TRIENNIAL INSPECTION OF HARBERTON HOUSE AND FORT JAMES CHILDREN'S HOMES 1994 - WHSSB

1. In May 1992 I joined the Social Services Inspectorate as a Social Services Inspector. Under Section 168 of the Children and Young Persons Act (NI) 1968, I undertook the triennial inspection of WHSSB's statutory children's homes (Harberton House, Fort James, and Coneywarren) and, the annual inspection of Nazareth House in Londonderry in 1993/94. Mr N Chambers (Inspection Manager) and I provided an overview of the key findings of the inspections to senior Board staff on 26th June 1994.

2. The previous triennial inspection of the three statutory children's homes was undertaken in 1991 by Mr D P O'Brien. Mr O'Brien provided a briefing on the homes prior to me undertaking the inspections, having previously introduced me to the Officers in Charge of each home. Mr O'Brien also made me aware of the findings of a report on the circumstances surrounding incidents of peer child abuse at Harberton House children's home which were identified in March 1990 (Annex 1 refers - see the Bunting Report). He also provided me with a copy of the report to provide me with a wider context for the inspection.

3. The inspection files and general WHSSB Family and Child Care files opened and retained by me are not now available; probably due to the implementation of the Department's file destruction policy.

4. The following comments are, therefore, based on a review of:

   - the inspection reports prepared by me in respect of Fort James and Harberton House children's homes;
   - the Harberton House peer abuse report (the Bunting Report); and
   - a lever arched file of WHSSB documentation provided to me by the Department's legal advisor.

(i) WHSSB Homes

5. In 1994 the WHSSB's homes provided residential care for children in three large children's homes; two of which were located in Londonderry and the other in Omagh. It also had access to voluntary children's home places in Nazareth House (Londonderry) and Nazareth Lodge (Belfast). Children whose behaviour was not able to be managed within a children's home setting were transferred to training schools located in either Belfast or Bangor and accessed according to the child's religion.

6. Unlike voluntary children's home the Department has no regulatory requirement in respect of Board's statutory children's homes, as they were required to provide homes for children in their care. (Section 92 of the Children and Young Persons Act (NI) 1950, re-enacted by the Children and Young Persons Act (NI) 1968). Day to day responsibility for the management of these statutory homes lay with an Assistant Principal Social Worker located within Foyle's Family and Child Care Programme of Care who reported to the Programme Manager.

(ii) Fort James Inspection 1994

7. Fort James children's home was structured into two units:

- an Adolescent Resource Team providing 12 residential places for young people aged over 13 years. Its aim was to provide "a care service from reception to long stay which would address the assessed needs of residents." and
- a Leaving and Aftercare Team which had access to three flats providing four places for young people preparing to leave care. An aftercare support/crisis intervention service was also provided for young people who had left care.

8. The 1994 inspection of Fort James took place between the 17th and 21st January 1994. A total of 52.5 hours were assigned to completing the inspection fieldwork. At that time the future of the home was uncertain as the Board had

informed staff in September 1993 of its intention to close the facility. A "decommissioning group" was in place to undertake work on taking forward plans for the home. Uncertainty about the home's future caused some residential staff to "express difficulty investing in their work and developing the service." (Annex 2 refers -see Para 11.2, Page 35 of the Inspection Report)

9. In the year preceding the inspection, there was considerable disruption within the home, due in part to the high number of admissions to, and discharges from Fort James. The behavioural challenges presented by children and young people also contributed to an unsettled care environment; as had instability within the staff group caused by high levels of sick leave and the recruitment of temporary staff.

10. The layout of the building, particularly in the bathroom and bedroom areas, made the supervision of children and young people difficult; a problem recognised by staff, Board managers and noted in previous Inspection Reports. Problems of young people entering other residents' bedrooms during the night were identified. Not all such instances were, however, detected by staff.

11. In December 1993 staff became aware that young people were using pipes in the home to tap out messages to others. They also found a young person hidden in the divan base in another boy's room. The boys acknowledged that this incident was not a one off event. The re-employment of waking night staff was, therefore, being considered.

