of this are the supervision of children is difficult. Children tend to be admitted wherever a vacancy exists rather than to a specialist facility selected to assess their assessed needs. None of the homes were operational according to their stated aims and objectives and throughput levels in the three statutory homes are high. This influences the stability and continuity of care which can be provided to children with long-term needs.

There is no specialisation of function in terms of age, assessed needs of the children or the likely length of time they will spend in care."

Talks about staffing and professional practice and issues that arose out of that, and monitoring of fire regulations, and she says:

"I hope this brief outline is of assistance."

So essentially she is giving an overview of the difficulties that she perceived as a -- with the homes that were being operated by the Western Board in 198... -- '94. Sorry. So that would have been a general summary of the reports on all of the homes at that time.

There is a letter from -- to Marion Reynolds from Dominic Burke responding to the inspection report of Harberton House, the 1994. This is a letter of 22nd

February 1995 at 20267:

"The recommendations in respect of your report of Harberton House have now been considered with the Unit of Management and I would make the following response.

The Unit of Management should ensure its Supplies Department provides choices of furniture and fabrics for children's homes which are of a domestic nature. This recommendation has been addressed.

The aims and objectives are currently under review both in terms of interim arrangements supporting the closure of Fort James and in terms of long-term planning within the strategic objectives for residential care.

The draft area purchasing plan indicates that residential childcare strategy is to reduce the number of childcare -- residential childcare places provided by the Board from 74 to 18" -- sorry -- "to 56."

If we can just go on, the Board have agreed to purchase 18 residential childcare places from Nazareth House.

About preventative, fostering and community based alternative.

He sets out what progress has been made on that recommendation and he says:

"Consideration should be given to developing an admission policy."

He says:

"It continues to be the policy in Harberton House to admit children to the reception-assessment unit where at all possible. Increased efforts will be made to plan admissions to this unit."

If you can just scroll on down, residential staff getting training. He talks about they have undertaken a further training course.

"Support system. The Unit of Management are currently reviewing the nature of support required by staff who are the subject of a complaint."

Then he talks about the review of the service provided to the Area Mental Health Unit sector.

System of recording contact and home's menu, use of the daybook. Just goes on to talk about the other recommendations in the report.

"Efforts to improve the privacy of children's bedrooms.

Some steps have been taken to address this recommendation, for example, one three-bedded room now converted into two single rooms. Most children now have accommodation in a single room. Staff are currently examining ways in which children can secure their bedrooms and personal property.

Sanctions are recorded and monitored by team

leaders. Intention of the monitoring of sanctions will form part of the child's individual care plan and be considered at residential reviews.

Vetting procedures.

This recommendation has been actioned. It is recognised, however, that there are some delays in having vetting carried out."

The gender and balance within the teams to provide boys with appropriate male role models was an issue.

Essentially that's his response as Director of Social Care to the 1994 inspection.

There is some other general inspection matters in the bundle, but the main inspection reports can be seen at those pages that I have drawn reference to.

I am going to -- I see the time now in any event, but I was going to move on to what the papers disclose about the area of particular concern to the Inquiry and that is the issue of child peer abuse.

I just wanted -- there is some material that we received from the police obviously in respect of this, and if I may just summarise what that material shows in terms of what occurred in the two homes in the area without going into the details of the actual allegations. If I just find it. Sorry. Yes.

We received 29 police files relating to allegations

of peer abuse covering the time frame relevant to the terms of reference of the Inquiry. Ten of those files relate to Fort James and cover the period between 1982 and 1991. There was one file from 1982, one from '83, one from '85, one in 1987. There were three files in 1989 and two files in 1990. There was also a file in 1991, and, in fact, I will in due course look at some of the details of what those files are disclosing, but just basically to give this -- these statistics by way of background.

In respect of Harberton House 19 files were -- cover the period between 1982 and 1995. There is one file in 1982, two files in 1983, two files in 1984, one from 1985, one for '87, two for '88.

CHAIRMAN: A little bit more slowly, please.

MS SMITH: Sorry. I can provide you with a copy of this, Chairman, which will probably save you having to make a note of it.

There was one file in 1989. One file in 1990, which is the major file that we are going to have a look at this afternoon, involved nine children and implicated other children. There was another file in 1981 -- sorry -- '91 -- I beg your pardon -- and two files in 1992, another in '93 and two files in 1994, one of which involved four children, and two files in 1995.

The earliest report to police appears to have been summer of 1982 and that was in relation to an allegation about Fort James. There are other police files that disclose that there were investigations into this type of behaviour after the end of the Inquiry terms of reference. As I said, the only file in relation to an allegation against a member of staff is that relating to FJ5, which I outlined this morning.

There is also in the police material at FJH31071 an occurrence book entry, where a child alleged assault by a member of staff in 1986, and that complaint was not proceeded with.

That brief run-through of what the police material shows in terms of the numbers of files takes us quite neatly to lunchtime.

CHAIRMAN: Very well. 2 o'clock.

(1.00 pm)

(Short break)

(2.00 pm)

MS SMITH: Good afternoon, Chairman, Panel Members, ladies and gentlemen. I indicated before lunch I am about to start with an exploration of the documents surrounding the incident of peer abuse that occurred in 1989/1990 in Harberton House.

If we could look, first of all, at 15515, now these

are some memos before the matter came to light, which -- this is a memo from Mr Carey to the acting officer in charge of Harberton House. In the course of that there is mention made of the lack of beds in the home. If we can just scroll on down through it, he says:

"It is obviously necessary to monitor developments on an ongoing basis and for my part I will be anxious to provide whatever support I can to help ameliorate these problems.

I am aware" --

Sorry. The paragraph above:

"I am aware that this places additional pressures on staff who are already dealing with disturbed children and I am encouraged by the positive attitude shown by them in responding to the demands placed on them."

So there is a substantial increase in children requiring admission to care and that's putting a strain on Harberton House at that time.

There is another minute -- a memo from SND 502 SND 502 to Tom Haverty at 10200 of the same date, 15th February 1990. You will see there that she is keeping him:

"... up-to-date on the difficulties we are currently experiencing in childcare, particularly residential care. You will be aware that a large number of children

were admitted to care during the past three weeks with the result that we are now over our numbers in both Fort James and Harberton House. As you would expect, this is creating additional stresses and strains for the staff and not helping the staff morale."

She goes on to give details of the number of children admitted.

Then a further -- I should say that there's a minute of a meeting then on 8th March 1990 at 15495, and this is a meeting at Riverview in March 1990, and it is talking about the immediate demand for children:

"Three children requiring placements from tomorrow. Another child in foster placement must be terminated tomorrow due to foster mother's ill health."

Again it talks about the possible resolution.

"The opening of the bungalow at Harberton House for four children under 6 years."

That you will recall was the cottage that was then opened in 1990. We saw the daybooks from that cottage.

The matter came to light in March 1990 when an untoward incident report dated 15th March 1990 was filed by houseparent FJ37 . We can look at this at 10063. This is the untoward incident report which, as you will see -- I think it is fair to go through this in some detail, because this, as you will

see, involved some seven children named here. She records that:

"At the tea table on Tuesday, 13th March 1990 began to talk to a senior houseparent about when he would be moving to the other end of the unit. She replied that she wasn't sure. then said that moving would mean that all the craic would stop.

was asked what he meant by 'craic'. replied, 'The screwing and that'. He was asked to elaborate and was told that early in the mornings or changing after school that they stick their choo-choo up the girls' tunnels. When asked to explain this further, stated it is when he sticks his willy into a fanny. She stated that she would speak to about this later. Then another 9-year-old" -- I should say was 9 years of age at this stage -- "then another 9-year-old then said to her that was telling the truth.

She describes as being very high and began to name others who were involved, another 9-year-old boy, a 12-year-old boy, another 9-year-old boy and a girl aged 9 and a girl aged 13 and then a further 9-year-old."

So what happens then is that as a result of this the children are spoken to.

" was collected from gymnastics and instead of going to visit her sister she was returned to the unit. She was spoken to by the houseparent and confirmed that a child aged 12 had come into her bedroom on a number of occasions and lain on top of her bed. He had also woken the group of children named above, including , early in the mornings and taken them up to the sitting room, where he had lain on top of her with his clothes on. She had no pants on during this time. also stated that had tied her up with string, binding her legs and hands to the front of her. When asked to explain what happened during these times, stated that they 'rided'. She went on to add that both and had done this to her. reflected back to the alleged abuse carried out by her former foster father and stated that it used to hurt her private parts. When asked about the incidents with the other two boys, she stated that her privates parts used to be sore, but she did not say to staff in case she would get battered. She also confirmed that the incidents took place early in the mornings, especially Saturday, and during the time when uniforms were being changed. When asked how this could take place, she stated that they would take off their school clothes and go into the wardrobes or under beds.

went on to state that on occasions she was present in the visitors' room prior to Christmas. and were there. and would show each other their private parts. During a particular incident about two days before Christmas told that she was in Harberton because they thought she was having a baby. asked if she was and she replied 'No'. then asked if she would like one. said 'Yes' and then proceeded to take down her pants. took down his pants and lay on the floor. lay on top of her. When asked what they were doing, replied 'Riding'. When asked to explain, she said put his willy into and referred to her former foster father again. stated that she left the room when this happened and stated that she was glad it was out in the open, as she had become frightened.

, who was aged 13, was brought into the office, where she was informed about information, and she agreed without much emotion that the events with had occurred. She was asked why she had agreed to become involved with and she replied, 'Because he asked me'. I asked if this had happened before within the unit and she replied 'No'. I asked her if it had occurred with any of the other

boys. She replied 'No'.

, aged 9, was implicated by the other children as having played an active role in taking off her clothes and being screwed by and She was also along with the group who was awakened early in the morning by She denied any involvement when spoken to by the houseparent.

