The Inquiry into Historical Institutional Abuse 1922 to 1985

Witness Statement: Denis O'Brien

Date of Birth: 5th October 1937

1. Relevant Career Path

1968 Teacher, St Patrick's Training School, Belfast. Contract included undertaking extraneous duties for not less than 15 hours each week.

1973 Deputy Headmaster, Lisnevin Training School, Newtownards.

1975 /1976 University of Bristol, training as a social worker specialising in the residential care of children and young people.

1979 Transferred to Whitefield House, Belfast to initiate a day assessment service for children and their families.

1981 Appointed as a Social Work Adviser in the Department of Health and Social Services.

1986 Following a change in the focus in our work which gave priority to inspection of services, I was designated as a Social Services Inspector.

1997 I retired from the Social Services Inspectorate at the beginning of October and have not had any involvement since then.

2. Type of Inspections Carried Out

As a Social Services Inspector I was involved in the inspection of several children's homes, some of them more than once, and of the four training schools. I also inspected three voluntary adoption societies prior to their registration by the Department and took part in the inspection of foster care provision within two Boards. I contributed also to the investigation into the activities of a serial child abuser which led to the publication of An Abuse of Trust (DHSS 1993).

3. The Inspection Process for Childrens Homes

Notification for an inspection was sent to the responsible authority by the inspector carrying out the task advising when the work would take place. It would also carry a request for information including:-

- location of the facility and number of places provided,
- aims and objectives of the home,
- age range of the children in residence and authorities responsible for their care,
- the management and staff working in the home,
- which records were held there.

While it was emphasised that Inspectors were not engaged in a staff inspection, inspectors interviewed management and key staff about their responsibilities within the facility. Children would not be interviewed though inspectors would ensure that some of the children were met informally during the visit to the home. Records held in the home under legislation pertaining to children or health and safety provision,

would be scrutinised as was information held on individual files. From the outset it was acknowledged that inspection was not a substitute for regular monitoring which should normally be carried out by management external to the home or by the appointment of a suitably qualified person who should report to the responsible authority. Following the inspection a report was drafted on the home. The main areas considered were a description of the facility and its suitability, a profile of the residents, management and staff, their approach to the residential social work task including record keeping and review arrangements, conclusions and recommendations. Following discussion with the Deputy Chief Inspector the report would be finalised and issued to the relevant authority in confidence.

4. Standards

The Social Services Inspectorate had not developed a full set of standards for inspecting children's homes. This was because new legislation (Children Order) was being brought forward. However, the following were used as interim standards:-

- The Children's Homes Regulations,
- The Model Scheme of Boarding Out Allowances (pocket money and clothing),
- The Castle Priory Report (staffing levels).

5. 1986 Inspection of Harberton House

The following are the main findings of the 1986 Inspection:-

- the home had an occupancy capacity of 25 places for children; there were 20 children in residence at the time of the inspection;
- staff ratios met the Castle Priory standards but there was some lack of opportunity for staff secondment to professional and in-service training;
- night staffing cover had been reviewed by Management as a result of a recommendation in the 1983 SWAG report. Senior staff were "on call" but not necessarily on the premises overnight;
- only two out of a required four visits annually by the Board's Personal Social Services Committee had been made. There was, however, a significantly high level of visitation (122 visits) by the Board's nominated visiting social worker during the year;
- Departmental representatives were to meet the Board's officers to discuss monitoring arrangements and the Board's monitoring statement for 1984;
- The Board's complaints booklet had not been issued to children due to an embargo by staff side interests. One complaint however, had been received from the mother of a child who had dislocated her elbow while fighting with another resident;
- Five residents had been removed to training school, resulting in a recommendation that the decision to place a child there should only be taken following a review by senior management; and
- Parts of the home were in need of decoration and some furniture needed replacing.