12. A negative pregnancy result, in respect of a girl who claimed to be pregnant by one of the male residents, did not trigger a fuller investigation of the risks posed by this boy although staff had "concerns about the appropriateness of this young man's contact with a number of girls in the unit." (Annex 2 refers - see Para 9.2, Page 27 of the Inspection Report)

13. The majority of young people resident in Fort James had previously been sexually abused. Staff were alert to the risk of inappropriate sexual abuse but "given the age group of the residents, their past experience of abuse and the

layout of the building it was often difficult to detect incidents." (Annex 2 refers - see Para 9.2, Page 27 of the Inspection Report).

In the Untoward Incident File, three incidents of inappropriate sexual behaviour involving young people had been recorded in the year preceding the inspection. It was my view that the records possibly underestimated the scale of the problem due to the issues raised at Para 8 and 9 above.

14. Under the Standard, "Each child has the right to be protected" I noted problems such as:

- a high incidence of self-harming behaviours, possibly correlated to children and young people's past experience of sexual abuse;
- solvent abuse;
- bullying and horseplay at times resulting in injury to the young people involved; and
- the use of restraint to effect compliance rather than to afford protection.

15. In total, 196 Untoward Incidents were recorded in the year preceding 1st January 1994. The scale and nature of the Untoward Incidents was in my opinion linked to matters which included:

- the constant throughput of young people with a range of challenging behaviours. In the year prior to the inspection there were 31 admissions to Fort James of whom 25 were discharged in year, along with 12 other discharges;
- the inability of the home to operate to its Aims and Objectives given the demand for residential child care places within Foyle Trust as illustrated by its admission of eight children in year aged under 13 years of age;
- the practice of admitting children and young people on an emergency rather than on a planned basis;
- admissions at time appeared chosen as a last resort rather than as a positive choice. This meant that at times residential care was used too late in the care planning process;

- some young people were admitted in the absence of alternatives and entered the home with staff feeling they could not realistically meet their needs;
- considerable instability in the staff group due to sick leave, casual sick leave, the use of temporary staff and high levels of overtime averaging 123 hours per month in the year preceding 1st November 1993 (range 72½ - 215 hours).

16. In addition to the 196 Untoward Incidents there were 10 complaints recorded; one of which was made by Contact Card. Five complaints were made by a young person with learning difficulties who was the subject of ongoing victimisation by his peers. Three complaints were against staff and related to allegations of force, attitude to young people and misuse of the Board car. None of the complaints related to sexual acts between children although the Board's policy required all allegations of a sexual nature to be recorded as such. The number of recorded complaints is, therefore, lower than would have been the case had the Board's policy been operationalised.

17. Of significant concern was the Board's plan to close Fort James given the level of demand placed on the home and the likely impact such a closure would have on the effective operation of the Board's other homes. Of particular concern was the plan to increase the occupancy of Harberton House to 28 places to cope with the decommissioning of Fort James. In April 1992 Harberton House's numbers had been reduced from 25 to 20, following incidents of peer sexual abuse at the facility.

18. Due to concerns regarding the Board's plans SSI took action through the Child Care Policy Branch, the Management Executive, and, in direct liaison with the WHSSB and Foyle Trust to ensure that its plans for residential care were based upon:

- a comprehensive child care strategy;
- a detailed preventative strategy;

- a review of the number of beds required to support the Board's overall child care strategy;
- the development of a range of alternative placement options; and
- an assessment of the likely impact of closure on the remaining homes within the Board's area.

19. The Board and Trust, however, continued to progress the plan to close Fort James. The home closed on 31st March 1995. To assist the Board manage the situation, it increased the number of places at Harberton House from 20 to 28.

(iii) Harberton House Inspection 1994

20. Harberton House was inspected between the 21st and 25th February 1994. A total of 52 hours was assigned to the inspection fieldwork. The home had two units of 10 structure as:

- a reception/assessment unit; and
- a medium stay unit.

Both units were intended to care for children aged between five and twelve years of age for a period of up to one year. The occupancy level of the home in the year preceding the inspection was 98% and for more than half of the time (54%) it operated at full or over capacity levels.