, who was aged 12, was taken into the office on the afternoon of 14th March. He denied touching either or He stated that he only kissed them. He said that was never involved in any of the activities. kept asking if kissing could put a person in Training School, and he also stated that had asked them to ride her, not to touch her but to do more. stated that was too young to ride, but it was okay to kiss her. deflected every question to blame other children rather than himself.

was brought into the office along with . He was very high and tried to make light of what had been occurring. He agreed that all the events talked about did take place.

stated that woke them up every -- very early in the morning and brought them to the sitting room to ride . He went on to state that

asks everybody to screw her and comes to their rooms with either no knickers or no clothes on. stated that if asks him to screw her, then he does. He also confirmed that the incidents took place in the playroom, room (in the wardrobe) or the sitting room early in the mornings or after school.

Later the houseparent spoke to on his own account about his tying up of He agreed that he did do this, but stated that if someone resists you, the thing to do is to tie them up. When asked where he had seen this being done, he replied 'At home' but quickly altered this to 'On the TV'. Later stated that his father used to tie him up and have anal intercourse with him. He drew out a picture of the anal intercourse for the houseparent and also stated that an uncle also abused him in this manner.

He went on to say that he was present when the uncle rubbed chocolate on the uncle's penis and had a group of girls lick it off. When they had done this, the uncle would lick around their faces. stated that he had wanted to tie up aged 9, in the same way as and screw her. He stated that was involved in the incidents of showing private parts and lying on top of each other. French kissing was also said to have taken place between all the group involved.

aged 9.

and all stated that had been riding , aged 7. A statement taken from and is as follows.

They told FJ38 , a houseparent, that last Monday out at the palm trees at the rear of the unit and were involved in what and called 'riding each other'. FJ38 asked them if it was sexual intercourse and replied 'Yes'. appeared to be baffled, asking 'What's that?' and then asked 'How do you know?'

was spoken to on the way to her school. She said that and had been screwing. A senior houseparent asked her to describe this and she said that underclothes had been taken down and that had been lying on her. She gave no further details.

and also stated that , and were involved in tying to one of the trees. At a later stage a 6-year-old boy, , was involved to act as look-out.

was spoken to by the houseparents and he denied everything but said he had been only kissing and nothing else.

according to the rest of the children played

a very minor role in all of the incidents. It was said that he lay down on when both had their clothes on. He was French kissing with the girls but appears to have been an onlooker to incidents. He also stated that it was who got them all up early in the morning to go to the sitting room.

was spoken to by staff regarding the incident with She vehemently denied that anything untoward had taken place and stated, 'I don't want to talk about it'."

Then you see that the social workers for each of the individual children, the fieldwork social workers, were told about the incidents. Then there is various information about the relevant details to the children who were involved.

You will see, as described, he himself had been abused. The 13-year-old had been involved in sexual relationships with a number of boys prior to entering into care. disclosed that he had been abused by his father and an uncle. was out of his mother's control. There was no history of sexual abuse. had been sexually abused. was alleged to have been abused by her former foster parent. was admitted due to suspected sexual abuse by family members. Another child, , was in because of her

father's inability to cope with her, but she had projected overly sexualised behaviour within the unit on numerous occasions.

If we look at 15595 -- or maybe we have just been looking at that. Yes. This is a document described as "Sequence of events as to what occurred".

On the Tuesday you will see that began to give information in the evening.

Then on the Wednesday the other children mentioned by him were interviewed by staff. The relevant social workers/team leaders and assistant principal social workers were informed.

TL 4 couldn't be informed directly but he was informed the next day and informed his line managers, Mr Carey and Mr Haverty.

He then called at Harberton House to discuss the incidents.

Mr Haverty called at Harberton House.

An untoward incident report was completed and taken to the Area Board Headquarters by Mr Haverty.

The child who seems to have been a major player in all of this, was transferred to Training School.

On 16th March a case conference was held including all the relevant social workers when it was decided to:

Inform all the parents.

Notify the CARE Unit, which is the Child and Adult Rape -- Child Abuse and Rape Enquiry Unit of the police.

Take individual action in respect of the children named.

Waking night cover was provided from this date for it says one week in this.

Then there was a statutory holiday.

On 20th March Mr Carey had a discussion with the Acting Principal Social Worker about

Case conference was held on him with Training School proposed as an option.

Mr Carey discussed the situation with Mr Haverty.

Mr Carey spoke to the acting deputy officer in charge about the action taken and that required to safeguard children in the unit.

Childcare Branch in the Department, Mr Wesley Donnell, was contacted by Mr Carey on 22nd March 1990.

The core evaluation team minutes of 23rd March noted that, "Precautions are being taken to prevent the recent untoward incident from happening again".

On 18th May Mr Carey met with the constable from the CARE Unit about the incidents.

A presentation to the Area Executive Team by Mr Carey and TL 4 was made on 24th May 1990 setting

out:

Current demand.

Incidents in Harberton House.

On 1st June there was a presentation to the Community Care Committee by Mr Carey and TL 4

Then there was a discussion at the community evaluation team about .

Case conference took place at Rathgael about William.

On 19th June Mr Carey, TL 4 and HH 22 , the acting officer in charge, met to discuss the implication of coming back to Harberton. As I go through further documents, you will see that he was only placed at Rathgael on a temporary basis.

Dr McCoy visited Harberton House on 26th June 1990.

Placement meetings then started to resume at the end of June. You see there are placement meetings through July and August.

On 6th August Mr Carey met with senior staff in Harberton House about the review team. He carried out an audit in August of 1990 and then placement meetings continued.

Now at 11055 there are minutes of a case conference that was held on 16th March 1990. You will see that there was quite an attendance at that case conference.

"A report was presented and read by all involved. It was recognised that all the children with the exception of one has been involved in the past in some type of inappropriate sexual behaviour."

An update on information received in relation to the seven children involved was then given. I am not going to go through all of that. If we can scroll down through that, please, the conclusions were that:

"Relevant social work teams will inform parents of their child's involvement and action taken.

Staff within Harberton will share information with the police, and

Social workers will pass on the information to the investigating officers."

That's when the night duty commenced, the waking night duty commenced.

There is another case conference on 21st March, which can be seen at 15554. Again remind people of the purpose of the meeting, which was:

"... to discuss s difficult behaviour within Harberton and discuss the part played by him in more recent disclosures of inappropriate sexual activity within the unit."

People were given an update of his involvement. I am just going -- if we can scroll on down through

that, the case conference was solely on what should happen to If you just pause there:

"The option of Rathgael Training School, who are opening a pre-teen unit, was discussed. Due to age (the fact that he is only 9 years old), some discussion took place as to the legal aspect of the case.

A lengthy discussion then took place in relation to his behaviours. Freely acknowledged that Harberton House was no longer offering the necessary levels of care, protection and control which -- to be of any therapeutic benefit to him."

Then a phone call was received confirming that provided that Rathgael were prepared to accept the Board were within their rights to follow that option.

From 15563 to 15567 there are notes of conversations between social workers and the children involved. Just if we look at that, please, and you will see that -- sorry. This is much later. Yes, this was later on. As I indicated earlier, there were other children subsequently implicated by one of the original children. At this stage this occurred during the summer and at that stage conversations were carried out with the girls and children that he had named as being

involved in such activities.

This is a note of a conversation between one of the residents and the senior houseparent and the deputy officer in charge about that. If we can just scroll on down, please, you will see these conversations then -- that's one girl who was implicated -- in fact, two girls were implicated by him at that stage.

If we can just scroll on down to the next page, and you will see that is the conversation with the other girl who was named. She had been, in fact, out of the jurisdiction on holiday during the summer. So they waited until she came back before speaking to her.

Then there's a conversation in June 1990 where discusses this other girl's involvement in the incidents that led to his transfer to the Training School. You will see that he makes the comment that:

"Anyone who touted to staff was tied to a tree and tortured by this girl. This would involve other children dancing round the victim and then would whip them. This happened to to stop her from touting. They indicated that this older girl was very powerful and went on to say in front of staff she acts like an angel. Behind their back she's evil."

That conversation is continued.

Then if we look at 11041, this is a memo from

Mr Carey to SND 502 about a letter of complaint about Fort James and it says:

"Further to the letter of complaint which you received from , I arranged to meet with him on Friday.

During the course of our meeting he raised very much the same sorts of issues that he raised in the letter, that is that given the fact that there are three to a room, he feels that his privacy is being invaded and that the overcrowding in the house is putting additional pressure on him and the staff. You will be aware that there are currently 19 children and young people in the main house which is meant to accommodate 15."

It goes on to talk about that 's behaviour gave such concern that he ended up being transferred to St. Patrick's Training School.

"According to -- explained to that the current overcrowding is a direct result of the pressure we've experienced recently for young people requiring care. I also indicated that we would take steps to reduce the overcrowding as soon as this was feasible. He did suggest that perhaps overcrowding could be partially reduced by moving people around within the main house and I undertook to examine the suggestion. Overall I feel that is pleased with our discussion, particularly the fact there had been

a response to his complaint."

So again this is in March 1990 a child who was resident within the home was complaining about the overcrowding in the home and that was elevated right up to the Principal Social Worker.

At 15579 Mr Carey on the same date's as he is writing to SND 502 sent a memo to -- sorry. 75. 15575. He sends a note to Mr Haverty about the incidents in Harberton House and he says:

"I refer to the recent incidents in Harberton House involving sexual activity on the part of a number of young people which I have investigated with staff. It would seem that the incidents took place:

1. Early in the morning between 3.00 am and 6.00 am.

2. After school -- between 2.50 and 4.15 approximately.

3. In the grounds of the unit during the course of the day.

The most serious incidents appear to have taken place in the early hours of the morning when one of the boys, who appears to be the main perpetrator in this situation, would have gotten up out of bed and roused the other children. This particular boy's behaviour had been causing concern and it would appear that he was

capable of manipulating and intimidating other children in the unit. However, the fact that this young person could indulge in this sort of activity during the night raises a problem that needs to be addressed.

