HIA REF: [ ]

NAME: FJ 33

DATE: [22nd May 2015]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Witness Statement of FJ 33

I, FJ 33 will say as follows: -

1. My name is FJ 33 known as FJ 33 and I was born [redacted] and having completed my secondary education I went on to achieve the following academic qualifications:

1969-1972 Bachelor of Social Science (Honours) [redacted]
1972-1973 Higher Diploma in Education [redacted]
1973-1974 MA in Applied Social Studies and CQSW [redacted]
1987-1988 Certificate in Advanced Social Work [redacted]

My career history is as follows:

1968-1969 Assistant Teacher [redacted]
1972-1973 Teacher [redacted]
1974-1980 Social Worker [redacted]

[redacted]

2. In May 1984 I took up the post of [redacted] Fort James Children's Home Derry and remained there for six years. The Home was an adapted 3 storey building, originally constructed as a private residence. It was located 3 miles from Derry city centre and set within spacious grounds with mature trees and shrubbery and connected to the entrance by a driveway. There was a two metre high wall surrounding the property which was situated between two housing estates, Tullyally and Currynierin and about a quarter of a mile from the main Derry-Belfast road.

3. To my best of my knowledge the timeline for the Home is as follows:

- **1862** The property, later to become known as Fort James, was first built as a private residence set in its own grounds with stables at the rear.
- **1970** The property was purchased by Londonderry Development Commission
- **1973** A Children's Home was opened by the Western Health and Social Services Board (WHSSB). This catered mainly for babies and infants from one week old to 1½ years old. There was a Matron in charge of the home and she was assisted by a number of nursery assistants.
- **1974** HH 36 was [redacted]. He later went to work in [redacted] a [redacted] Health and Social Services Board children's home in [redacted] which has since closed.
- **1975** HH 22 was appointed as [redacted]. [redacted] remained there until early 1980 when [redacted] moved to the newly opened Harberton House [redacted].
- **1978** HH 5 was [redacted] At this stage the home continued to cater for babies and infants, but there were also a number of adolescents in residence. Gradually the numbers of babies and infants decreased and the numbers of older children increased. From 1980 no more babies or infants were accommodated in the Home. Although the function of the Home had changed, the existing staff remained, some going on to become qualified social care workers. HH 5 remained in post until late

1979 [redacted]

- **1980** FJ 7 **a member of staff in the Home since 1975, was** [redacted] **By this stage, Termonbacca, a local Voluntary Children's Home had closed down and some of the children were transferred to Fort James. There were no longer babies or infants in Fort James and children ranged in age from 5-16 years of age. The Home was designated as a 16 bed unit.**
- **1981** FJ 5 **was** [redacted] FJ 7 **was** [redacted]. FJ 5 **remained in post until July 1983 when he resigned and** [redacted]
- **1983** FJ 7 **was** [redacted]. **Sometime after this a resident made an allegation of a sexual nature against** FJ 5. **I don't know the precise details of the allegation. This was investigated by the police** [redacted]
- **1984 I,** FJ 33 **was** [redacted] FJ 7 [redacted]. **I remained in post until August 1990.The Outbuildings at the back of the main building were renovated. These were converted into office accommodation, a playgroup and 4 flats (2 double flats and two singles) for older teenagers preparing for independent living. The Home was re-designated as a 19 bed unit. This work was almost completed when I arrived in 1984. The flats were not operationalized until the following year.**
- **1990 I,** FJ 33 **resigned to take up another post with the Trust.** [redacted] FJ 7 **also resigned to take up another post in the Western Trust.** FJ 23 **was** [redacted] **and** FJ 38 **was appointed Acting Deputy Officer in Charge.**
- **1995** Fort James Children's Home closed down on the 31st March 1995. Residents of the Home were transferred to other Western Trust facilities or independent accommodation as appropriate.

- **1995** The Fort James property was taken over [redacted] It is now known as Ashleywood House.

Resident Population in Fort James

4. When I took up post in the Home in 1984 there were 16 residents, male and female, aged from 5-16 years of age. The capacity of the Home was increased to 19 when the independent living accommodation became operational in the mid-1980s. Accommodation in the main house consisted of four single rooms and six shared rooms. The Independent Living units normally accommodated one resident each.

5. In theory, Fort James was described as a long-stay unit; in practice the Home had to accommodate all types of admissions when there were emergencies or when other options were not available to social workers. The Officer in Charge did not have the right to refuse admissions; this was decided by his line manager who had responsibility for oversight of all the Board's children's homes. Planned admissions to the Home normally took place after the young person had been assessed at Harberton House and found to be in need of medium to long-stay care. Harberton was the first residential assessment unit in the Western Board area. Prior to that, emergencies would be admitted directly to the children's home following consultation between the responsible field social worker and their senior. Planned admissions would take place after discussion at a Case Conference, taking into account reports and assessments by various agencies and social workers.