6. 1987 Inspection of Harberton House

The following are the main findings of the 1987 Inspection:-

- there were 20 children in the home during period of the inspection;
- the number of accidents and untoward incidents involving residents and the continuing use of training schools for short and long term placement, were a matter for concern;
- children who were spoken to informally had no serious complaints to make although the Western Board had not yet implemented the Departmental complaints circular. The officer-in-charge felt that staff sometimes had difficulty distinguishing between an untoward incident and a complaint and it was recommended that this might addressed through an in-service training course;
- staff ratios met the Castle Priory standards and there appeared to be some improvements on the 1986 situation with regard to staff professional and inservice training. A senior staff member was on the premises each night;
- the Board's visiting social worker, who had made 102 visits to Harberton during the year, was satisfied with the care provided to children, the administration of the home and the level of fieldwork visiting. The designated Personal Social Services Committee member had made the required four visits to the home;
- due to the number of accidents to children, there was a need for staff to be extra vigilant during the children's recreation time;
- some children were receiving specialist help due to alleged or suspected abuse and referrals had also been made to adolescent/child psychiatry services;
- the Unit of Management's Principal Social Worker (PSW) expressed a view that the methods of control and discipline employed by staff were "inadequate to cope with the type of children currently being admitted to care....in his opinion many of them came into children's homes with well established anti social problems which are difficult to modify and in some cases acceptable/unacceptable behaviour is difficult to identify". He also felt that the sanctions used by staff had little effect on residents.
- In the twelve months before the inspection took place, 6 children had been discharged from the home on Training School Orders and consequently it was recommended that management should review methods of control and discipline currently in use with a view to improving staff practice.

7. Report of Untoward Incidents in Harberton House

At 8th May 1990 SND 502 Acting Director of Social Services, wrote to me advising of child care difficulties being experienced in the Foyle Community Unit of Management. She indicated that the Unit had experienced an upsurge in the number of children requiring care and that this had stretched the resources for accommodating them particularly in the residential care sector. She expressed a view that the admission of a number of sexually abused children had particular relevance as it had been discovered that since February some of them had been abusing each other within Harberton House.

Attached to her letter was a copy of an Untoward Incident Report detailing this activity which involved seven children who were between 10 and 13 years old. SND 502 advised that the RUC were investigating and that the Board's General Manager and the Area Executive Team had been informed. She also sent a copy of a Status Report which detailed the use being made of care resources within the Unit of Management at 10th April 1990.

At 21st June 1990 I sent a minute to Dr McCoy, Chief Inspector, to update him on the situation pertaining in the Boards children's homes in anticipation of him making a planned visit to Harberton House and Fort James. Upon his return he wrote to Mr Hunter saying that the incident at Harberton House was a worrying development on two fronts (1) the overt sexual activity of pre-teenage children; and (2) the organised sexual activity in a children's home. He was particularly concerned that the group activity went on for some time without being detected until one of the children spoke of it to a staff member. At the time of Dr McCoy's visit, the Board had not put in place a full investigation into how this could happen or provided psychiatric / psychological care and treatment for the children and staff. In conclusion he asked that consideration be given to what could be learned, and what action should be taken from such an incident.

On 25th July 1990 I attended a meeting held to take forward the initiative made by the Chief Inspector. Attending also were Mr Hunter, Dr Harbison, Dr Sloan, Mr Kearney and Mr McElfatrick. After careful consideration it was agreed that further inquiries should be made into the incidents at Harberton House to investigate;

- why the incidents were not detected earlier;
- the role of individual staff members and the arrangements for the supervision of the children;
- what lessons can be learned from the incidents, including lessons for therapeutic work on a multi-disciplinary basis;
- the implications for training.

It was agreed that the Western Board should have ownership of the inquiry, which would be carried out by a person with experience of residential child care management. It was desirable that the work would be undertaken by someone outside of the Unit of management and it was suggested that a joint investigation with the Social Services Inspectorate might be appropriate. Following further discussions with Departmental representatives the Western Board initiated "a review of some current issues in the childcare service". This was undertaken by a team led by Mr R Bunting, Assistant Director of Social Services, Eastern Board, and comprised of MR J T Armstrong, Senior Social Services Manager and HH 37 Principal Social Worker, both from the Western Board. This team made 19 recommendations in its Report on the Circumstances Surrounding Incidents of Peer Child Abuse Which Occurred within Residential Care for SND 502 Acting Director of Social Services.