As far as we know at this stage, the activity engaged in after school seems mostly to have been kissing and cuddling and occurred at a time when a number of staff are out collecting the children from school. They are about four runs to ten different schools and that has to be undertaken, and even though taxis are used in addition to the unit Estate car, I understand the taxi drivers insist on escorts for insurance purposes, so that a member of staff always has to accompany them. The children return to the unit at various times between 3.00 pm and 5.15 (sic) and are encouraged to change out of their school uniforms straightaway. The corridors in which the children's bedrooms are situated are not segregated by sex and this increases the risk of something happening during this time. I did, in fact, examine the possibility of segregating the corridors to make supervision easier, but this would be difficult in view of the fact that at any one time there may be more boys than girls in the unit or vice versa. The only satisfactory way around this problem would be to explore the possibility of

using volunteers to provide the escorts to and from school so that sufficient staff are on the floor of the unit to provide supervision.

In the interim it is hoped that we may be able to use the domestic staff to help out, though clearly this could only be a short-term measure.

A number of the incidents apparently took place in the grounds of the unit. As you know, there are quite extensive grounds at the rear of Harberton House and it would seem that look-outs were used to ensure that staff did not discover what was going on.

Having looked at a number of possibilities to provide better supervision the two most feasible options that were suggested were that:

(a) staff step up their vigilance by increasing the number of times which they check on children in the grounds of the unit.

(b) that they focus their attention particularly on supervising those children known to pose a risk to others and those who are known to be vulnerable.

In terms of corrective -- overall corrective action needed to be taken to prevent the recurrence of these incidents, you will be aware that you gave approval for the employment of a waking night worker. During the time that this lady was employed there were no incidents

and I suspect that this was largely due to fact this the main perpetrator was removed to training school. Indeed another young person who was also allegedly involved in these incidents was removed to training school in recent days. His behaviour had also been giving grave concern -- grave cause for concern in recent months and I would hope that access to psychiatric and psychological services in Rathgael Training School will greatly help us to plan the future of this young man.

I had hoped to extend the employment of the waking night worker, but I understand that she received an offer of other employment. As an alternative I have suggested to staff that one of the sleeping in staff get up at 5.00 am in the morning and are paid for the two hours between 5.00 and 7.00 am, when they would normally be getting up. In this way I would hope to provide additional supervision in the unit. However, in the long-term I feel that we need to install an alarm system similar to which is installed in Coneywarren Children's Home in Omagh. This system entails the installation of an electrical device in the door of each of the bedrooms, and when the door is opened and the electrical circuit broken, an alarm sounds in the sleeping in room. Therefore if any children leave their bedrooms during the course of the night, sleeping in staff will be

aroused.

One further measure which we clarified with Mr -- with the Group Fire Prevention Officer was that the doors giving access to the mid section of the unit should be locked at night. This will ensure that children do not have access to parts of the building where it is less likely that they may be detected."

It does not pose a fire risk doing that.

"I would hope to discuss this whole situation with TL 4 , the Assistant Principal Social Worker, on his return to work to ensure that the corrective measures that have been initiated are monitored and reviews as appropriate.

In addition, since the police investigation into the incidents is ongoing, it may well be that further information might emerge which will require further action to be taken. Obviously I have highlighted to staff the need to be vigilant and to learn from this experience and I also expect that TL 4 will reinforce this message. Given the fact that these incidents arose, however, I think it is also important that we consider how we could apply the lessons learned here to Fort James where there are also a number of vulnerable young people who have been initiated into sexual behaviour. I believe that it may be necessary to

consider the installation of an alarm system at Fort James similar to that which I am suggesting should be installed in Harberton and I intend to ask the Works Department to obtain an estimate for this work for Fort James."

That was signed on 26th March 1990.

Just in passing I note that in April 1990 the visiting member of the Personal Social Services Committee, Imelda McGowan, noted -- she sent a report to Tom Haverty with a covering letter indicating that there was staff shortages and overcrowding in the home. He sent her an update in May of 1990. Those documents can be found at 10010 through to 10011 and then at 10047 and Mr Haverty's update is of 18th May 1990 at 10095.

On 2nd May at 10655 we see a detailed memo about social work staffing levels which was prepared by Mr Carey. I am not going to open this up, but if we can just scroll down through it, please. Sorry. If we could just scroll up slightly for a moment. There is one point there that -- it's said:

"From Figure 1 below it will be seen that the social workers per 1000 of the population from the Western Board on a comparative basis with both the other three Boards and indeed England is seriously disadvantaged. This situation also pertains to trained social workers

per 1000 of the population, and when one collates this type of information and combines it with the very serious trends in the numbers of extremely complex and difficult childcare cases presented to social work staff, it is clear that appropriate action will need to be undertaken if we are to maintain the quality and range of protection and preventative services in the childcare field."

Now obviously this is not just social workers in the residential sector, but social workers within the Board area generally.

If we could scroll on down, please, he talks about the number of children on the Child Protection Register, the types of cases. Then sexual abuse referrals from 1985 up until 1989 and the numbers increasing over that period. He says:

"This development has had a number of effects. Firstly, due to the complexity of this type of case the expertise, time, commitment and levels of stress for workers have significantly increased. Secondly, due to the level of risk there is an increased likelihood that the children are admitted to care or at the very least placed on the Child Protection Register. The Department is increasingly using wardship as a means of protection for children."

If we can scroll on down, please, it talks about court work and wardships and the number of wardship orders that were issued and also reports under the Matrimonial Causes Order 1987. There is also mention of the Adoption Order.

If we can scroll on down, then it talks about children in care and it says:

"The report has tended to highlight the massive increases in the workloads in various areas of childcare such as child protection, wardship, matrimonial causes, adoption and so on. However, it is important not to lose sight of the additional commitments that workers have to children already in the care of the Board."

It talks about the foster care system and the teams responsible for the children itself. It says:

"For example, of the children in residential care, some 39 are awaiting long-term foster placements. In other words, all these children have been identified as being unable to return home in the immediate term and thus are ready for a long-term placement and are presently inappropriately placed within the residential unit. This fact in itself creates a tremendous amount of work for the social worker, which hopefully will be partly offset by the provision of two additional workers for the fostering unit. However, even with this

increase in staff for the unit social workers and childcare teams will still have to be involved in home finding in the immediate future in order to adequately address the numbers of children in care waiting for foster placements.

In conclusion, I would hope that the factors and evidence outlined above reflect the urgent need for additional childcare staff in order to cope effectively with the current work demands."

Just scroll on down, please. He said the impact on staff morale is something that causes him concern particularly when -- he talks about child deaths in England and the effect that that would have had. He said:

"The central problem is that of insufficient staff to meet the workload demand. We are working below DHSS recommended targets with a childcare staffing complement which has only been increased by one worker in recent years."

So clearly at this period in May 1990, when a review is done of all the social workers involved in childcare, Mr Carey is saying that the Western Board is shortchanged, if I can put it that way, in terms of the number of staff that it has and the effects that that has on them.

CHAIRMAN: He is making the case that this is reflected in the problems of insufficient care staff available for childcare work specifically, not just all the other areas.

MS SMITH: No, it is not specifically. Yes. No. This only relates to childcare within the Western Board area as well, but it doesn't solely relate to residential care. Obviously it's the whole childcare picture.

There is a letter from SND 502 of 8th May 1990 to Dennis O'Brien about children complaining about conditions in Fort James, which can be seen at 11040, which again is reflective of the issues that were pertaining around the time. You will see that this is the child who had complained and, as I said, Mr Carey had looked at his complaint, but what she says is:

"Since the beginning of January we have had an absolute epidemic of serious child abuse within the community and we have been required to admit very traumatised children, who have in turn been behaving in inappropriate ways.

You will note that in the addendum to Mr Carey's report", which I looked at, "I understand I may be receiving complaints from other children and young people in Fort James.

I think the only positive side in this unfortunate

situation is that the children are feeling free to complain within the organisation and indeed direct to me. I shall be forwarding you a more detailed letter indicating the current crisis which we are in the process of handling."

She says:

"There is evidence to suggest that we are now beginning to see the child abuse which we have known for many years was about but wasn't, in fact, coming our way."

There is a memo of 9th April 1990 from TL 4 to Tom Haverty about the occupancy in homes at 10034. You will see there that Harberton had 28 children, including two in Training School whose beds were retained; Fort James had 21 children, 3 in the semi-independent flats and 18 in the main unit; and there were 24 children in Nazareth, which was four above their occupancy level.

He gives a status return on 10th April 1990 at 100... -- sorry -- 11036. You will see that this is "Status report on the care situation in Foyle Community Unit of Management, 10th April 1990". It talks about the current situation in respect of care resources:

"All of the children admitted were urgently in need of care. The current situation in Harberton House is 28

children in residence, 24 in the main unit and four in the detached bungalow."

If we scroll down, please:

"At one stage during the past month their occupancy had risen to 32 children, which is 7 above their occupancy level. In order to meet the demands of this level of occupancy, it was necessary to employ six additional care staff. The approximate additional cost of this is £5000 per month.

Fort James currently has 21 children in residence, 3 in the semi-independent flats and 18 in the main unit, which normally accommodates 15 children. At the moment we have not recruited additional staff to meet this demand, as none are available in the job market.

Nazareth House has currently 24 children, exceeding their occupancy level by 4. The additional cost of fees to Nazareth House is 3640 per month.

Coneywarren had 5 more than their occupancy level.

Nazareth Lodge in Belfast. It had been necessary to place three children from this Unit of Management in Nazareth Lodge and it would appear that they will appear (sic) there for the next three months before they can be returned home. In addition to social workers' travelling expenses and time, fees paid to Nazareth Lodge will be approximately 3800 per month."

Then it talks about children placed in foster care outside the Unit of Management and the additional number of children placed in foster care and children awaiting long-term fostering placements.

"The implications of the current situation are financial. The high demand of in care places has financial implications in terms of the need to employ additional staff on a temporary basis to meet the demand or to pay for additional fostering placements. As the in care service is a demand-led one, financial targets in terms of existing budgets require to be amended."