6. Children of school-going age attended primary or secondary schools in the area making use of public transport where possible. Children were encouraged to maintain links with their local communities and many attended activities or clubs, depending on their interests. On Sundays children were facilitated to attend whatever religious services they were accustomed to attend.

7. Between1984-1990 there was a lot of tension and unrest in the community and with a mixed resident group situated between two estates, one predominantly

protestant/loyalist the other predominantly catholic/nationalist, it was not an easy task to maintain a semblance of normal life. The older teenagers sometimes formed relationships with their peers from another tradition and, staff had to be extra vigilant to keep them safe and control attempts to access the building by means of the fire escape in the evenings and at night. When relationships broke down our young people were vulnerable to sectarian abuse and bullying from people with whom they had confided personal information about themselves and their families.

8. Within the Home there was a mixed staff group and a mixed resident group and we promoted tolerance and respect for all traditions and on the whole this was achieved.

9. Children in the home had access to two TV and Recreation rooms downstairs. The Home had its own kitchen staff to prepare meals and an attempt was made to keep this as homely as possible by acknowledging special occasions such as birthdays.

10. Children were encouraged to keep contact with their families and relatives and many went on visits at the weekend. Others had their families visit them on pre-arranged visits, with bus passes provided. All visits were arranged through the child's keyworker or through the senior houseparent on duty and normally took place in a sitting room at the front of the house.

Management Arrangements

11. For most of my time in Fort James there was a separate line management structure for field work services and residential & day-care services. This changed towards the end of my stay with the creation of Programmes of Care. Henceforth, Child Care Field Social Work and Child Care Residential Social Work came under the same management structure.

12. A Senior Social Worker (Residential & Day Care) known as [redacted] TL 4 designated as "The Visiting Social Worker" under the Conduct of Children's

Homes Direction (NI) 1975, [redacted]. He reported to the Principal Social Worker (Residential & Day Care) TL 20 [redacted]. He, in turn, was responsible to the Assistant Director at District level, Mr Tom Haverty, for the management of the Home.

Staffing Structure

13. During my time in the Fort James the management structure of the Home consisted of the Officer in Charge (OIC) Deputy Officer in Charge (DOIC), 4 Senior House Parents and 9 House Parents. The OIC supervised the DOIC and two of the Senior House Parents, while the DOIC supervised the other two House Parents. Generally supervision took place every two months and lasted at least one hour. At all times, one of the senior staff was on duty.

14. Staff worked on a shift basis 8 am - 3pm; 2pm -10pm or occasionally 10 pm - 6pm. The Officer-in-Charge and Deputy Officer- in- Charge generally worked day shifts, 9am – 5pm but also took turns covering the sleep-in rota when other senior staff members were on holiday or sick leave.

15. Each night a senior staff member and a Houseparent did Sleep- In duty from 10 pm – 3pm. Their responsibility was to settle the young people for the night, complete written records, check the security and safety of the building and deal with any emergencies or disturbances during the night. When satisfied that everything was in order they retired for the night to separate rooms, one on each floor of the building. If an emergency arose where they required additional help they could call on the Officer In Charge or Deputy Officer In Charge by telephone. Next morning staff were on duty again at 7am to help the children get ready for school, work etc.

16. Each Houseparent was allocated two or three children, to act as their Key Worker during their stay in the Home. The Keyworker's duty was to spend extra time getting to know everything about their Key Child, family background, problems and difficulties they were dealing with, liaise with their school or work placement, prepare their Review reports, attend Review meetings with them and

generally act as their advocate. Key workers were the link with field social workers and families and were involved in the detail of all arrangements concerning their key children.

17. Communication within the home took a number of forms. Each day there was a handover meeting between staff going off duty and those coming on duty; this took place between 2pm - 3pm in the front sitting room. Key information about events, incidents, visitors, maintenance, significant conversations, appointments, etc. was shared at this meeting. This information was also recorded in the Daily Log book, for reference purposes.

18. Staff met as a team on a monthly basis, chaired by the Officer in Charge or one of the senior staff in his absence. This meeting provided a forum to share information, resolve difficulties, review progress and plan ahead. Occasionally it was used for training or staff development. In addition to this meeting, the Officer In Charge held meetings with the Senior House Parents on a regular basis.