8. 1991 Inspection of Harberton House

This was the first inspection made of Harberton House following the discovery of incidents of peer child abuse there and the publication of the Review Team's report. The main findings and recommendations include the following:-

 Harberton House had a staffing establishment of 20 but in practice 28 were employed there. Seven were temporary staff covering in the absence of 4 staff on training courses and to help cover for an excess of children above its capacity;

- Six staff held relevant qualifications and many staff had more than 5 years experience;
- Management policy is for a senior staff member to be available in the home at all times and this responsibility is shared between 6 staff;
- While there was a good deal of informal supervision, formal supervision was only carried out once in every two months;
- Board policy is to encourage staff meetings but only when there was sufficient staff available to supervise the children;
- Exceptionally one boy had there for 2 years and 7 months though all of the others had lived there for less than 1 year and 4 months;
- Fifty children had been admitted and 22 discharged in the 12 months prior to 1st November 1990. However, another 13 children, who had been admitted previously, also left the home making a total of 35 discharges and this substantiates the home's claim of delivering a short to medium service for children in care.
- It would appear that the role of the Core Executive Team (CET) for vetting applications for admissions and for monitoring the progress of assessments has diminished;
- The primary worker and "backup" arrangement may be confusing for some of the residents.
- Although the Board had introduced a policy of access to their own files for children aged 14 and over this had not been implemented at Harberton;
- Generally the statutory records held in the home were found to be satisfactory;
- The Complaints Procedure for Children in Residential Care and their Parents (Departmental Circular HSS (CC) 2/85 had not been implemented in Harberton.

9. 1982 Inspection of Fort James Children's Home

There were 23 recommendations made following the 1982 inspection. These included the need to address the following management and professional practice issues;

- an urgent review of the use of Fort James for the emergency admission of children:
- pressure on the children's bedroom accommodation;
- contact between residential staff and foster carers in prospective fostering placements;
- the "arrangement" implemented by the officer in charge to be compatible with Circular HSS(F)12/74;
- clearer definition of management roles with clarification of the limits of delegated authority;
- formal arrangements for the professional supervision of staff;
- an increase in the staffing establishment;
- the employment of male staff to be encouraged;
- the Medical Book to be regularly maintained.

10. 1987 Inspection of Fort James

There had been several positive developments at this facility since it had been previously been inspected. These included the following:-

- a reduction in capacity to 19 places for children, 16 resident in the main building and 3 others living in adjoining flats where they were being prepared for living independently;
- it was noted that 6 of the children had been assessed in Harberton House before coming to Fort James;
- although the Department's Complaints Procedure had not been introduced, the
 officer-in-charge had recorded three complaints brought to him and of the action
 taken as a result, and the children spoken to by the inspector said that if they were
 unhappy about anything they would complain to their key workers;
- the children's files kept in the home held relevant information, were orderly and recording was up to date;
- of 16 staff working in Fort James 11 held relevant qualifications. There was evidence of in-service training and formal staff supervision;
- the senior social worker (residential child care), who also supervises the officer-incharge, had visited the home over 100 times in the 12 months prior to the inspection.
 Board members had also visited regularly;

There was only one recommendation arising from the inspection and that was that the home should be redecorated.

11. 1991 Inspection of Fort James

The main recommendations made following the 1991 inspection included the following;

- the aims and objectives of the home to be reviewed;
- the policy of staff "acting up" to fill senior staff vacancies to be reviewed;
- better staff cover to be introduced at the weekends;
- formal staff supervision arrangements to be revised and fully implemented;
- care and supervision of the young people in the independence training unit to be reviewed;
- urgent consideration to be given to the location of the home and to whether a security service should be employed to patrol and check the buildings at night.

Following the 1991 inspection there was some misunderstandings about the recommendations made in the report. These were addressed in an inspection follow up meeting held on 17th December 1991between myself, an assistant chief inspector, and Unit management.