He talks about Fieldwork Services and then goes on to the effect on residential staff and says:

"Overloading the residential facilities has had implications both for staff and for residents. Residents, particularly in longer stay units like Fort James and Nazareth House, have complained about the seriously disruptive effect on their daily lives of attempting to accommodate more than the occupancy level. In order to accommodate emergency admissions some children have had to either move from their existing bedrooms or share their bedrooms. In addition, existing quiet sitting rooms have had to be used as bedrooms.

The need to recruit additional temporary staff while providing us with an acceptable number of staff on duty

has resulted in a dilution of the level of qualified staff available within the units. All of the additional temporary staff who were recruited are unqualified, untrained and inexperienced. As such, they have required a high level -- higher level of support from existing staff."

He signed that at the end of that. He talks about the effect on the fostering unit also.

That was ... If we look at 10035 -- sorry. In fact, if we go back to 10045, please, you will see that this is now on 10th April, a month -- I wonder if that's the same one? I think it is maybe just -- sorry. Apologies. That is just another version of the same document.

In fact, if we can just scroll down to the bottom of that page, please, and go over the next page, I think this might actually have been provided -- this is a different document, but it is signed by Mr Carey. The original one was TL 4 I think this was -- we actually have to go back to 10044. Unfortunately these are out of sequence. It's a three-page document and the third page -- no. Same document. Apologies.

At 10035 the update on the situation is of 9th May 1990 and you see the occupancy rates there are pretty similar. They is still 28 in Harberton, 21 in

Fort James, 23 in Nazareth House, 3 in Nazareth Lodge in Belfast and 181 children in foster care.

There is a memo of TL 4 to Tom Haverty on 20th April 1990 at 10098. This is a report of a visit on Miss McGowan's -- the report that she prepared for the Community Care Committee after her visit to Harberton on 6th April 1990 that I mentioned:

"Although I cannot contradict the factual information contained in the report, it has been the subject of much discussion and correspondence through the line management structure and to Board's headquarters. I am concerned about the inference that managers are failing to address the issues raised.

The high demand for places in care over the past few months has been reflected in other Units of Management within this Board and in other Board areas. The unprecedented number of admissions was exacerbated because many of the children were members of large sibling groups. When fostering resources became saturated, residential and fostering placements were sought outside the Board. When these were not available options, it was necessary to extend our residential provision by utilising the bungalow at Harberton House. Despite all our efforts, the only staff available on a temporary basis were relatively inexperienced staff,

who nevertheless were required to provide care for four children under the age of 6, none of whom required intensive therapeutic help. I appreciate that overall HH 22 had to cope with an exceptionally difficult situation with a staff team whose skill and experience were diluted. However, in meeting our statutory responsibility we were required to provide care and protection which of necessity had to be of a higher quality than that faced by those children remaining at home. This I feel we accomplished.

In terms of overall resources there has been a recognition for many years that the childcare programme is under-resourced in terms of departmental guidelines. I am aware that this is a situation which has been raised forcefully by social work managers and seems to find some response in terms of recent decisions by the Area Executive Team to provide funding for additional staff. I am aware that these developments are not as a result of Miss McGowan's criticism but rather the result of the efforts of Social Services managers to seek resolution to difficulties already recognised by them."

At 10029 there is a handwritten note of the children who were admitted and needing to be admitted to care between January 1990 and February 1990. So within that

month these are the names of the children there who were admitted to care. In fact, there were 27. Children awaiting care as of February were 11, leaving eight places to be found. Then:

"? bungalow."

So all of this documentation is showing that at this period of time not just Harberton House but the entire residential childcare section within the Western Board was being heavily stretched in terms of admissions of children and the effects that that was having on other children and on the staffing.

There is a memo at 10056 from -- this might be something we have been aware of before. This is 15th February 1990. I am not quite sure if that -- if this is one we have looked at before, but no.

"As you will be aware, there has been a substantial increase in children requiring to be admitted to care in recent times. Since 19th January there have been 28 children admitted to care. With the exception of one who was taken on a Place of Safety to Training School, the remainder were found places in either residential or foster care. As of 14th February there were ten children -- there are ten children awaiting admission to care, at least one of which is a fairly concerning physical abuse case which has had to be deferred as

a result of the requirement to obtain places for other children. In addition, I understand from the Senior Social Worker that there is a foster placement about to break down, so we'll have to obtain an alternative placement for that child also. I would stress, however, that the majority of children who were admitted to care came to our attention because of neglect/physical abuse and the inability of parents to provide proper care and not because of sexual abuse. However, that is not to say that some of the disorganised families' children have been admitted to care that disclosures of sexual abuse will not become an issue at a later stage."

He talks about the difficulty that that has created for residential staff in particular and fieldwork staff:

"I met on 14th February with various managers to assess the situation and to look at options available to cope with the demand for residential and fostering places."

He talks about who was present at the meeting. He said:

"The situation at present is as follows.

There are 27 beds taken up at Harberton House at the present time, though one of those young persons is currently in Training School and the court case is to be heard on 27th February, where it is expected that

a Training School Order will be made. Therefore in terms of actual numbers there are 27 young people in Harberton. There are two people on the waiting list for assessment. One of these is the case of physical abuse I referred to above. The other is a young person who is currently in Training School and we may be able to buy time to keep them there until a bed is available. There is also one other young person undergoing assessment whom we are considering for discharge."

It goes on to talk about the capacity in Fort James being 19, but currently 20 children on the books.

"Obviously staff will be looking at whether any of the children in the main unit can be moved out to the flats."

It says:

"To resolve this situation the following measures are being implemented:

Contacting other Boards to obtain residential and foster care places.

Reviewing the situation for the children currently in care to ascertain the possibility of discharge.

Using the resources within the community such as day centres and looking at the costs associated with opening up the bungalow at Harberton House, which would provide a maximum of four places, but there would be substantial

associated cost considerations."

Although these are not directly linked to what was being done in terms of the disclosures that were being made, it is indicative of the situation that was there at the time just preceding the incident coming to light.

Now at 10030 matters having been now brought out into the open and there having been meetings about that, there's a memo from Mr Frawley to SND 502 , saying:

"Further to your presentation at the Area Executive Team on Thursday, 19th April on the above, I have now considered the implications. I am very satisfied with the steps you have taken to date to protect the interests of children both at home and in care. However, I would now be anxious that we examine particularly within the context of Foyle Community Unit the implications of developing a task force, which clearly would have resource implications but would take a more comprehensive analysis of this difficult issue."

He points out, you know, SND 502 suggestion of a task force to address these issues would have resource implications.

At 15594 I think this is maybe the document we looked at of 2nd May 1990. I should apologise. Some of these documents are duplicated within the bundle. Yes. I think that's -- we have looked at that. That is just

simply setting out the -- the documents set out the comparative disadvantage of the Western Board.

At 10027 I think again that might be a repeat document of SND 502 letter to Dennis O'Brien about the situation in Foyle. If we can just check that, please. 10027. This is where she writes on 8th May to:

"... formally advise the Department of our childcare difficulties in the Londonderry, Limavady & Strabane Unit of Management (now known as Foyle Community since the beginning of January) and indeed we continue to have the problem of a virtual epidemic of children requiring care. We had thought initially around February that this was a phase but it would now appear that it is an established upward trend in the referral rate and our residential resources have been over-stretched in the extreme.

I have enclosed internal memos dated 15th February from Mr Haverty and one from Mr Gabriel Carey to Mr Haverty highlighting the problems in February.

As a result of the admission of many physically abused children and indeed since February a considerable number of sexually abused children, we discovered in mid-March that some children were sexually abusing each other in Harberton House. This is currently being

investigated by the RUC at our request. The report dated 15th March makes horrific reading and has given us considerable cause for concern. I have brought the matter of high admission rate abuse and the abuse among the children to the attention of the General Manager and our Area Executive Team and have received a most sympathetic understanding response, which has resulted in the monies being released for two additional full-time social workers in the fostering unit and four additional social workers for Foyle Community.
I believe this will do much to free up the situation in the residential homes.

I think the untoward incident report highlights for me how difficult it is to keep a residential home safe and naturally this gives me much cause for concern."

She encloses a copy of a memo from Mr Frawley:

"... and can assure you that we as a management team are doing all that is humanly possible to address this frightening increase in abuse."

That was 5th May 1990.

There is a memo from Tom Haverty to both TL 4 TL 4 and to Gabriel Carey about a presentation to the Childcare Committee on 17th May 1990. That's at 10089. If we can just scroll down through that, I think that's just about the presentation really.

At 15542 we see that the suggestion of an alarm system was costed. We see that on 17th May 1990:

"I have received the budget cost to supply and install an alarm system at Harberton House.

The systems would each consist of a control panel, mains operated and so forth. The budget cost is as follows. Cost to supply, install, commissioning and one year's maintenance, £870 plus VAT."

There's a control panel, which is optional, and pocket pager, which is optional.

"I would like to point out that this installation would require specification and drawing to be drawn up before it could be installed. If you wish to proceed, it would be necessary for you to process this through your Unit General Manager for prioritising."

At 10071 there is an update from Gabriel Carey to Tom Haverty about the police situation:

"The police investigation not yet complete but the main perpetrators have been interviewed and rather than any -- delay any further, I am anxious to consider the allegations in relation to the various children who have been identified. At this stage I will furnish you with a report on the situation."

At 10097 there's a memo of 19th June 1990 from

"Further to our reporting of the untoward incidents to the DHSS, Mr O'Brien has asked for a breakdown of the children admitted over our very difficult period. The purpose of this information is two-fold:

1. Acquaint Department.

2. Highlight the childcare difficulties which we are having and hopefully this will impact on our request for resources for 1991/'92", I presume that should be.

"3. The Chief Social Services Inspector would intend visiting Fort James and Harberton on 26th June in the afternoon."

Those statistics on admission to care from January to April 1990 can be seen at 10072. If we can scroll on down, the number of direct admissions was 57, but if we can scroll on down, please, just those continue on. Those are the names of the children who were admitted I think. Then there's a breakdown there of the reasons for admission, the estimated term, the type of placement, and a lot you will see were placed in residential care at that time.

At 100... -- 11020 -- I should say that that goes on -- yes, that's the last page at 10077.