19. Staff in the Home were encouraged and facilitated to attend relevant in-service training programmes and courses. Unqualified staff members were encouraged to become professionally qualified and each year of my tenure there was generally at least one staff member attending professional training. At that time there was a very small proportion of qualified staff in any residential institution in Ireland or the UK. Staff attended short courses and seminars and basically learned on the job. An example of the courses offered was a twelve week Open University Course entitled "Caring for Children and Young People", with a half-day group session each week facilitated by a training team which included myself and HH 5 [redacted]. A number of staff completed courses that granted a recognised qualification for working in Residential Care. In Fort James, there was no separation of roles for qualified and unqualified staff. Qualified staff members were more likely to become Senior Houseparents. During my time all six senior staff members were qualified and three or four of the nine Houseparents achieved their qualification over that period. There was no set ratio of qualified to unqualified because it was difficult to retain qualified staff.

[redacted] I took the lead on two key initiatives relating to staff development and support, namely, a project on "Implementing a Staff Supervision Framework" (reference appendix 1) and an 8 week training programme on "Handling Aggression and Violence"

Recording

20. As mentioned above a daily log book was filled in each day to record significant events and to facilitate good communication between staff. In addition each Key Worker kept a record of significant information relating to their key child. This was then used to inform the report the Key Worker prepared for the 3 monthly Reviews of the children. These reviews were attended by the field social worker, senior social worker, the residential worker and by the child if he or she so wished. Where the child did not wish to attend, his/her views were conveyed to the meeting in writing or in person by the Key Worker. The reviews were chaired by [redacted] TL 4 Senior Social Worker (Residential & Day Care).

21. When unusual or concerning events took place in the home, or involved residents from the home, e.g. accidents, absconding, assaults, and damage to property, etc. an untoward incident report was completed and forwarded to the Senior Social Worker (Residential & Day Care), [redacted] TL 4 and to the Board Administrator.

22. When complaints were received from residents, staff or the public, they were recorded and dealt with by the Officer in Charge as appropriate and shared with management staff. Towards the end of my stay a more formalised system for responding to complaints was put in place. This consisted of a booklet entitled "Guide for Children in Care and their Parents" explaining the rights of the child in care, guidance about how to complain and a self-addressed card to the Assistant Director for Social Services at Area Board to make the complaint.

23. An individual file was kept on each child and this was kept in a cabinet in the office of the Officer in Charge. Key Workers had access to this whenever they needed to.

Control and Discipline

24. Maintaining control and discipline was a constant challenge for staff working in the Home. Managing a relatively large group of boys and girls with complex needs and social problems it was important to have a daily routine in the home. In consultation with staff, management and the children themselves house rules were put in place governing things like rising times, bed times, week-end routine, visitors, respect for others, vandalism, alcohol use, absence from the Home etc.

25. Staff attempted to influence behaviour through their positive relationships with the young people and through positive reinforcement for good behaviour. Sanctions used were withdrawal of privileges, confinement to the unit for a period – known as "grounding, reduction of pocket money etc. Physical punishment of any kind was not permitted and was not used.

Monitoring & Inspections

26. [redacted] TL 4 Senior Social Worker, later upgraded to Assistant Principal Social Worker, (Residential & Day Care) [redacted]. He visited the Home on average twice a week and compiled a monthly report on the home. These reports went to the Principal Social Worker (Residential & Day Care), the Assistant Director of the District Office and finally to the Director of Social Services.

27. The Principal Social Worker (Residential & Day Care) visited the Home on a monthly basis, sometimes accompanied by the Senior Social Worker (Residential & Day Care) and spoke to the Officer In Charge or Deputy Officer In Charge. These meetings provided an opportunity to discuss current issues and concerns.

28. Under the Conduct of Children's Homes Direction a member of the Board's Personal Social Services Committee visited the Home on a quarterly basis. This person did a walk around the building; observed interaction between staff and

& Day Care) and spoke to the Officer In Charge or Deputy Officer In Charge. These meetings provided an opportunity to discuss current issues and concerns. Under the Conduct of Children's Homes Direction a member of the Board's Personal Social Services Committee visited the Home on a quarterly basis. This person did a walk around the building; observed interaction between staff and children, Inspected records and took a note of any issues raised by management staff. There were a number of different Board Officers who visited the home, one of which was called FJ 39 .

28. Finally, during my time at Fort James there were a number of inspections carried out by Mr Dennis O'Brien, an inspector from the Social Services Inspectorate at the DHSS. These were thorough inspections of all aspects of the Home, usually lasting two days. As well as checking records and viewing the home, the inspector took the opportunity to speak with staff and residents and took note of issues and concerns raised. The findings of these reports were shared with the staff team through the management structure. There was then a process of engagement between the Inspectorate and Board officers in relation to the implementation of these recommendations. In subsequent inspections, the progress made in implementing the recommendations was noted and further action taken as required.

Statement of Truth

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

Signed FJ 33

Dated 22/5/2015

HIA REF: [ ]

NAME: FJ 33

DATE: [2nd June 2015]

THE INQUIRY INTO HISTORICAL INSTITUTIONAL ABUSE 1922 TO 1995

Supplemental Witness Statement of FJ 33

I FJ 33 will say as follows: -

1. Further to my previous statement, I now wish to provide further information to the Inquiry in response to issues identified in the Schedule 9 Notice.