Signed: Laun F. O. Rayni

Date: 10th June 2015

FJH-5242

SWAG/7/86

STANDARD FOR MONITORING AND INSPECTION OF RESIDENTIAL CHILD CARE

ACTIVITY	STANDARD	LEGAL, PROFESSIONAL OR ADVISORY STANDARD	EVIDENCE
INVIRONMENT			-
iting of wilding	i. Residential area - avoiding isolation and extremes of housing standards (eg upper class residential areas or slum housing)	By agreement between Department and Boards	By observation
**.	ii. Easy access (ie walking distance or good public transport to schools, shops, employment, recreational facilities etc)		
	iii. Avoiding areas of particular sectarian tensions which would inhibit the placement of some children		
	iv. Inconspicious - the building should not be sited where its institutional nature is readily apparent		
ize of uilding	The size and design should be such as to avoid institutional buildings and current stock should be suitably adapted so as to achieve an environment which is consistent with the needs of the residents.		
ccommodation	i. Size of rooms should at least be to the standards set in the Community Home Design Guide ie -	Community Home Design Guide	By measurement
	a. Bedrooms - room that comfortably accommodates bed, wardrobe/dressing table and chair b. Living and dining rooms		
	b. Living and dining rooms c. Kitchen		
	d. Bathroom		
	e. Administration	:	

Accommodation (continued)	ii.	Where possible there should be bedrooms of varied size, including a proportion of single rooms so as to facilitate flexible use. Dormitory style provision which is impersonal in character should be avoided.	By agreement between Department and Boards	By Observatio
	iii.			n
·	iv.	Good standard of maintenance - no obvious signs of damage by residents, all systems and equipment functioning, (a system of maintenance that enables defects to be remedied rapidly)	a	ti
	v.	Decoration - domestic in character and variety providing "warm" environment - avoiding use of institutional colours, gloss paint on walls etc	"	н
	vi.	Furniture - domestic in character - quality good enough to a. encourage residents to respect it and b. survive some abuse and rough treatment		n _e - e
-	vii.	Pay telephone for residents	10	11
	viii.	Safe outdoor play area.	n .	"
recautions	,	Building and equipment conforming to standards laid down by Health and Safety Inspectorate/Northern Ireland Fire Authority.	Health and Safety at Work (Northern Ireland) Order 1978	Examination of Records
	ii. ~	Periodic inspection by Health and Safety/Northern Ireland Fire Authority	Conduct of Children's Home Regs. (NI) 1975 Para 8(b) C&YP (Vol Homes) Regs (NI) 1975 Para 10(b)	Examination of Records
	iii.	Regular inspections by Unit of Management Fire Prevention Officer	By agreement between Department and Boards	

Fire
precautions
(continued)

- iv. All staff trained in fire prevention and management. Staff knowledgeable of procedures to be used in the event of a fire or other emergency.
- v. Fire drills to be held regularly and arranged by the officer in charge or his nominated deputy in a manner to ensure all staff gain fire practice experience. Norm of one every two months but Observation and Assessment centre may require more, Family Group Home fewer.

MONITORING

Visit by PSSC Member

Every three months, preferably when the children are in the home

Production of report covering names of all staff seen; records inspected; physical condition of the home, its furnishings and equipment; impression of the operation of the home; complaints by staff or children.

Visit by managing Social Worker (APSW) 55W Monthly to meet reporting requirements. However, it is expected the manager in the Unit of Management will need to be in the home much more frequently in their supportive managerial role.

Production of report covering general management of the home; standards of professional practice; admissions and discharges; staffing matter; training; maintenance of statutory records and compliance with Direction/Regulation; untoward events; complaints; identification of any matters requiring attention by management.

Visit by Assistant Director or Principal Social Worker Annual: Production of comprehensive monitoring report including the aims and objectives of the home; the extent to which they are being achieved; the adequacy of staffing levels; the proportion of staff who are professionally qualified; training programmes; the effectiveness of senior staff in deploying resources; adequacy of systems of supervision for staff; standards of professional practice; identification of any statutory or agency requirements not being met.