21. At the time of the inspection 14 children had their own bedroom. When numbers exceed 20 the incidence of sharing bedrooms also increases. The layout of the building with its central corridor and bedroom wings at either end of it made the supervision of children difficult, particularly as children moved freely across both units and the homes extensive grounds. This finding was previously noted in the Bunting report of 1990:

"... the juxtaposition of assessment and medium stay care is not advisable as there is separation in name only." (Annex 3 refers - see Para 10.11, Page 53)

22. As both of the units catered for children across the 5 -12 age range, it meant that staff had to address the needs of children across the group. In addition, the home also cared for older children. At the time of the inspection there were 21 children resident. The average age of 10 of them was 10 years 6 months (range 6 years 3 months – 10 years 7 months). The average age of the other 11 children was 14 years 11 months (range 13 years 2 months to 17 years 2 months). In addition to not operating within its stated age range, the home also did not operate within its stated timescale of placements lasting for up to a year. Nine of the current children had been resident for on average, 2 years 4 months (range 1 year 4 months to 4 years 5 months); while in the year preceding the inspection, 26% of discharge children had lived in the home for an average of 1 year 10 months (range 1 year 1 month – 3 years 6 months).

23. The home was unable to operate to its Aims and Objectives for reasons which included:

- the absence of a statutory children's home to care for younger children who required long-term care, particularly Protestant children;
- a number of children settled in the home and did not want to leave;
- it did not generally operate as a feeder unit to other residential facilities; and
- the level of demand for residential places meant the home had to admit children regardless of their age whenever there was a vacancy at the home;
- in the preceding two years there was an increased demand for residential places in Foyle for older adolescents.

24. To deal with the increase in demand, the Assistant Principal Social Worker responsible for Foyle's children's homes noted that a bungalow on the site could be opened as a four bedded unit. In effect this would increase the capacity of Harberton House to a maximum of 29 and a minimum of 24.

25. Rarely were children admitted on a planned and phased basis to the unit.

26. I found significant levels of bullying which in part, was explained by the age range of children cared for within each unit. A total of 14 complaints were recorded in the complaints register half of which related to bullying or inappropriate sexual behaviour between children. Seven complaints were made against staff, three of which were made by parents. The investigation of one complaint ceased when the mother withdrew it even though her daughter had sustained bruising as the result of having been restrained.

27. I had concern about the lack of independence in investigating complaints. I also noted one complaint made by a 10½ year old boy to his social worker and a residential care worker about his treatment was not recorded as a complaint, though it was recorded in the unit's day book. The matter took four months to come to light when children in another children's home brought it to staff's attention.

28. The number of complaints was probably under recorded. This view is based on findings from a sample of children's case files. In addition, the WHSSB's policy required that all sexual activity between children should be recorded as a complaint. Of the five such incidents recorded in the Untoward Incident file, two were recorded as complaints. Some children also reported that they felt pursuing a complaint would adversely affect their relationship with staff. There was also evidence that staff felt vulnerable about complaints being made against them. The suggestion from the Team Meeting minutes was of a series of unfounded allegations or complaints being made against them. The Complaints Register did not, however, substantiate this view.

29. I also identified issues relating to the use of restraint for compliance purposes and the practice of using a duvet to wrap around a child as part of the restraint technique employed. Issues identified by the children included:

- difficulties living in a group comprising younger and older children;
- bullying, name calling and feeling picked on;
- items going missing from their rooms.

30. In relation to the protection of children it should be noted that the majority of children resident in Harberton House had previously been sexually abused or there were suspicions that they had been abused in this manner. The staff were aware of the increased risks associated with the children's previous experience of abuse and were familiar with the Board's Child Protection Policy and Procedures. A number of the incidents of child sexual abuse occurring within the unit were dealt with under the Child Protection Policy and Procedures.

31. In the year preceding 1st January 1994 there were 34 Untoward Incidents recorded: five of which related to inappropriate sexual behaviour; seven were incidents of self-harm or the misuse of tablets; two related to bullying; nine related to absconding; and four involved restraint. I identified substantial under-recording of Untoward Incidents within the unit. For example, only two instances of bullying were recorded yet 53% of children responding to the questionnaire identified bullying as a problem. See also paragraph 26 above in which I note that I found significant levels of bullying.

32. I also identified that there had been breaches relating to the vetting of two staff. The vetting process was not completed prior to them taking up employment in Harberton House. After 18 and 20 days in employment these staff's contracts were terminated due to unsatisfactory vetting reports.