100... -- sorry -- 11020, 21st June 1990 Mr O'Brien writes to Mr McCoy within the Department about the state of play in homes in the Western Board's children's homes

and he talks about the admission to care and the correspondence they have had and then the impact on residential care.

Then at paragraph 4 he says that:

"The Board has also received written complaints from some of the children in Fort James and Harberton relating to overcrowding, restriction of their movement, having to move bedrooms, etc. In a recent letter to the Principal Social Worker the children living in Harberton House have objected to the return there of the boy mentioned in the previous paragraph. It could be that some of the recent letters sent to management were inspired by staff interests."

He talks about the investigation of untoward incidents and remedial action by the management and implications for the Chief Inspector's visit:

"It is anticipated that some staff may view the planned visit by Dr McCoy as a consequence of the untoward incidents. It is conceivable that they may express to Dr McCoy their disagreement with management's policy on the placement of children admitted to care. They have already made representations to a Board member who was making a statutory visit to the home. It is clear that SND 502 would wish staff morale to be raised by the Chief Inspector's visit and for her staff

to feel that they have his support in the face of their current difficulties."

Again on 21st June at 15556 we have a letter from Mr O'Brien to SND 502 about the status report and what he says:

"It is clear the admission of 58 children to care over such a big period has put a considerable stain on placement resources within the Foyle Community Unit of Management. I hope this may be of a short duration and that the excessive numbers in the children's homes may soon be reduced. Hopefully this will be achieved through strengthening the Fostering Unit, thereby overcoming the logistical and professional problems which have arisen."

At 15568 there is a detailed update by Gabriel Carey to Tom Haverty on the allegations and the investigations. He talks about:

"The investigation was quite complex with accusations and counter-accusations and to give this report some coherence I followed the same approach as the CARE Unit, who deal particularly with the victims of crime, and I will outline the statements made by the girls to the police."

So I am not going to open these, but if we can just scroll down through this, please, you will see the

detail that is provided there updating Mr Haverty on the allegations that have been made and the investigations that have been carried out.

I think I missed -- there is a letter from -- just scroll right down then, please. That goes to -- we have the end page here. The conclusion, though, there is:

"Clearly the allegations that have been made are very serious and I know from my conversation with staff in Harberton House that they have had a devastating impact upon them. The behaviour in which these young people engaged was extremely inappropriate and from what we know is a reflection of what they experienced before coming into care. Obviously the immediate reaction we took -- action we took was to remove the two main perpetrators. Also within the unit we took other management action to try to improve the level of supervision."

But just before I do -- the preceding paragraph:

"One child was removed on an Interim Order to Rathgael. It seems likely that Rathgael will be recommending that he is not Training School material and that he should return to us."

This is the 9-year-old boy. You recall that some of the children were concerned about -- I think it was actually the other boy's return to the home, but it

says:

"In the longer term in addition to learning the lessons from what happened I have asked the group manager to cost a door alarm system", which you have seen.

"It is important to consider the incidents which occurred in context. Harberton House has a significant number of children who have been sexually abused and research evidence would seem to indicate that in the first instance children who have been initiated to sexual behaviour will carry on being involved in some sort of sexual activity; secondly, that those who have been abused often become abusers. As the proportion of sexually abused children in the unit increases, obviously this is going to have significant ramifications for the management and philosophy within the home.

Another point to be borne in mind is that the incidents arose at a time when the unit was going through a crisis, when there were children placed there over and above the stated occupancy level. At one stage there were 32 children in a unit meant to accommodate 25 and this entailed opening the staff bungalow and employing six additional staff members. These were unqualified and inexperienced staff, who required a lot

of support from the regular staff. Moreover, because of the numbers, the focus was on meeting children's primary needs and the therapeutic work which normally is the feature of work in Harberton House took second place. The combination of these factors probably meant that the incidents occurring were not picked up as soon as they might have been had this crisis not been going on. Nevertheless, this has led to staff engaging in regular reviews of the situation in an attempt to ensure that such an occurrence does not arise again."

It goes on to talk about therapeutic work with the children. It says:

"As a measure of the overall problem it is interesting to note that in the last five years we have only experienced ten untoward events of a sexual nature in the home, and given the number of children in the unit who have been sexually abused, I believe this does reflect the vigilance of staff."

CHAIRMAN: I think we will take a break. Ten minutes.

(3.10 pm)

(Short break)

(3.20 pm)

MS SMITH: There are a number of memos, interdepartmental and interboard memos, about what happened between June 1990 and onwards. for example, the Board -- I am

not going to call these documents up, but, for example, Mr McCoy is expressing concerns to the Department that this was only discovered by chance and there's a suggestion of an independent investigation, but the Board itself had suggested initiating an investigation that would provide learning for Boards across the way, and a review team was then set up led by Mr Bob Bunting, who is someone the Inquiry has heard of before.

Now the full report of Bob Bunting's review -- and I don't want to call this up at the moment, because the initial copy that we had had a page missing. So I'm going to refer to the document where the page is missing, but the full report can be found at 20297 to 20357 in the bundle.

If we look, first of all, just briefly at -- there are a couple of documents about the establishment of the review team at 10147. You will see that the background is set out there, the membership of the review team, who is Mr Bunting, who then was Assistant Director of Social Services of the Eastern Health & Social Services Board, Mr Armstrong, the Senior Social Services Manager for Western Health & Social Services Board, and the Principal Social Worker from the Western Health & Social Services Board, Training and Staff Development Branch,

FJ 39 .

CHAIRMAN: Sorry to interrupt you. I am not sure we got the correct reference perhaps for the full text of the report then.

MS SMITH: The full text will be at 20297.

CHAIRMAN: 20297 to?

MS SMITH: Going through to 20357.

CHAIRMAN: Thank you very much.

MS SMITH: The version I am going to refer to has page 11 missing, but for the purposes of what we are looking at today that will not matter, but just so you have the full report, that's where it is in the bundle.

Just see:

"The life of the team is short-term, purely related to the task outlined above and report to the Acting Director of Social Services by Monday, 24th September 1990."

You will see here "Values within which the review will be undertaken":

"It accepted the task rose in this spirit. The team's intention not to make judgements about action or lack of action unless there is information in a written record to substantiate their opinion, not to make assumptions about staff roles and functions and not make use of hindsight."

The terms of reference are then set out there, but

they are also set out in the report itself. So if we go to that at 10309, you will see it is quite simply headed "Report on the circumstances surrounding incidents of peer child abuse which occurred within residential care".

If we can scroll down to the next page, the contents are set out there. If we scroll on down then, please, to the terms of reference and the background, it says:

"On 3rd August 1990 the General Manager and Acting Director of Social Services established a review team to examine the implications for the family and childcare services of incidents of peer child abuse that had occurred within residential care."

Again the officers appointed to the review team are stated.

"The terms of reference given to the review team were as follows:

1. To review the background to the incidents of peer child abuse as referred to above.

2. To explore the lessons to be learned in order to enable us to respond more appropriately to the needs of children who have been traumatised in this way.

3. To examine the roles and functions of staff and also to examine the part played by the children.

4. To identify the training implications.

5. To examine the implications for multi-disciplinary working.

6. To examine the resource implications."

I am going to pause there to say that when one looks at the correspondence I referred to, the memos and that, the Department were not happy at this what they saw as an extension of the terms of reference by the Board to examine the resource implications.

CHAIRMAN: I am sure they weren't, judging by all we have heard so far.

MS SMITH: Well, the memos will certainly bear that out and I will provide with you a list of the documents to which you can look at later in respect of that, but there is certainly documentation between Mr McCoy and Mr Hunter of August 1990 at 10985 where he talks about widening the terms of reference and using the review to seek to emphasise the inadequate revenue base of the Board.

I didn't mean to call that up document, but as it has been called up now, you will see that it is there. If we can just scroll down through that, you will see that:

"Although the terms of reference have been modified, enquiries have revealed their intentions that of all the matters ..."

Sorry. There is a paragraph -- paragraphs 5 and 6,

if we can scroll down to those, please, yes, it says:

"The net effect of all of this is to widen the terms of reference to the extent that the issues of supervision and management in Harberton House will not get the scrutiny they deserve. Paragraph 4 of the Board's terms of reference sets out the values which underlie the review, but these are overshadowed by the final paragraph on methods, which on two occasions refers to available resources. Given that the sixth term of reference is to examine the resource implications, this could be construed as guiding the review in a particular direction.

The presentation of the review by the General Manager to the meeting of the Community Care Committee on 3rd August would appear to confirm that the Board will use the review to emphasise their inadequate revenue base. The attached copy minute indicates that the General Manager identifies 'significant resource implications' arising from the review."

Sorry. Going back to the report itself, please, I think at page 10311 probably.

CHAIRMAN: May I just ask on the screen we can see paragraph 5.

MS SMITH: It has been highlighted.

CHAIRMAN: Was that by us in the preparation of these

documents?

MS SMITH: No, that was how the document came to the Inquiry, Chairman.

CHAIRMAN: Thank you.

MS SMITH: At this stage it is not clear whose highlighting that is, but I would imagine, as it was in -- well, it may -- it came to us from the Health & Social Care Board, but it may have been their highlighting or it may have been an interdepartmental highlight.

CHAIRMAN: We see in paragraph 9 -- this is Dr McCoy writing, is it not?

MS SMITH: Yes.

CHAIRMAN: Well, I am not surprised the Department wasn't too keen on this, judging by what we have seen from other documents today where people in the Western Board area were saying for years that the resources were inadequate. They identified inadequate staffing and so on as at least contributing to this unhappy state of affairs and here is somebody trying to cut the terms of reference down.

MS SMITH: That would certainly appear to be the position from that document, Chairman.

CHAIRMAN: I will be interested to hear what Dr McCoy is going to tell us about that.

MS SMITH: I don't see anyone present from the Department,

but certainly we can --

CHAIRMAN: Well, I am sure you will convey to Mr O'Reilly our interests in what Mr McCoy will say to explain this effort to cut down the terms of reference.