2. As I previously explained, from 1984-1990 I was [redacted]. As a staff team we were alert to the possibility of sexual activity taking place between the young people living in the Home. There is potential for this wherever children and adolescents are in a communal living setting. We were aware that some of the children were victims of sexual abuse, confirmed or unconfirmed, so we looked out for behaviour that related to this i.e. over sexualised conversation or behaviour, precocious behaviour, over-familiarity with adults and lack of appreciation of one's own and other's body space. Behaviours like this were noted and recorded in the daily log book , children's files and referred to in reports for review meetings. Where appropriate, Keyworkers would address this behaviour with the children concerned.

3. Between 1984 -1990 there were sporadic incidents of a sexual nature involving children in the home and these were dealt with as they arose. I am not aware of any orchestrated pattern of peer abuse as was uncovered at Harberton House in March 1990. I was made aware of the investigation at Harberton by [redacted] TL 4 .

4. Some examples of the way in which the incidents that arose in Fort James were dealt with are as follows:
   (i) A fifteen year old boy and a fourteen year old girl were engaged in a number of incidents of a sexual nature on 6th July, 7th July, and 10th

August 1989. From admission staff were aware of the girl's background. It was suspected that she had been sexually abused over a lengthy period in her own home. However nothing was proven and the child denied that anything untoward took place. However, this child was very sexually aware, had no concept of appropriate personal body space and always seemed to be on the look-out for opportunities to engage in sexual behaviour. For this reason House Parents were vigilant in trying to keep an eye on her movements. These incidents were reported and recorded in accordance with standard Western Health and Social Services Board procedures. House Parents on duty spoke to both young people about their behaviour and the need for constant vigilance was emphasised at handover meetings and subsequent team meetings. [redacted] an officer from the RUC Care Unit to speak with both young people to underline the seriousness of their behaviour. This is referred to in a statement I made to the police on 23rd August 1989, see FJH 3007.

(ii) On another occasion I was [redacted] with [redacted] FJ 12 . [redacted] I heard voices coming from one of the single rooms occupied by a 13 year old girl. On entering the room I found a 17 year old male lying on top of the bed beside her. He was an older resident, living in one of the flats, and had been noticed flirting with this girl for some days previously. I noticed a smell of alcohol on his breathe as I confronted him and asked him to return to his own accommodation. He suddenly went into a rage, started to run towards the other bedrooms and threatened to wreck the house. I physically restrained him while FJ 12 rang the police for help. When two policemen arrived twenty minutes later he immediately calmed down and agreed to return to his flat. During the night he trashed his flat and absconded to Liverpool. Some months later he was arrested and charged with paramilitary offences and sent to a young offenders centre. The incident was recorded in accordance with procedure and support and counselling was provided for the teenage girl to help her keep safe.

(iii) On 6th July 1989 a seventeen year old female resident confided to a member of staff that she had consensual sexual intercourse with an eighteen year old male resident on three separate occasions. Both young people were living in the independent flats at the time. A Senior House Parent spoke with both young people about their behaviour and the possible implications, legal and otherwise. The young female had a pregnancy test which proved negative. She was counselled about personal relationships and given information and advice about

contraception. The incident was reported and recorded in accordance with standard WHSSB procedures.
This case illustrates some of the issues for staff in residential settings:

- Consensual Sexual activity between older teenagers, one just below the legal age of consent- should young people be criminalised for this?
- How much supervision is appropriate for young people in Independent Living Flats; when does consensual sexual activity become abuse;
- The WHSSB duty of care for young people versus their right to experience life and learn from their mistakes, like their peers in the community.

5. In relation to whether the Board considers that there were practices and policies within either Home that permitted or facilitated such behaviour, what was done in relation to this issue, were any managerial or operational changes made to seek to prevent such behaviour and if so explain what steps were taken and by whom, I would respond as follows;

5.1 After the discovery of orchestrated peer abuse in Harberton House there was a realisation by the Board that there was a need to have night waking staff on duty, in addition to staff sleeping-in, to guard against similar incidents recurring. This was subsequently implemented in both homes. In relation to young people living in the flats at Fort James there was a growing realisation that the young people needed much greater support and guidance than we were resourced to provide and over the next few years dedicated staff were allocated for this purpose. Today there is a fully dedicated team of staff supporting young people leaving care, called the 16 Plus Team.

5.2 The DL 518 report contains a series of recommendations to address these issues. I am unable to confirm how these were implemented or any subsequent changes as I had moved on to work in a different post [redacted]

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

Signed [redacted]

Dated 2nd June 2015