Conduct of Children's Homes Direction (NI) 1975 Para 8 (2) C&YP (Vol Homes) Regs (NI) 1975 Para 10(2)

Conduct of Children's Home Direction (NI) 1975 Para 8 (2) C&YP (Vol Homes) Regs 1975 Para 10 (2)

Conduct of Children's Home Direction (NI) 1975 Para 3 (2)

Conduct of Children's Home Directions (NI) 1975 Para 3 (3)

Board's monitoring statements

WESTERN HEALTH AND SOCIAL SERVICES BOARD LONDONDERRY, LIMAVADY AND STRABANE UNIT OF MANAGEMENT

INSPECTION OF:-

Fort James Children's Home

15 Ardmore Road

Tullyally

Londonderry

Telephone (0504) 4311

TYPE/FUNCTION OF HOME:-

Fort James provides medium/long term residential care for up to 19 children between the ages of 5 and 18 years but with an increasing tendency towards catering for adolescents. Sixteen children can be accommodated in the main building and the other occupy flats to the rear of Fort James where they are preparing for living independently in the community.

RESIDENT CHILDREN BY AGE AND SEX (30/5/87)

	BOYS	GIRLS
Under 7	0	0
8-11	3	2
12-15	8	2
16-18	_0	<u>2</u>
TOTAL	11	6
DATES OF INSPEC	TT (N · _	

17/18 June 1987

TIMES OF ARRIVAL/DEPARTURE:-

Wednesday 17 June 1030-1600 Thursday 18 June 0930-1430

SOCIAL SERVICES INSPECTOR:-

D P O'Brien



FOYLE COMMUNITY UNIT



Please use this reference in your reply

Our Ref:

6th Sept 1991

Your Ref: Date

Mr Dennis O'Brien Social Services Inspector Department of Health and Social Services Dundonald House Upper Newtownards Rd BELFAST BT4 3SS

Dear Dennis

RE: FORT JAMES INSPECTION - DRAFT REPORT

Further to our meeting on the 23rd August 1991 I thought I would take this opportunity of highlightling some of the main points of our discussion.

Firstly, I was very disappointed about the negative tone of the report and though I did not seek to dispute some of the matters of fact I indicated to you that the report was unbalanced in that it did not take account of the action which management had initiated to address some of the very points that you had highlighted. You may recall that in the course of my meeting with you in January 1991 I discussed with you action that I and other managers had instigated and I was subsequently in correspondence with you to make you aware of the progress in respect of the Extern scheme with youths from the Tullyally area. The report, in my review ,gives the impression that management were aware of some of the difficulties and that we did not take any corrective action. This is very much contrary to the actual situation.

In specific terms we had initiated action to renovate the interior of the unit not only to improve the quality of the physical environment but also to address issues surrounding improving the level of supervision and the quality of life for individual residents to which you referred in your report. This programme commenced in April 1991 and I understand was brought to your attention at the time of your visit. Similarly I recall talking to you at some length about the efforts we had made in speaking to the local community, local public representatives, the police and Extern to address the issue of intrusion on Fort James property by youths from the local area. Up until the present time the action we took has had a beneficial impact in that there has been a significant reduction in this sort of incident. During my meeting with you I also referred to Paragraph 4.3 of your report which indicated that management should not have released both the Officer-in-Charge and the Deputy Officer-in-Charge to take up post elsewhere within the WH&SSB within such a brief timescale. I indicated to you that we had no control over this situation particularly

Riverview House, Abercorn Road, Londonderry, N.Ireland BT 48 6SB Telephone L'Derry (0504) 266111

LH₉

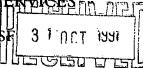


DÉPARTMENT OF HEALTH AND SOCIAL SERVICES

Dundonald House Upper Newtownards Road Belfast BT4 38

Telex 74578

Telephone 0232 (Belfast) 650111 ext 420



Mr G Carey
Assistant Unit General Manager (Acting)
Foyle Community Unit
Western Health and Social Services Board
Riverview House
Abbercorn Road
LONDONDERRY BT48 6SB

Please reply to The Secretary Your reference

Our reference

Date

29 October 1991

Dear Gabriel

FORT JAMES CHILDREN'S HOME

You will recall that we met 23 January last after I had carried out an inspection of Fort James Children's Home. At that time I expressed concerns about the conditions I found there, the management and staffing arrangements, difficulties arising for staff and residents because of the location of the home, and, the frequency of untoward incidents arising involving local youths.