MS SMITH: Going back to the review report itself, as I said, I think we were on page 10311 perhaps. Yes. Just I have gone through the terms of reference there. If we can just scroll on down, please, then, and it says -- actually I just say, Chairman, you were asking about the highlighting. I have been informed by Ms Hall that the highlighting would have been done by someone within the Board on these documents.

CHAIRMAN: You mean at the time this preparation was being done for the Inquiry or just --

MS SMITH: Yes, possibly. She seems to suggest that's the case. In fact, it may have even been Ms Hall's highlighting herself? No.

It says:

"When considering the terms of reference the review team concluded that it would be essential to obtain information on the children and families concerned.

In addition, as there are different perceptions and definitions of child abuse, we decided that our assessment should be within the context of the definitions outlined in the procedures for dealing with

child protection of the Board.

We also felt that the residential childcare services could not be looked at in isolation and that consequently there was a need for us to look -- to view these services within the context of the total family and childcare programme for the unit."

So if we can scroll on down, it says:

"The review team's approach to the task in order to fulfil its terms of reference was to:

1. Obtain all the relevant reports and information.

2. Analyse the information.

3. Identify gaps in the information available and seek further information where necessary.

4. Evaluate on a professional basis the care and services provided to the child, taking into consideration resources available, workload, etc.

5. Determine whether the decisions in relation to each child were realistic, having regard to the demands placed on management and staff, keeping in mind the state of knowledge at the time and the resources which were available."

It then says how many times they met and with whom.

"The review team tried not to make judgments about action or lack of action unless there was information in the records to substantiate our opinions.

All of the conclusions reached and opinions expressed are the unanimous views of the review team."

Just scrolling on down, you will see family and childcare services and needs are set out there, the programme of childcare structure, the fieldwork staff -- I am just highlighting -- the needs and the range and level of services that were available. Then it goes on to discuss the residential facility. It talks about the size, structure and function, the objectives of the home, the physical accommodation and location and the staffing of the home, what staff supervision and support there was and the organisation of care within the home. It talks about the statutory requirements, the management arrangements, the core evaluation team, the home as a resource. Sorry. If we just slow down slightly, there it says:

"This home represents a substantial resource for the residential assessment and medium stay care of children and appears to have been used to its maximum."

If we can scroll on down then, the next chapter deals with admissions and discharges, and at paragraph 4 here at 4.2(iii) it says -- it identifies -- it says 25 children were too many for the types of children. The issue was not so much one of numbers as the disruptive nature of the children themselves and inexperienced

staff that were the problem.

We see this at 4.2(iii) of the analysis -- if we just scroll to the next page, please -- where they say:

"If 25 was considered to be a manageable size for a home, then the total number of children in the home was not excessive until March 1990. However, we believe that this size of home is too large for the type of children requiring residential care and that a few extra difficult children are consequently enough to make the situation unmanageable."

Then at paragraph 6, which is at 10348 -- I should say that paragraph 5 -- chapter 5 rather than paragraph 5 deals with the children involved and, as I indicated earlier, initially eight children were identified as having been involved in abuse either as abusers or victims, but following further allegations, it increased that number to nine.

We have moved on anyway. The staff, performance of their roles and functions. It talks about the practitioner staff within the home. It said:

"The information that we obtained indicates that the residential staff performed their roles and functions with commitment and due concern for the children. While their performance was adequate, the disruption planned by the children and the number of staff on duty resulted

in insufficient time being available for them to undertake the quality of work they would have wished to achieve."

It goes on -- the implications for the staff go on then through to the next page at 10349. The information -- it talks about the team leaders, the middle and senior management. At paragraph 7 the working together arrangements:

"An interagency and multi-disciplinary approach is fundamental to the provision of family and childcare services. This is now referred to as a 'working together approach'."

It basically talks about the arrangements and the core evaluation team playing a key role in that.

"The team did identify a particular difficulty in the length of time the police took to complete their investigations of the sexual abuse in the home. We consider that a protocol for joint investigation in cases where a criminal offence is alleged might help to overcome this problem."

We know from other documents we have seen certainly in later years the police and Social Services did develop such a protocol.

If we can scroll on down then, it talks about the training implication at paragraph 8, and the main

issues, if we can to paragraph 9, which I should say is 10345 -- 54. This is the nub of the report, as it were. There is an analysis of the main issues in paragraph or chapter 9. It says:

"(i) Staff awareness of the sexual abuse the children had suffered prior to admission to care; (ii) their knowledge about the care of sexually abused children; and (iii) the programmes of care provided, including the level and nature of supervision of the children.

It is clear from the records, the interviews of senior staff and the written responses obtained from the primary workers that only one child, a girl, was thought to have been sexually abused prior to admission to care. Another girl was known to have had sexual intercourse with a number of adolescent boys in the community.

All of the remaining seven children were admitted to care or transferred to the home because of behaviour problems or relationship difficulties with parent or foster parents.

A few of the children began to disclose past sexual abuse to the residential staff and prior to the sexual abuse within the home being disclosed in March, all but two of the nine children were thought to have been sexually abused, had witnessed sexual activity or been

involved in sexual activity with other children prior to the admission to care."

It talks about the experience that the staff had.

"The experienced staff were aware that sexually abused children are likely to act out overt sexual behaviour and were alert to the implications of this for other children and indeed staff."

It says:

"The programmes of care were planned for each child. However, in the main individual programmes were not implemented fully."

It goes on to talk about the duty rota for the staff on duty and it says:

"That was arranged in such a way that during school term staff only had care of a total group of children three days out of five."

It says:

"Given all these factors, group supervision arrangements were always likely to be stretched and the primary worker system largely inoperative. In effect there was very little staff time available for the individual care of children.

The latter was further constrained by the disruptive behaviour of the children, which manifested itself in arguments and physical violence between the children on

a regular basis. Staff were also subjected to verbal and physical abuse by some children. It is to their credit that throughout this very stressful period staff did not lose personal control and there are no substantiated complaints from any children regarding the care and treatment they received from the staff."

It talks about the resources available for the care of the children and it says:

"The most important resource in the provision of residential care is, of course, the childcare staff.

The residential childcare staff establishment for the home is 20 posts, including the officer in charge and deputy. The home is therefore staffed in accordance with Castle Priory guidelines agreed by the Boards and Department. However, it must be emphasised that these guidelines are now somewhat dated and were formulated in an era when sexual abuse had not begun to be identified.

The role of the officer in charge and in this case -- in the case of a large home such as this that of the deputy is one of management, that emphasis being on professional management to ensure the provision of high quality care. This leaves 18 care staff to undertake direct care of the children and implement individual programmes of care."

It talks about the added complication in this case

that the officer in charge was seconded for professional training at the end of 1989 and acting up arrangements were in place to cover the management responsibilities in his absence.

It talks about the qualifications of the staff who were there and that the majority of the staff had considerable experience in residential childcare. It says:

"In effect, the staff group represents a considerable resource in terms of experience and expertise."

They were concerned to learn that the home had been included in the privatisation of catering service and that initially had led to some problems.

"Other resources which were not used were not available on an ongoing basis as part of the services necessary for the care of children" -- sorry -- "which were used were not available on an ongoing basis" I should say.

"Use was made of educational and clinical psychologists, child psychiatrists and of a senior clinical medical officer from the Eastern Board, who specialises in disclosure work with sexually abused children."

It says:

"Because these resources were only available on an ad hoc basis, they did not provide a consistent and continuous contribution to the care of the children."

The physical resources were considered to be of a good standard. The home had just recently been decorated.

The education and training of staff to provide for the care of sexually abused children is discussed.

"While there were some programmes -- subsequent programmes developed stemming from a centrally funded initiative were considered helpful in developing staff's knowledge and competence in the area of work, it was noted that staff felt at times they were unable to put their knowledge and skills into practice due to the pressures which they faced on a day-to-day basis."

Staff training needed to be more effective.

"Whilst it was a development to be encouraged, they felt that every effort must be made to ensure that all residential care staff can avail of professional social work training, given the complex needs of children and the level of expertise required to work in this area."

It goes on to discuss the standard of records maintained.

If we can just scroll on down then, please, it talks about the level and quality of assessment and planning,

the support and supervision provided for primary workers and social workers and about the pressures that they were under. I am skimming through this very quickly but the report is, as you can see from this, quite detailed. There was a working together approach which they identified.

Then "The extent of the abuse and why this continued undetected for a period of at least three months". If we could just pause there, please:

"The sexual abuse which took place included fondling, oral sex, sexual intercourse and more bizarre manifestations such as bondage. The frequency is difficult to estimate, but the evidence suggests that it took place regularly over at least a three-month period from December 1989 until March 1990. In addition, some of the activities, particularly those which involved bondage, would have taken some time to perform.

The issue of sexual abuse in a residential facility continuing undetected over such a period of time is a concerning and important one. The team consequently gave this matter considerable thought and attention, which included discussing it individually with every senior member of the home's staff and with the appropriate management staff in the unit.

Not unexpectedly we found that the staff had already

focused on this issue and had looked for reasons as to why this had happened. In facing up to the issue staff had gone through the range of feelings and emotions which one would expect committed and caring staff to experience, including guilt, failure and anger.

Our analysis of this matter led us to identify a number of important aspects which in combination created exceptional conditions within the home and made it possible for sexual abuse to continue undetected:

(a) The involvement of practically all the children in the home in some form of sexual activity. In addition, the activities were usually group activities of three or more children. This facilitated secrecy being maintained by the children.

(b) The number of children, at least seven, who had been sexually abused, had witnessed sexual activity or been involved in sexual activity with other children prior to admission to the home. This was not known at the time of admission but emerged over succeeding months.

(c) Within the group at least two boys had been seriously sexually abused by adults prior to admission and who as a result had become abusers.

(d) The power exercised by these boys, particularly one boy aged 9, and an older adolescent girl. We

consider that these children both planned the activities and intimidated the other children to ensure their silence. The amount of planning by these children was considerable and involved staging confrontations to distract staff and divert their attention. In addition, times were selected when staff cover was at a minimum, for example, prior to staff coming on duty in the mornings.