33. Staffing included three waking night staff who were employed on temporary contracts. Staff reported that using inexperienced, temporary workers to cover vacancies or sick leave was at times counter-productive as it placed additional pressure on existing staff. Staff also expressed concern at the likely implications for the operation of Harberton House should the planned closure of Fort James proceed. Staff also reported that there was good team support and that generally morale was good.

Conclusion

34. The 1992/97 Regional Strategy highlighted the need for "a range of small, residential facilities geared to specialist tasks in order to meet the assessed

needs of children. The Board's plans to close Fort James and to increase numbers at Harberton House to support this objective ran counter to the Strategy.

35. In April 1995 I wrote to Chris Stewart, Management Executive, immediately following a meeting with Foyle Trust on 11th April 1995 to assess the adequacy of funding to the Trust's Family and Child Care Programme of Care (Annex 4 refers). At that meeting I was apprised that the Trust's funding was such that at times "decisions had had to be made relating to discharge of statutory functions and/or compliance with procedural guidance." I recall being told that funding was provided to the Board using the capitation funding with a weighting for social disadvantage and that the Department's funding was equitable. I further recall being told that the Board prioritised its spend across its Programme of Care and it was for the Board to re-profile its spending priorities.

Marion Reynolds
Date 9th June 2015

TRIENNIAL INSPECTION OF HARBERTON HOUSE AND FORT JAMES CHILDREN'S HOMES 1994 – WHSSB - SUPPLEMENTARY STATEMENT

1. The following supplementary Statement is provided to address questions posed by Counsel for the Inquiry on 14th June 2015 in relation to Paragraph 35 of my initial Statement.

2. Paragraph 35 states:

"In April 1995 I wrote to Chris Stewart, Management Executive, immediately following a meeting with Foyle Trust on 11th April 1995 to assess the adequacy of funding to the Trust's Family and Child Care Programme of Care. At that meeting I was apprised that the Trust's funding was such that at times "decisions had had to be made relating to discharge of statutory functions and/or compliance with procedural guidance." I recall being told that funding was provided to the Board using the capitation funding with a weighting for social disadvantage and that the Department's funding was equitable. I further recall being told that the Board prioritised its spend across its Programme of Care and it was for the Board to re-profile its spending priorities."

3. The following addresses each of the Inquiry's Questions:

(a) Was Chris Stewart a Departmental Official?

Chris Stewart was either a Deputy Principal Officer or a Principal Officer working within the Management Executive of the Department of Health and Social Services. I think amongst his duties he had responsibility for the WHSSB. I had previously experience working with Mr Stewart in relation to the funding of Nazareth House children's home in Londonderry.

(b) Who told her [Miss Reynolds] that the capitation formula was adequate?

In my initial Statement, I stated that I had been told that the Capitation Formula was “equitable”; I do not recall by whom this statement was made. I understood that “equitable” meant that there was a standard methodology by which monies were allocated across the four HSS Boards by the Department. In this respect the WHSSB was treated in the same way as the other Boards. I do not think any of the other Boards was claiming at that time that it was unable to discharge its statutory functions or comply with requirements although funded using the same methodology.

In this respect it is perhaps relevant to note that the WHSSB’s investment in developing fostering services in Foyle Trust to provide alternative care for children who subsequently were admitted to, or remained in, residential care was low, in my opinion. Foster care would have been in many cases a more appropriate way of meeting the needs of children as well as a more cost effective service model. It is my recollection that at the time of the 1994 inspections there was one Senior Social Worker (Fostering) with a small team of social workers; I think the team size was in the region of two fostering workers.

In addition the Board’s model of residential care was based on large children’s homes none of which were able to operate to their Aims and Objectives. The homes had to meet the demand for places either as vacancies occurred or by expanding their capacity to meet increased demand. The residential model caused, in my opinion, issues relating not only to the care of children but to increased operating costs. For example, through the recruitment of temporary staff, covering for significant levels of sick leave, and meeting the costs of high levels of overtime payments. Paragraph 15 of my initial Statement to the Inquiry records that at Fort James children’s home there were “high levels of overtime averaging 123 hours per month in the year preceding 1st November 1993 (range 72½ - 215 hours).