You said that you were already aware of most of the problems and felt that management was making a considered response to them. Specifically you told me that following a visit to the home by the Unit General Manager and an officer from the Board's Works Department, approximately £60,000 was to be made available for improvements to the main building and to secure the premises. You advised also that the Extern Organisation had been requested to undertake work with youths from the Tullyally area and indeed you subsequently sent me a progress report on this development (22 April 1991).

I want you to know that I was reassured by this discussion with you. Indeed I had spoken to Dr McCoy and Mr McElfatrick about my preliminary findings at Fort James and advised them that I thought urgent action was required to improve the situation. However, when I reported the content of our discussion to them they agreed that I should complete and issue the inspection report in the normal way.

I acknowledge receipt of your letter dated 6 September 1991 commenting on the draft inspection report which we discussed on 23 August. The measures which management had taken or proposed to take to address the problems identified in the report are referred to in paragraph 6.12.

Thank you for your assistance.

luis O'Brees

Yours sincerely

D P O'BRIEN

Social Services Inspector

WESTERN HEALTH & SOCIAL SERVICES BOARD

FOYLE COMMUNITY UNIT

MEMORANDUM

TO:

Mrs S Burnside, UGM

FROM:

Mr G Carey, A/AUGM

DATE:

12 November 1991

RE:

SSI Inspection Report on Fort James Children's Home - January 1991

I understand that you have now received the final copy of this inspection report. You may recall that I spoke to you some time ago about this matter when we received a copy of the draft report. At that time I was unhappy about both the tone and the content of the report and arranged to meet with Mr Denis O'Brien on 23 August 1991 to share my disappointment about the negative tone of the report and to appraise him of the action that management had initiated to address some of the very points that he had highlighted. I was especially disappointed that some of these corrective actions were not taken into account in the draft report since, in the course of my meeting with Denis O'Brien in January 1991, I had discussed with him the action that I and other managers had instigated and it is a matter of some regret that these were not taken into account in the final report. I did in fact write to Mr O'Brien on 6 September 1991 to highlight some of the main points of our discussion of 23 August 1991 and in his letter to me dated 29 October 1991 he indicated that "the measures that management had taken or proposed to take to address the problems identified in the report are referred to in paragraph 6.12". This paragraph certainly does not take adequate account of the points that I raised with him. I attach for your information a copy of my letter dated 6 September 1991.

I appreciate that this matter may be raised at Board level and with that in mind I thought it may be helpful for me to outline some of the reservations I have about the report by addressing the recommendations. This will also facilitate a critical analysis of some of the matters raised in the main body of the report.

Recommendation 1:

The aims and objectives of Fort James should be reviewed by management.

There was a recognition by management that the aims and objectives of Fort James should be reviewed because of the number of emergency admissions we had been experiencing over the last two years and in fact Mr O'Brien refers to the annual monitoring statement when it was acknowledged that because of this situation, the home had not met its principal objective as a long-stay unit for adolescents and in view of this, management is to "carefully monitor the situation on an ongoing basis". In addition, we were conscious of the

SSI/380/91

FOLLOW UP TO INSPECTION OF FORT JAMES CHILDREN'S HOME

INTRODUCTION

- Inspectorate during the week beginning 14 January 1991 and the inspection report was issued on 31 October 1991. On 23 January 1991 the inspector involved met with the assistant anit general manager (acting) with responsibility for social care and advised him of his preliminary findings at Fort James. Specifically he expressed concern about the condition of the premises, the management and staffing arrangements, the frequency of untoward incidence at the home involving youths from a nearby housing estate and other difficulties arising for staff and residents because of the home's location.
- The inspector was reassured by the response of the assistant and wanager who acknowledged most of the problems and shared his plans for tackling them. He disclosed that, following a visit to the home by the whit general manager, approximately £60,000 was to be made available for adaptations to the premises and that the Extern organisation had been asked to engage young people living in the immediate vicinity of the home in a programme of constructive activities. The inspector was informed about some of the developments made over the following months by correspondence and through discussion with