(e) The unforeseen situation that boys as young as this were capable of such behaviour. In effect, they had learned and were able to apply the techniques of abuse which adult had used on them.

(f) The inadequate staff-children ratios provided for by the staff rota arrangements when such a disruptive and difficult group of children had to be cared for. This stretched supervision to the limits and there were occasions when supervision of the children could not have been at a satisfactory level, for example, when the maximum numbers of children were exceeded and when bringing children home from school. The rota arrangements also led to discontinuity in group care during school term with individual members of staff being involved in caring for the total group three days out of five. In addition, insufficient staff time was available for staff to undertake their primary worker

role and give individual attention -- children adequate time and attention.

(g) Quite apart from the duty rota arrangements, the size of the home with two groups of 12 and 13 children makes it difficult to provide a satisfactory standard of care for the type of children and young people now requiring residential care.

(h) The grounds to the rear of the home with a mound running around the perimeter make it easy for children to hide from staff and indulge in unacceptable behaviour.

When all these aspects are put together, a picture emerges of a vulnerable situation at the home in which both children and staff were at unacceptable risk."

Paragraph 10 at 10... -- the next page just. If we can scroll down to that, please, the conclusions are set out there and it says:

"At least 17 children and young people were involved in either sexual abuse or sexual activities within the home.

Most of the sexual abuse was organised and carried out by two boys aged 9 and 12 and an adolescent girl aged 15.

Seven of the nine children reviewed had been sexually abused by adults, had witnessed sexual activity

between adults or been involved in sexual activity with other children prior to admission to the home.

At the time of the admission to the home staff were aware that one of the children had been sexually abused and another had been involved in sexual intercourse with adolescent boys.

No member of staff was aware that these activities were taking place in the home.

There was no lack of care, commitment or concern for the children by any member of staff.

The main problem for the home's staff was the care of a difficult, disruptive, sexualised group of children and young people. Other factors such as increased numbers and inexperienced staff perhaps obscured the central issue of dealing with an exceptional group in the home and concentrating the best use of resources on this problem.

The sexual abuse and sexual activities were not detected earlier because of a combination of factors which are outlined in section 9.8 of this report.

If there had been more staff caring for the total group and more time for staff to perform their primary worker role, then it is likely that the abuse would have been detected earlier.

The situation within the home represented

an unacceptable level of risk to both children and staff.

Both the size of the home and the size of the reception/assessment unit and medium stay unit within the home make it almost impossible to achieve the quality of care necessary for the type of children requiring residential assessment and care. In addition, the juxtaposition of assessment and medium stay care is not advisable, as there is separation in name only.

The performance of all residential and fieldwork practitioner staff involved was adequate, given the pressures they were under, the limits of their knowledge, awareness and resources available. In the case of the residential staff this conclusion is reached in the context of the number of staff on duty to care for the total group of children.

The performance of the management staff of the home and Senior Social Workers (team leaders) was adequate, given the pressures they were under and the resources available.

The performance of middle and senior management staff at Unit and Headquarters was adequate, given the increasing demands and the resources available.

We are unable to reach a conclusion on the communications and support provided by middle and senior

managements -- managers at Unit and Headquarters to the home's staff. The perception of the home's staff is that they were not really being listened to or their concerns acted upon. While systems were in place or introduced to create an adequate medium for communication, these did not appear to achieve the desired goal of shared ownership of the situation and confirmation that an equitable approach was in operation to deal with the demands.

The assessments of the children were thorough and plans appropriate within the limits of the core evaluation team membership and the resources available. On occasions certain options could not be pursued because of lack of resources. In addition, the multi-disciplinary approach to assessment and planning could not implemented fully, as other key professionals were not available as core members of the team.

There were no fundamental shortcomings or significant gaps in recent recordings in any of the files, though there is room for improvement.

There was clear evidence of good relationships between staff from different disciplines and agencies and a good working together approach was achieved.

Training provided for staff of both a professional and in-service nature was considered beneficial in

enabling them to develop expertise in the area of child sexual abuse. Whilst maximum use was made of the limited training resources available, it would appear that these training programmes lacked sufficient strategy to enable all staff to receive the training they ideally required in a planned and systematic way.

The sexual abuse in the home was identified by a senior houseparent. She deserves credit for the way in which she picked up a chance remark and pursued this with the child.

Sexual abuse began to be disclosed on the evening of 13th March 1990. By 14th March other children had corroborated that abuse had taken place. Attempts were made to contact the Assistant Principal Social Worker (Family and Childcare) on 14th March, but he was interviewing. Middle and senior management staff in the Unit of Management consequently were not informed until the morning of 15th March. The team is of the opinion that the appropriate management staff should have been notified on 14th March at the latest, given the serious situation which had been identified.

The Assistant Unit General Manager notified the Unit General Manager and Acting Director of Social Services on 15th March 1990.

The Acting Director of Social Services informed the

General Manager and the appropriate Social Services Inspector either on or close to 15th March 1990 and a report was forwarded to the Department of Health and Social Services on 8th May 1990.

Senior and middle management staff responded immediately and took appropriate action, including arrangements to ensure the safety of the children and for the Assistant Principal Social Worker to act as coordinator.

A specific file was not opened on this matter. This would have been beneficial in relation to having a composite record available of the investigation and action taken. The team is of the opinion that such a file should have been opened.

The investigation, which of necessity had to include disclosure work, was handled sensitively and competently. However, in the case of the police, the criminal investigations took longer than would be desirable from the childcare perspective.

The re-admission of one of the main abusers increased the risks to other children in the home and necessitated a member of staff being detailed to ensure that he received a satisfactory level of supervision. Indications that his earlier pattern of behaviour was re-emerging led to the need to have him returned to the

Training School. We are of the opinion that this boy should not have been re-admitted to the home, despite the views of the Training School staff that he could be managed in such a setting.

There was a substantial increase in work which gathered momentum in '89 and '90. A large part of this increase was in the area of child protection and particularly child abuse" -- sorry -- "sexual abuse.

There was a significant increase in the number of children admitted to care with 57 children admitted during the period 1st January to 31st March 1990.

Considerable efforts were made by middle and senior management staff at Unit and Headquarters to meet increased demands from January 1990. Particularly praiseworthy is the performance of the Foster Care Unit. However, a situation of inadequate resources existed prior to January 1990, and if resources had been acquired earlier, the crisis which arose during January-March 1990 might have been prevented or its impact lessened.

The workloads of the field social workers cannot be considered manageable in the context of providing a child protection service of satisfactory quality.

The management span of control of the Senior Social Workers (team leaders) means that they are constantly

under pressure if they are to provide the supervision and support which practitioners require in a child protection service of satisfactory quality.

The management span of control and workload of the Assistant Principal Social Worker (Family and Childcare) is such that it is an unrealistic expectation that it can be carried by one person.

The Unit of Management is under-resourced in relation to the amount, range, complexity and stressful nature of the family and childcare work which has to be undertaken. This remains the case, though the 6 additional social worker posts have reduced some of the pressures.

There are clear indications that the present situation represents a high level of risk for both children and staff in the Unit of Management."

Then there are recommendations at chapter 11.

"The team is aware that initiatives are already underway on a province-wide basis to improve the family and childcare services, and if this had not been the case, we would be recommending such initiatives.

These are:

(i) The professionalisation of the family and childcare services, which will ensure that all social work staff, whether working in fieldwork, residential or

daycare setting, will be professionally qualified and be paid similar salaries.

(ii) The development of a protocol with the police for the joint investigation of child abuse cases where a criminal offence is alleged to have been committed.

The Board should undertake a comprehensive assessment of need in a unit and agree a strategy to meet this need, including making available the resources required. However, there is sufficient information at present to recommend essential improvements and these are outlined in subsequent recommendations."

They talk about the fieldwork staffing and how that could be improved.

"An additional social worker should be appointed to the Foster Care Unit.

Fee earning fostering should be developed.

The range of services should be increased through the development of Kidscape, Homestart and family supports.

A panel of 6 child minders should be established to provide daycare for at risk children."

If we can scroll on down, please, it says:

"There should be an immediate review of the size and function of the home with a view to reducing the residential care component and concentrating this on one

function. If considered necessary, a further small residential facility should be developed in the Unit of Management.

The spare accommodation which would become available in the home could be used as an adolescent support centre and as a facility for a multi-disciplinary team to develop expertise in the assessment of sexually abused children.

There should be an immediate review of the staffing levels and duty rota arrangements in the two board homes in the unit to ensure that there are sufficient staff on duty at any point in time to provide satisfactory care for the total group of children and allow time for individual work.

The mound in the grounds of the home which follows the perimeter fence should be levelled to facilitate supervision of children.

A multi-disciplinary team should be developed to build up expertise in the assessment of sexually abused children. That team should have accommodation which will facilitate day attendance of parents and children and a remit to develop expertise in that aspect of work.

An adolescent support centre should be developed.

The training strategy outlined in section 8 should be accepted and additional training personnel appointed

to implement it.

Priority should be given to a structured supervision with a view to developing a staff profiling system to facilitate staff development.

The current status of the new system of recording should be clarified and there should be ongoing monitoring to ensure its effectiveness and relevance.

There should be an examination of the management span of control of the Assistant Principal Social Workers in the Unit of Management with a view to achieving a more equitable workload for the Assistant Principal Social Worker (Family and Childcare).

A workload management system should be introduced.

Consideration should be given to developing other services such as adolescent and child psychiatry.

One of the children reviewed by the team was a boy from a large family and the subject of Fit Person Orders and had been on home on trial prior to admission to residential care.

The father had been systematically sexually abusing all the children over a period of years and the abuse was not discovered until after the children were in residential care.

This case was being carried by the NSPCC.

The team was concerned at the extent and duration of

the abuse in this family and recommends that a joint review be undertaken in respect of that particular case."

Those were the recommendations of the review team.