I recall preparing a discussion paper for the Chief Social Services Inspector, Dr McCoy, in and around the mid-1990s on family and child care services in the WHSSB. I recall that among other things I expressed concern about the structure of the WHSSB children's services. I recall that the paper included reference to the number of Assistant Principal Social Workers who effectively worked as office managers for each of the local social services offices. This meant that the span of control for Senior Social Workers who had responsibility for staff supervision and support was too great. Conversely, the range of responsibilities for the Assistant Principal Social Worker with responsibility for Foyle Trust's residential homes was, in my opinion, too wide.

The Regional Strategy for 1992/97 envisaged residential care as operating from smaller more specialist units; a model inconsistent with provision in the WHSSB.

(c) What was the formula, when was it put in place and how was it calculated?

The capitation formula was established in 1978. The allocation of resources to HSS Boards was based on a formula called PARR (Proposal of the Allocation of Revenue Resources). It was a combination of the formula used in England to allocate funds to the Regional Health Authorities and Revenue Support Allocation which was used to calculate the Personal Social Services expenditure requirements of English Local Authorities. The formula was based on weighted populations based on a range of Health Services and Personal Social Services. These separately weighted populations were then combined to provide a single weighted population that was used to share the available resources between Boards.

The Department in addition to the annual allocation of monies to HSS Boards also provided capital allocations to the Boards. The Department also provided additional revenue and capital monies to meet particular requirements or to implement new Guidance or to support service developments.

(d) Was the Board accepting the formula was adequate to provide it with the resources it needed, or was it the Department's view that the capitation formula with its weighting for disadvantage was adequate and it was up to the Board to allocate its resources to cope with the risks she [Miss Reynolds] refers to but does not elaborate upon?

It is my understanding that all of the HSS Boards complained to the Department about the adequacy of their allocations and would have made cases for increases to meet various pressures. I was not involved in these discussions so have no personal knowledge of such discussions.

I understand that the Department allocated its share of the blocked grant to fund health and personal social services across Northern Ireland using the capitation formula. In my opinion the Department was responsive to the Boards when funding was available but had to live within the resources allocated to it from the block grant, upon which there were significant pressures.

The HSS Boards had significant levels of discretion regarding the use of the funds allocated to them by the Department guided, however, by the Department's policy directives.

I recall being told that the WHSSB disproportionally funded its older people Programme of Care to the detriment of its family and child care Programme of Care. I do not recall the source of this information.

In relation to the issue of risks referred to in Counsel's question, my comment in Paragraph 35 relates to Foyle Trust's expression of concern that "*the Trust's funding was such that at times decisions had had to be made relating to discharge of statutory functions and/or compliance with procedural guidance."* I do not recall being given specific examples to support the Trust's comment. Had specific examples been given I would have expected that these would have been detailed in my correspondence to Chris Stewart of 12th April 1995.

(e) What were those risks?

I have no recall of having had specific risks brought to my attention by Foyle Trust, see (d) above.

4. I recall that in the mid 1990s and subsequently work was ongoing within SSI to assess the adequacy of funding to family and child care services with a view to secure increased funding for this Programme of Care. The per capita spend on children when compared with England was identified as lower. A direct comparison was, however, difficult to establish as English Local Authorities provided juvenile justice services and also children's homes with education unlike their Northern Ireland counterparts.

Marion Reynolds

14th June 2015

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From : Marion Reynolds cc N J Chambers ACI

Date : 12 April 1995

C F Stewart 13/4/95

FOYLE COMMUNITY UNIT

1. On 11 April, 1995 I met with Mrs Elaine Way (U.G.M), Mr Gabriel Carey (Unit Director of Social Care) and Mr John Doherty (Programme Manager) to discuss professional practice issues relating to a specific case. During the course of the discussion I was informed that the level of funding was such that at times decisions had had to be made relating to discharge of statutory duties and/or compliance with procedural guidance.

2. The risks implicit in such a strategy are known to managers and the consequences have been apparent in cases coming to the attention of the Department. Given the claims made by the Senior Managers within Foyle there is a need to assess the adequacy of funding to the family and Child Care programme of care, particularly at this point in time.

3. I would welcome an opportunity to discuss these matters with you as written confirmation of the discussion will be required.

Marion Reynolds

MARION REYNOLDS