On 7th December 1999 -- 1990 we see minutes of the Western Health & Social Serve Board's -- Social Services Board's Community Care Committee at which Mr Bunting presented the report.

There is then on 21st December a memo from Mr Harbison to Mr McCoy, which we can look at at 10459, where he discusses the wider implications of the report. This is again 21st December and it is copied to people within the Department. He says:

"I found the report a carefully documented and comprehensive record of the incident which is most valuable. Whilst the report is provided for the Western Board, I believe it raises a number of fairly fundamental questions which must be considered at regional level.

I retain concern that in a home which has got adequate (in terms of departmental guidelines) staffing, good physical resources, staff who have experienced in the main appropriate training to sensitise them to the difficulties of sexually abused children, good staff relationships and communication, generally good

professional practice, reasonable support, etc, the staff did not detect the extensive abnormal behaviours over such a considerable length of time. Should this ring alarm bells with us?

The report is mainly written from a Social Services perspective and some of the multi-disciplinary recommendations and implications could have been developed.

The wider implications of the findings as articulated in paragraph 8 sound an ominous note."

He quotes it.

"This more general point is not picked up in the conclusions or recommendations but must have considerable ramifications for childcare provision in all four Boards.

On the basis of the above points and particularly the closing lines of section 10, the wider implications of the conclusion that there are clear indications that the present situation represents a high level of risk for both children and staff in the Unit of Management must be considered. Such a conclusion may not be limited to this Unit of Management and could have implications across Northern Ireland for our current provision and resource considerations.

Because of the wider importance of the report,

I believe we should meet to discuss its implications and potential further action."

There is on 28th December 1990 at 10443 --

CHAIRMAN: Do we have a subsequent report or document that shows some years later these matters are still being addressed?

MS SMITH: Yes, indeed, Chairman. There is a number of matters that were still taking some time. Just as a minor point there's a document which shows that the grassy mound was still there in 1995.

CHAIRMAN: I was thinking perhaps of the entry before in your notes.

MS SMITH: Yes, that's -- yes, it's on 11th January 1995 at 20097.

CHAIRMAN: Yes.

MS SMITH: Sorry. Can we just go, please, to 20097? This is a memo from the Programme Manager, Mr Doherty, to the Unit General Manager of the Western Health & Social Services Board, Foyle Community Unit. He says:

"You recently passed to me a report on the circumstances surrounding incidents of peer child abuse which occurred within residential care for comment. I will address each of the questions detailed by you as follows."

I don't have unfortunately the actual areas that --

what prompted this response from Mr Doherty to Mrs Way.

CHAIRMAN: He seems to be saying several years later many of these key problems are still --

MS SMITH: Still in existence.

CHAIRMAN: -- in existence.

MS SMITH: That is correct. He talks about the fieldwork staffing levels and the comparative figures at that stage and the present caseloads of the family and childcare programmes. The caseload in '93 was 1800 cases. The figure has risen to 2150 in 1995.

If we can just scroll down, please. If we can just keep on scrolling down there. Recommendation in relation to fieldwork staffing:

"8 social workers to be appointed to reduce caseloads to around 20 families per worker. I can confirm that only an additional 4 field social work staff have been appointed."

He says:

"I feel that the picture that emerges (not only from this review but also from the report of the case management review conducted into another case) is that the Unit of Management is not adequately resourced to meet the demands placed upon it. I believe that we would need to be robust in our discussions with the purchaser with a view to obtaining an additional input

of resources so that we can maintain the high quality of standards that we set for ourselves. I would be pleased to discuss this matter."

Obviously this is more dealing with the field social work situation than the residential care, but the issue of resources is still very much a live one in 1995.

CHAIRMAN: I should just perhaps say, as David Lane has pointed out to me, if you look at your notes you have at the bottom of page 12, 10373, that seems to be a more contemporary response from the Department.

MS SMITH: Yes, in 1992. Well, there's -- in fact, if we go -- 10373, there is a letter from Dr McCoy to -- to -- sorry -- Dr McCoy from Dominic Burke about the steps that were taken by the Western Health & Social Services Board after delivery of the report. That's -- if we can just scroll down:

"I indicated in my letter the steps taken to increase the staffing levels at Harberton House and the additional resources provided for foster care services.

I would now wish to advise you that the consultant psychiatrist post is currently advertised.

The Board is expressing -- experiencing difficulty in addressing all the recommendations made by the review group because of the competing demand for resources. Since I wrote to you in February, staff both at Board

Headquarters and Unit of Management have examined the report in detail again with a view to taking follow-up action on the recommendations made. The following is the position in relation to the recommendations."

I am not going to go through them, but he goes through setting out -- if we can just scroll down, please -- what has been -- what the recommendation has been and then what the -- sorry -- just take it a little bit more slowly -- and what the Board has done in response to those recommendations, the recommendation being underlined.

If we can scroll on down. Scroll on down through this, please.

So Mr Burke at this stage is certainty advising the Department of what has been done.

CHAIRMAN: Just pause at this page. Some of the key matters are dealt with there --

MS SMITH: Yes. If we scroll back up --

CHAIRMAN: -- just at the top of the page.

MS SMITH: Yes. Just scroll back up, please. It says:

"An immediate review of the size and function of Harberton House"

was one of the recommendations and it said:

"A review of the structure of all three residential children's homes in the Board area is being carried out

in line with the implementation of the Hughes 6 recommendation. In Harberton it is the intention to have 2 teams each lead by a team leader. It is also the intention to reduce the numbers in the first instance from 25 to 20. Within this the management are looking at the possibility of developing a smaller unit of 4 to 5 places which will be designed to provide treatment for disruptive children with special needs, including children who have been abused or abusers.

As part of the development of an integrated childcare service I would mention that in Fort James it is the intention to develop two units, each under the management of a team leader, an adolescent unit and a leaving care unit. Coneywarren, where there will be three units under the management of a team leader, an admission/reception unit, medium/long stay unit, special needs unit. This will also complement the provision provided at Nazareth House Voluntary Children's Home where two units will be established each under the management of a team leader.

You will be aware that it is our plan to reduce the number of residential places on a progressive basis. This, however, will require some additional resources but not perhaps as much as referred to earlier."

I make the point that -- I think that should be:

"The mound", rather than the mould, "in the ground of the home should be levelled.

It is not regarded as a high priority need."

We know that in 1995 it had not been done.

"A multi-disciplinary team being developed to build up expertise in the assessment of sexually abused children."

If we can just scroll on down through the document again, please, the training strategy, the status of the recording systems.

CHAIRMAN: Can you just go back a page --

MS SMITH: Yes.

CHAIRMAN: -- to the top of the page I think? This is a reference to work to be done in Fort James and Harberton. Again this is for preventative work. Yes. Thank you.

MS SMITH: As I've indicated, after the review itself there -- I have given the Panel and yourself, Chairman, a note of page references in the bundle to a number of memos, both again interboard and departmental, referencing the -- what took place after Mr Bunting's report had -- was presented.

There is a memo, just to -- I am not going to open these, but just so you can have a look at them -- at 14... -- 10456 of 23rd January 1991 from Dennis O'Brien

to Mr McElfatrick within the Department about what action could be taken at regional levels following the review report. Mr McCoy asks for information about the extent of the problem to be compiled.

There's -- sorry. There is one other memo that I felt ought to be drawn to your attention, but I just can't put my finger on it at the moment, I am afraid, but certainly --

CHAIRMAN: I see 16342, page 13 you have a note about.

MS SMITH: Yes, about the finance. I think I did look at that this morning when I dealt with the finance issues, though, Chairman, but in April 1991 the Western Health & Social Services Board had asked -- been asking for money after the review team report.

CHAIRMAN: Now this, of course, is a departmental memo. Perhaps we could just look at that again.

MS SMITH: Yes. That is 16342.

CHAIRMAN: Yes.

MS SMITH: It is dated 8th April 1991, and it says:

"I attach, with apologies for the delay, a copy of Mr -- Dr McCoy's minute of 28th March recording the outcome of an internal meeting with Mr Simpson about the Western Board's response to this report and any further action to be taken by the management executive/department."

This is to deal with the -- paragraph 3 records:

"I would ask you to monitor the establishment of child and adolescent psychiatry service, and the background to this was that the minutes of the Board's Resource Allocation Committee meeting on 13th March had identified the need under development proposals for 1991/'92 for services for mentally ill people for a sum of £99,000 to develop a child and adolescent psychiatry services -- service on an area-wide basis.

The Director of Social Care had raised with Dr McCoy the possibility of an allocation from the Department to allow the Board to develop an assessment and treatment unit within the Board, located at Harberton House. We have no money for this, and we must await the outcome of our PES bid for child sexual abuse, which, if successful, would provide resources for treatment issues among others in 1992. However, it did seem to me that given the intention to develop a child and psychiatric -- child and adolescent psychiatric service, it should be possible for the Board to start to develop therapeutic programmes with sexually abused children if this aspect was recognised as a priority by the new consultant child and adolescent psychiatrist. It is in this context that I say that it would be helpful if in the course of your contacts with the consultant you

would highlight the importance of this work. I had not in mind any special monitoring exercise, but rather that we should keep in touch with developments in establishing the service and ensure that maximum use is made of it for child protection purposes."

So in seeking to address the recommendations of the review report the Western Health & Social Services Board recognised that there were resource implications for them and they sought further funding for -- from the Department.

CHAIRMAN: Yes. Thank you.

MS SMITH: Chairman, the only other material in the bundle that I haven't actually looked at in any detail other than to give you some statistics about what they disclose is the police material. Essentially I can summarise each file individually, if that is felt necessary, but alternatively I can provide you with a list of the page references in respect of each little summary.

CHAIRMAN: I think that would be sufficient. Thank you.

MS SMITH: Well, then that concludes what has been a race through the material in the bundle and tomorrow we will start to examine some of the witnesses.

CHAIRMAN: Yes. Usual time tomorrow.

MS SMITH: 10 o'clock.

(4.20 pm)

(Inquiry adjourned until 10 o'clock tomorrow morning)

--ooOoo--

I N D E X